The development of the allied health support workforce

An evaluation for Health Education England

Health and Society Knowledge Exchange (HASKE)

HASKE

HEALTH & SOCIETY KNOWLEDGE EXCHANGE

University of Cumbria

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This project was commissioned by Health Education England (HEE).

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Executive summary

Context:

Health and Society Knowledge Exchange (HASKE) was commissioned by Health Education England (HEE) to evaluate the development of the support workforce across the fourteen allied health professions. This project aimed to map the existing allied health support workforce and bring together current knowledge and examples of workforce development. It was therefore delivered in close dialogue with the related project developing the enabling Education and Career Framework. The analysis and conclusions of the evaluation were used to produce a toolkit to enable departmental managers to successfully prepare for and implement the framework.

Methodology:

The data collection involved three stages:

- Scoping the current support landscape through conducting a review of existing literature, contacting allied health professional bodies, and interviewing AHP regional leads;
- The collation of quantitative data to map the current support workforce; and
- Deep dive interviews to explore the development of the allied health support workforce.

Findings:

- The study shows that the allied health support workforce landscape is varied and complex. Support workers have an integral role in supporting AHPs and enhancing patient care, but this is achieved in multifarious ways within and across the different allied health professions.

- The research findings indicate there are approximately 35,064 FTE support workers in the allied health professions across England: 34,358 FTE are employed in the NHS and 706 FTE are employed by independent healthcare providers. In February 2020, the 34,358 FTE support staff employed in NHS settings across England included: 17,773 FTE ambulance support staff, along with 16,585 FTE support workers in chiropody/podiatry, dietetics, occupational therapy, orthoptics, physiotherapy, radiography (diagnostic and therapeutic), art/music/drama therapy, prosthetics and orthotics, speech and language therapy, and operating departments.

- It is currently difficult to accurately map the size and scope of the support workforce due to the limited data available at both national and regional levels.

- The findings highlight significant variation in the job titles of the allied health support workers, which can be attributed to the distinct development of each profession and organisational factors. The support workers have a diverse scope of practice that is very much determined by the allied health service in which they are based and the specific needs of the patients in their care.

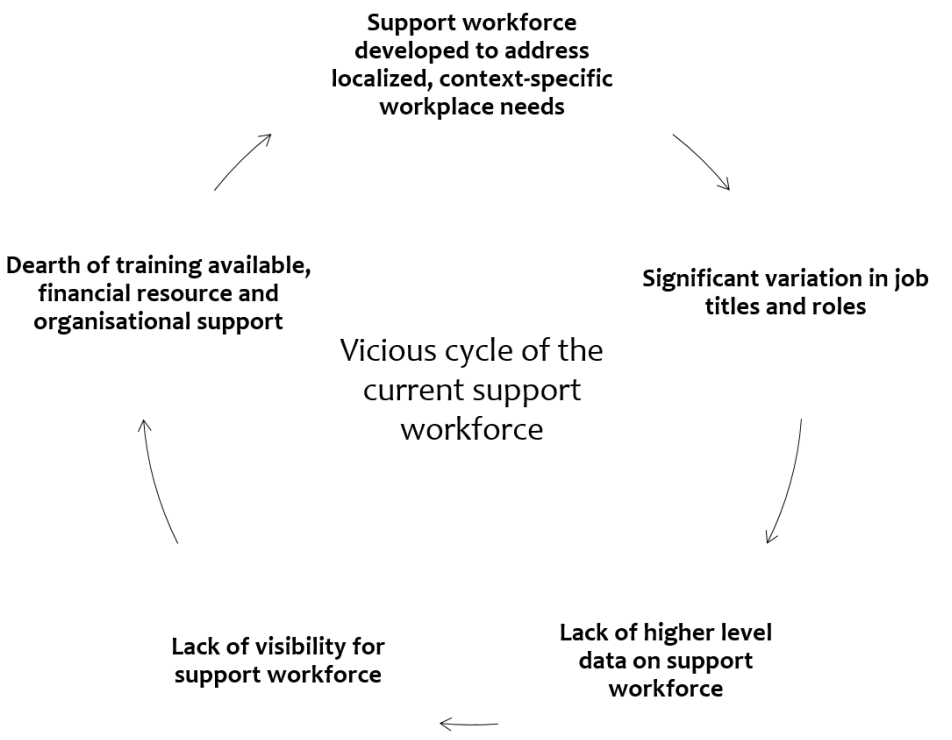
- The process of developing the support workforce can be hindered by a dearth of training aimed specifically at support roles, financial issues, time constraints and a lack of organisational support. In addition, the unregistered status of the assistant practitioner role can result in a lack of awareness about the scope of this role and the potential benefits for the whole allied health team.

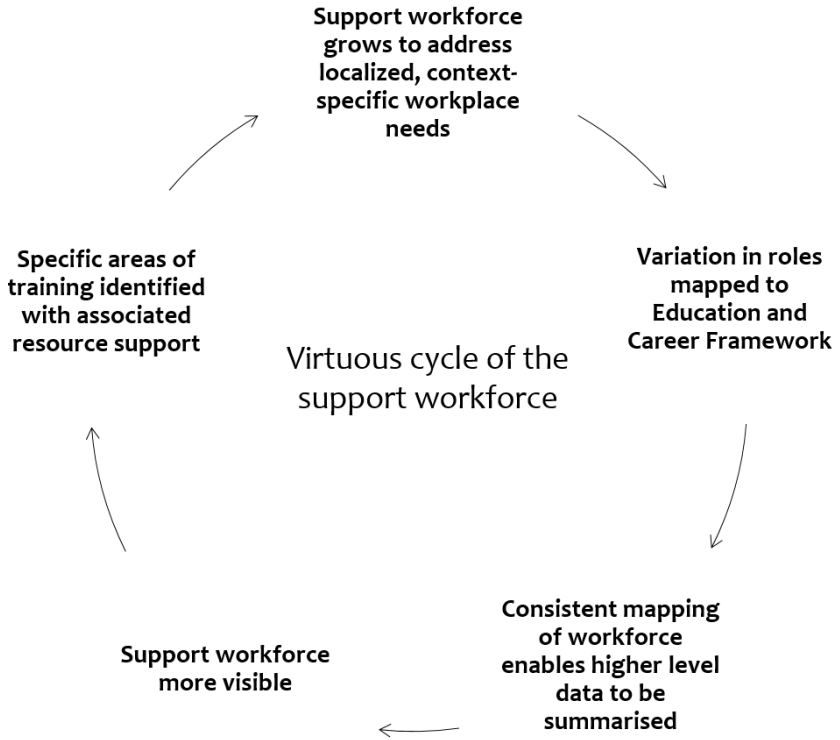
- However, upskilling has been successfully implemented in a number of different Trusts, through formal learning (e.g. the Care Certificate, level 2 and 3 NVQs, the level 5 assistant practitioner qualification, degree apprenticeships) and informal learning opportunities within the workplace. There was a particular emphasis on the development of niche skills to create sustainable learning for the support workers which enables role development and fulfils the specific needs of their service. The apprenticeship levy and band 4 assistant practitioner role particularly significant for some services.

- A theory of change was constructed based on the findings to capture the inputs, outputs and longer term outcomes of support workforce implementation.

- Overall, the findings show that developing the support workforce can be beneficial for the individual, the allied health service and the patients:
    - The support workers develop personally and professionally, expand their scope of practice and feel valued as members of the team.
    - The allied health service can improve staff retention, enhance the skill mix within the team, develop the scope of their service and experience a positive culture shift.
    - Patients can benefit from shorter waiting lists due to an increased capacity for appointments, along with a consistent and enhanced level of care.

- In this respect, the findings can be represented in terms of two cycles of practise: on the one hand, the current state of the workforce exists in what we might term a vicious cycle, where the localised significance of support roles do not translate into wider development opportunities to address population health needs. The challenge for the future is to turn this vicious cycle into a virtuous one, improving the representation of support workers and their activities and establishing them more effectively within wider organisational strategies, without losing their responsiveness to local need.





Conclusions and Recommendations

- In order to successfully implement change, it is important to undertake detailed workforce planning, engage relevant stakeholders and articulate a clear vision to their allied health team.

- This can only be done with a more consistent approach to data collection and reporting measures. Guidance for this is included in the Implementation Toolkit. Adopting a standardised approach to documenting the support workforce will enable the data to be easily reviewed and provide an accurate picture of the workforce. A template for this document is provided in the accompanying Implementation Toolkit.

- It is recommended that mechanisms for standardising the various job titles across the allied health support workforce are explored. This is likely to require consultation across professional bodies.

- The assistant practitioner role has been around for several years, but remains a less visible path into allied health professions. It would be beneficial to promote the role in specifically in terms of its ability to enhance the scope of practice for the whole allied health team, and to clarify any misperceptions that still exist about this unregistered workforce.

- Although some of the allied health professional bodies are actively involved with their support workforce, this is not the case across all 14 professions. Therefore, it is recommended that the professional bodies should review their approach to engaging support workers and consider strategies for raising the profile of their support workforce, including professional development opportunities.

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Acronyms

AfC	Agenda for Change
APEL	Accreditation of prior experiential learning
AHP(s)	Allied health professional(s)
BTEC	Business and Technology Education Council
CSP	Chartered Society of Physiotherapy
CT	Computed tomography
ESR	Electronic staff record
FTE	Full-time equivalent
GP	General Practitioner
GOsC	General Osteopathic Council
HASKE	Health and Society Knowledge Exchange
HEE	Health Education England
HCPC	Health and Care Professions Council
IAPT	Improving Access to Psychological Therapies
MRI	Magnetic resonance imaging
MSK	Musculoskeletal
NHS	National Health Service
NVQ	National Vocational Qualification
OT	Occupational therapy
RCOT	Royal College of Occupational Therapists
RCSLT	Royal College of Speech and Language Therapists
TAPs	Trainee assistant practitioners
TNAs	Trainee nursing associates

1. Introduction

1.1 Aims of the evaluation

Health and Society Knowledge Exchange (HASKE) was commissioned by Health Education England (HEE) to evaluate the development of the support workforce across the fourteen allied health professions. This project aimed to map the existing allied health support workforce and bring together current knowledge and examples of workforce development.

1.2 Context

1.2.1 The allied health professions

The allied health professions consist of 14 professional groups: art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, paramedics, physiotherapists, prosthetists and orthotists, radiographers, along with speech and language therapists. Thirteen of the allied health professions are regulated by the Health and Care Professions Council (HCPC), with the exception being osteopaths who are regulated by the General Osteopathic Council (GOsC).

In 2017, NHS England published *Allied Health Professions into Action* to provide a framework for effective practice and highlight the positive impact of a wide range of allied health roles on patient care. This strategy document emphasised that allied health professions are 'key to transforming health, care and wellbeing in England' (NHS England, 2017: 9). Allied health professionals (AHPs) are the third largest clinical workforce in the NHS and provide care for patients across most pathways:

> 'AHPs provide system-wide care to assess, treat, diagnose and discharge patients across social care, housing, education, and independent and voluntary sectors. By adopting a holistic approach to healthcare, AHPs are able to help manage patients' care from birth to palliative care. They focus on prevention and improving health and wellbeing to maximise the potential for people to live full and active lives within their family circles, social networks, education/training and the workplace.' (NHS Improvement, 2019)

According to HCPC data, there were 224,460 registered AHPs across the UK in February 2020. This included: 4765 art therapists; 13,037 chiropodists/podiatrists; 10,152 dietitians; 39,884 occupational therapists; 14,410 operating department practitioners; 1485 orthoptists; 28,901 paramedics; 57,992 physiotherapists; 1087 prosthetists/orthotists; 36,230 radiographers; and 16,517 speech and language therapists. The GOsC also had 5,334 registered osteopaths across the UK in March 2019. The registration figures represent professionals practicing in all sectors (e.g. both NHS and private practice), along with those who are still registered as AHPs but not currently practicing. In February 2020, NHS workforce statistics indicated there were approximately 99,958 full-time equivalent (FTE) AHPs in England working in the NHS, the ambulance service and independent healthcare providers (NHS Digital 2020a).

1.2.2 The allied health support workforce

1.2.2.a Support workforce roles

The 14 allied health professions are supported by a large group of unregulated workers who assist with the various services provided by AHPs. This support workforce has a wide range of job roles across the allied health professions, for example: dietetic assistant; healthcare assistant; occupational therapy support worker (also known as OT assistant, rehabilitation assistant, technical instructor, OT technician); physiotherapy assistant/support worker; radiography assistant or imaging support worker; speech and language therapy assistant; prosthetic technician; and assistant practitioner (sometimes known as associate practitioner)[1].

According to NHS Employers, 'more than a third of the NHS's workforce is made up of support workers in band 1-4 roles'. The majority of the support roles mentioned above are at levels 2 and 3 on the NHS Career Framework, and paid at bands 2 – 3 on the Agenda for Change (AfC) scale. The assistant practitioner role requires a higher level of knowledge and is therefore positioned at level 4 on the NHS Career Framework, and band 4 on the AfC scale. Although assistant practitioners are still unregistered, they are 'able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals' (Skills for Health, 2009: 2).

[1] This list is not exhaustive but provides an example of the support worker roles in different allied health professions.

It is evident that the wide variety of job titles used to identify the various roles across the allied health support workforce can result in a lack of role clarity (Imison et al., 2016; Cavendish, 2013). In a study of the allied health support workforce in London, it was reported that some trusts had tried to standardise the job titles used by their support workers, whereas other job titles were 'determined by the specific nature of the work they do or the locally agreed preference' (Allied Health Solutions, 2017: 34).

Core standards have been introduced for assistant practitioners (Skills for Health, 2009), but there is still a lack of standardisation for this higher level role with inconsistencies in the job title and duties, and various routes to acquiring the position (Mizzi, 2020; Miller et al., 2015; Miller, 2013; Bungay et al., 2013; Skills for Health, 2011; Spilsbury et al., 2011; Royal College of Nursing, 2010). Although the assistant practitioner role has been formally developed within some professions such as radiography (Johnson, 2012), particularly diagnostic imaging (Palmer et al., 2018), the implementation of this band 4 role across allied health professions has reportedly 'been patchy throughout the country' (Bungay et al., 2013: 8).

In addition, studies have shown that most of these support roles are undertaken by females (Skills for health, 2015; Kessler et al. 2010), with assistant practitioners reportedly most likely to identify as 'white British' females (Spilsbury et al., 2011).

1.2.2.b Support workers' qualifications

There is variation in the entry requirements for allied health support workforce roles, but most positions currently require GCSEs (e.g. maths and English, and possibly science), along with some experience of healthcare which can be acquired through voluntary or paid work, or caring for a family member (Health Careers Website). Some roles might also require NVQ or BTEC qualifications in healthcare/health and social care.

However, Skills for Health (2015: 21) reported that approximately a quarter of the support workforce are actually 'qualified to level 4 and above of the National Qualifications Framework'. Furthermore, a study of support workers across London reported that over 25% of their research participants were 'well educated with either a first degree, or a professional qualification from another country' which was not recognised by the HCPC (Allied Health Solutions, 2017: 6). Research also suggests that assistant practitioners are often 'home-grown' through internal training programmes (Spilsbury et al., 2011), which can mean that their specific experience is not

necessarily transferrable to other departments or organisations (Miller et al., 2015; Royal College of Nursing, 2010).

1.2.2.c The care provided by the support workforce

Several studies have highlighted the valuable contribution that the allied health support workforce makes to healthcare services (Allied Health Solutions, 2017; Imison et al., 2016; Willis, 2015; Skills for Health, 2015; Spilsbury et al., 2011; Lizarondo et al., 2010; Schneider et al., 2010). The support workforce can improve outcomes from the perspectives of both the patients and AHPs (Lizarondo et al. 2010). For example:

> 'There is good evidence that support workers can provide good-quality, patient-focused care as well as reduce the workload of more highly qualified staff' (Imison et al., 2016: 3).

The NHS support workforce 'provides a significant proportion of face-to-face patient care' (NHS Employers); this was evident in a study of secondary healthcare settings which identified that support workers in hospitals spend more of their time with the patients than the clinical staff do (Kessler et al., 2010).

The tasks undertaken by the allied health support workforce can vary depending on their skills and qualifications, the specific department(s) in which they work and how they are managed within the healthcare team. It has been suggested that the support workers typically undertake a range of 'clinical and nonclinical or administrative duties' which include 'assisting, supporting, monitoring, and maintaining' (Lizarondo et al., 2010: 151-152). In contrast, the duties involving 'evaluating, assessing, diagnosing, and planning' are generally undertaken by the registered AHPs (Lizarondo et al., 2010: 151-152).

The blurring of boundaries between support roles and AHPs has been identified as an issue within some professions. For example, the initial introduction of the podiatry assistant role was met with concerns about protecting the professional status of registered podiatrists (Webb et al., 2004), and the introduction of assistant practitioners in occupational therapy created ambiguity about role boundaries as there were overlaps in the tasks undertaken by the support worker and AHP (Nancarrow and Mackay, 2005). A key barrier to the assistant practitioner role has been the lack of registration (Hardie and Smith, 2017; Miller et al., 2015), along with a lack of understanding

amongst professionals about the role and responsibilities of assistant practitioners (Miller et al., 2015). Despite the initial ambiguity within occupational therapy, it has been suggested that the roles are differentiated by the assistant practitioner's level of responsibility, the language used by the AHP and assistant practitioner, and the management roles typically undertaken by occupational therapists (Nancarrow and Mackay, 2005). Furthermore, AHPs have suggested that 'the clinical reasoning behind the approach is what differentiates the professional from the support worker' (Allied Health Solutions, 2017: 50).

1.2.2.d Training and development opportunities

There has recently been a move towards developing the allied health support workforce and recognising the value of their various roles within healthcare services (for example: Allied Health Solutions, 2017; Imison et al., 2016; Rycroft-Malone et al., 2016; Willis, 2015; HEE, 2014; Cavendish, 2013; Spilsbury et al., 2011). In 2013, The Cavendish Review stated that the public image of the support workforce as providers of 'basic care' was outdated, as support workers were often responsible for undertaking a range of advanced and challenging tasks when providing patient care. The Cavendish review drew attention to a lack of consistency in training and job roles, which resulted in some support workers feeling 'undervalued and overlooked' (Cavendish, 2013: 6), and it was recommended that it was 'time to start seeing these support workers as a strategic resource, to both the NHS and social care' (Cavendish, 2013: 83).

Several studies have emphasised the lack of training and development opportunities for the support workforce (Allied Heath Solutions, 2017; Willis, 2015; HEE, 2014; Cavendish, 2013; Spilsbury et al., 2011; Kessler et al., 2010; Schneider et al., 2010). Most of the training available to support workers has been 'delivered through the in-service model' (Allied Health Solutions, 2017: 6), which has raised concerns about some qualifications not being transferable to other organisations (HEE, 2014).

In order to address inconsistencies in training and competencies, The *Talent for Care* framework was published in 2014 to encourage the healthcare workforce to 'Get in, Get on, Go further' (HEE, 2014). This strategic framework focussed on creating more opportunities for individuals to get into the field of care, supporting individuals in the job they do and enhancing career progression opportunities for the support workforce, including routes to registered AHP roles (HEE, 2014). Following this, the standardised Care Certificate was introduced in April 2015 for all new starters in the healthcare support workforce, and the apprenticeship levy came into effect in 2017 to encourage employers to develop their workforce. The Health Careers website currently indicates

that level 2 certificates, level 3 diplomas and apprenticeships are available for some allied health support roles, along with level 5 foundation degrees for assistant practitioners.

2. Methodology

2.1 Methodological approach

This research was informed by a realist model of evaluation which seeks to identify 'what works for whom in what circumstances and in what respects?' (Pawson, 2013: 29). This approach enables identification of the mechanisms that achieve effective outcomes within specific contexts.

2.2 Data collection and analysis

The data collection involved three key stages:

1) Scoping the current support landscape through conducting a review of existing literature, contacting allied health professional bodies, and interviewing AHP regional leads;
2) The collation of quantitative data to map the current support workforce; and
3) Deep dive interviews to explore the development of the allied health support workforce.

Ethical approval was granted for this mixed-methods study by the University of Cumbria Research Ethics Panel. The participants were provided with an information sheet detailing the research process and how their personal data would be used, and they were also asked to sign a consent form. The data was anonymised and pseudonyms were used to maintain confidentiality.

2.2.1 Scoping the landscape

A brief desk-based review of existing literature was conducted in order to develop an understanding of the allied health support workforce landscape (see section 1.2 of this report) and to identify potential sources for the deep dive interviews. The literature was drawn from a range of sources including: NHS, HEE and allied health professional body websites, reports and documentation; grey literature; and academic journals.

Emails were sent to the professional bodies for the 14 allied health professions, along with the regional hub contacts listed on the Council for Allied Health Professions Research website, to enquire about their provision for support workers and elicit examples of progressive support workforce development. The emails for the 14 professional bodies were initially directed to the contact listed on their website, and then additional emails were sent to contacts provided by HEE.

A purposive sampling strategy was used to identify AHP regional leads across England: HEE provided the main contact for each region (South East, South West, London, Midlands, East of England, North West, North East and Yorkshire), and the regional leads were then invited to take part in an interview to discuss the support workforce and identify examples of good practice in their area. As detailed in section 2.2.4, the timing of the project presented a challenge for the data collection and only one AHP regional lead was available for interview. However, three of the other AHP regional leads engaged with the project by sharing information and signposting the researcher to potential sites for the deep dive interviews.

2.2.2 Quantitative mapping of the support workforce

Although several sources appear to collect data about the registered AHPs (e.g. HCPC, GOsC, NHS Digital), the data relating to the unregistered support workforce is limited. At the start of the project, a request was sent to AHP regional leads for data about the number of support workers currently employed across each region; follow-up conversations with regional leads and HEE indicated that this data was not readily available at a regional level. Furthermore, communication (both written and verbal) with NHS Digital and NHS Improvement highlighted a lack of data relating to the allied health support workforce, with *NHS Workforce Statistics* being identified as the key source. NHS Improvement made a request for the researcher to gain temporary access to Model Hospital data, but unfortunately it was not possible to achieve this during the timeframe of the project.

The majority of the data presented in section 3 of this report was collated from the *NHS Workforce Statistics - February 2020* (NHS Digital, 2020a), published online in May 2020. As noted in section 2.2.4, the timing of this project coincided with the outbreak of COVID-19 which resulted in the NHS employing a significant number of (temporary) staff in both clinical and support roles. Although the NHS Workforce Statistics were updated within the duration of this project, it was agreed with the commissioner that the data collated in February 2020 provided a more accurate representation of the NHS workforce prior to the pandemic. In addition, *Independent Healthcare Provider Workforce Statistics – September 2019, Experimental* (NHS Digital, 2020b) and *NHS Workforce Statistics – March 2020 (*NHS Digital, 2020c) were also used to map the current support workforce. The quantitative data drawn from the NHS sources was analysed descriptively.

2.2.3 Qualitative deep dive interviews

Eleven deep dive, semi-structured interviews were conducted with 12 participants who had been identified through initial scoping phase of the project. The interviews were conducted via Microsoft Teams (eight) and telephone (three), and varied in length from approximately 40 minutes to 1.5 hours. All of the participants gave consent to record the interview for transcription purposes. The semi-structured interviews were guided by a schedule of questions (see Appendix 1), but the participants were still free to expand on their responses; this approach is often viewed 'like a conversation with a purpose' (Mason, 2002: 67).

The research participants were based in the following allied health professions: occupational therapy, operating department practice, orthoptics, physiotherapy, podiatry, radiography (diagnostic), and speech and language therapy. In addition, three interviews were conducted with participants involved with the development of assistant practitioner training routes, and a training course for support workers providing support to AHP students. The 12 participants were spread across five regions: South East, South West, Midlands, North West, North East and Yorkshire.

Using the basic principles of thematic analysis (Braun and Clarke, 2006), the qualitative data was categorised and coded to enable the identification of themes. Following the realist methodology, the key themes were then configured as *contexts, disabling mechanisms, enabling mechanisms* and *outcomes*.

2.3 Challenges with data collection

The timing of this project coincided with the COVID-19 pandemic which impacted on the recruitment of participants and access to information. It was evident that some of the individuals approached by the research team were not undertaking their usual duties, which affected their engagement with the project and caused significant delays in communication and interview scheduling.

3. Findings 1: mapping the allied health support workforce

3.1 Support workforce numbers

Although the HCPC, GOsC and some allied health professional bodies provide various data about the number of registered AHPs across the UK, they do not collect the equivalent data about the unregistered support workforce. This made it challenging to calculate the precise number of support workers within the allied health professions, as detailed in section 3.5. Therefore, the main data source for the information presented in this section was the NHS Workforce Statistics published by NHS Digital, which are based on monthly data collated through the electronic staff record (ESR).

The data presented in sections 3.2 – 3.3 indicate that the NHS and independent healthcare providers employ a total of 35,064 FTE allied health support workers across England (NHS Digital 2020a, 2020b).

3.2 Support workers employed by the NHS

In February 2020, NHS Workforce Statistics reported that the total size of the workforce providing support to clinical staff across England was 347,682 FTE or 401,365 headcount. This NHS support workforce includes three core staff groups:

- Support to doctors, nurses and midwives (262,540 FTE or 304,610 headcount);
- Support to scientific, therapeutic and technical staff (62,428 FTE or 72,428 headcount); and
- Support to ambulance staff (22,714 FTE or 24,690 headcount).

The NHS data relating specifically to the allied health support workforce is recorded across three staff groups:

- Support to AHPs - this contains data for 11 professions and is part of the core staff group 'support to scientific, therapeutic and technical staff';
- Support to ambulance service; and
- Operating theatres - this is a sub-category within the staff group entitled 'support to other scientific, therapeutic and technical staff'.

In order to calculate the size of the allied health support workforce within the NHS, the data was examined according to the roles listed under 'support to ambulance staff', 'support to AHPs' and 'operating theatres', and the relevant figures were extracted. As shown in Table 1, the data indicates that in February 2020, there were 34,358 FTE support staff working with AHPs across England:

NHS staff group	Number in staff group (FTE)	Support worker job roles	Number of support workers (FTE)
Support to ambulance staff	22,714*	Ambulance personnel & trainees (e.g. associate practitioner, assistance practitioner, emergency/urgent care support worker)	17,676
		Healthcare assistants & support workers	97
Support to scientific, therapeutic & technical staff	62,428 †	Support to AHPs: Chiropody/podiatry, Dietetics, occupational therapy, orthoptics/optics, Physiotherapy, Radiography (diagnostic), Radiography (therapeutic), art/music/drama therapy, prosthetics and orthotics, speech & language therapy	14,679
Support to other to scientific, therapeutic & technical staff: operating theatres	1906	Assistant practitioner, trainee/student, assistant	1906
		Total (FTE)	34,358

** Total figure includes: clerical & estates*
† Total figure includes: support to AHPs; support to healthcare scientists; support to other scientific, therapeutic & technical staff; clerical & administrative; estates

Table 1: Support staff employed by the NHS in February 2020 (NHS Digital, 2020a)

It should be noted that this is a conservative estimate which does not capture the entire allied health support workforce because the NHS workforce data does not explicitly record the number of staff supporting osteopaths and, as discussed later in section 3.5, the data about support for operating department practitioners is reportedly flawed due to the variation in the occupation codes recorded on ESR.

Table 2 presents the data for the 14,679 FTE support workers listed under 'support to AHPs' according to their support roles across each allied health profession[2]. Within all professions, the majority of support workers have been coded as *assistants*.

Allied Health Profession	Support role					Total number of support workers
	Assistant practitioner	Trainee/ student	Assistant	Healthcare assistant	Support worker	
Chiropody/podiatry	36	7	303	9	17	372
Dietetics	130	2	447	N/A	N/A	579
Occupational Therapy	543	41	2366	52	171	3172
Orthoptics/optics	105	47	196	N/A	N/A	348
Physiotherapy	755	23	3339	56	198	4371
Radiography (diagnostic)	659	121	3149	341	497	4767
Radiography (therapeutic)	31	11	170	N/A	N/A	212
Art / Music / Drama therapy	9	N/A	16	N/A	N/A	25
Prosthetics and Orthotics	3	N/A	3	N/A	N/A	6
Speech & language therapy	185	3	583	39	16	827
					Total (FTE)	14,679

Table 2: NHS support workers by allied health profession and support role (NHS Digital, 2020a)

Although operating department practitioners were formally classed as AHPs in 2017, the ESR data does not yet include them in the main staff group for 'allied health professions', which subsequently means that the support workforce is not yet included in the main staff group 'support to AHPs'. Therefore, in order to calculate the number of staff supporting operating department practitioners, the data relating to 'operating theatres' within the staff group 'support to other ST&T staff' was reviewed. As shown in Table 3, there were 1906 FTE support workers providing support to operating department practitioners:

[2] The data presented in Table 2 follows the professions and occupations as detailed in the NHS Workforce Statistics. For example: the professions of art, music and drama therapy are combined; the radiography support workforce is separated into diagnostic and therapeutic staff; there is no data indicating how many support workers provide support to osteopaths; and operating department practitioners are not recorded under the staff group 'support to AHPs'. In addition, 'N/A' indicates that the support staff role was not listed for that particular allied health profession.

Allied health profession	Support role			Total number of support workers (FTE)
	Assistant practitioner	Trainee/student	Assistant	
Operating Department Practice	337	94	1475	1906

Table 3: Operating department support workers employed by the NHS (NHS Digital, 2020a)

In February 2020, the total number of 'ambulance personnel & trainees' employed by the NHS was 17,676 FTE and the number of 'healthcare assistants & support workers' was 97 FTE, making a total of 17,773 ambulance support staff (see Table 1 above). Table 4 presents the data relating to the ambulance support workforce according to support role and care setting. It is evident that the majority of the ambulance support workforce are employed as *ambulance technicians/associate practitioners, emergency/urgent care support workers* and *ambulance care assistants*.

Staff group	Care setting	Support roles	Number of staff (FTE)
Ambulance personnel & trainees	Emergency Care	Ambulance Technician / Associate Practitioner	6096
		Assistant Practitioner	1502
		Trainee Ambulance Technician	10
		Emergency / Urgent Care Support Worker	4651
		Ambulance Personnel	1378
	Hazardous Area Response Team	Ambulance Technician / Associate Practitioner	2
		Assistant Practitioner	0
	Patient Transport Service	Ambulance Technician / Associate Practitioner	5
		Assistant Practitioner	0
		Emergency / Urgent Care Support Worker	35
		Ambulance Care Assistant	3002
	Education	Ambulance Technician / Associate Practitioner	4
	Call Handling	Ambulance Technician / Associate Practitioner	271
		Emergency / Urgent Care Support Worker	720
Healthcare assistants & support workers	Ambulance Service	Healthcare Assistant	3
		Support Worker	94
		Total (FTE)	17,773

Table 4: Ambulance support staff by care setting and staff roles (NHS Digital, 2020a)

The data presented in this section indicates that paramedics, diagnostic radiography, physiotherapy and occupational therapy employ the highest number of support workers within the NHS. This reflects the overall size of each profession as the four largest groups of AHPs are: physiotherapists (20,081 FTE), paramedics (16,783 FTE), occupational therapists (15,611 FTE) and diagnostic radiographers (15,105 FTE) (NHS Digital, 2002a).

In contrast, the professions which employ the lowest number of support workers across the NHS are prosthetics and orthotics, art/music/drama therapy and therapeutic radiography. Similarly, two of these professions also have the smallest number of AHPs: prosthetics and orthotics (82 FTE), and art/music/drama therapy (408 FTE). However, therapeutic radiography has an AHP workforce (2930 FTE) that is slightly larger than orthoptics (1667 FTE) and chiropody/podiatry (2682 FTE) (NHS Digital, 2002a).

The NHS Workforce Statistics for March 2020 are a quarterly analysis, published in June 2020, which include the 'area of work' for ambulance support workforce (NHS Digital, 2020c). As shown in Table 5, the majority of NHS ambulance support staff are based in ambulance services, followed by accident and emergency settings, and then administration.

Area of work	Number of ambulance support staff (FTE)
Accident and Emergency	2,323
Administration	1,070
Ambulance Services	18,034
Building Services	17
Clinical Governance	9
Clinical Informatics	4
Clinical Support	44
Community Health Services	119
Corporate	361
Dental/Oral	5
Domestic Services	3
Education	63
Estates	134
Facilities	12

Finance	32
General Medicine	7
Health and Safety	1
Human Resources	35
Infectious Diseases	1
Informatics	19
Intensive Care	1
Medical Physics	3
Mental Health Primary Care	1
Occupational Health	0
Paediatrics	1
Palliative Medicine	1
Performance Management	2
Primary Care	10
Purchasing and Supplies	1
Renal Medicine	6
Research and Development	1
Security	5
Service Planning	1
Staff Facilities	30
Telephone Services	247
Transport	350
Voluntary Services	5

Table 5: Areas of work for ambulance support staff (NHS Digital, 2020c)

3.3 Support workers employed by independent healthcare providers

In September 2019, the total number of support workers employed by independent healthcare providers in England was 706 FTE, which consisted of 701 FTE support to AHPs and 5 FTE support to ambulance staff (NHS Digital, 2020b). Although the NHS Digital data included working patterns, gender, age band, ethnicity and nationality, it was not possible to extract information about the number of support workers in each allied health profession or the specific areas in which they work.

3.4 Regional data for the allied health support workforce

The NHS Workforce Statistics provide regional data for the main staff groups - 'ambulance staff', 'support to ambulance staff', 'scientific, therapeutic & technical staff' and 'support to scientific, therapeutic & technical staff'. Although regional data is available for those supporting the paramedic profession, it is not possible to extract the regional data relating to the support workforce in the other 13 allied health professions. Therefore, the data presented in Table 6 includes a wide range of staff groups across each region of England:

	Number of NHS staff across each region (FTE)							
Staff group	**London**	**South West of England**	**South East of England**	**Midlands**	**East of England**	**North West**	**North East and Yorkshire**	**Total (FTE)**
Ambulance staff	2546	1975	2515	3628	1611	2326	2182	16,783
Support to ambulance staff	2797	1716	3573	4994	2637	3087	3910	22,714
Scientific, therapeutic & technical staff	27,928	13,881	19,050	26,044	12,519	22,449	24,351	146,222
Support to scientific, therapeutic & technical staff	9,372	6591	8401	11,714	6079	9583	10,688	62,428

Table 6: Regional data for ambulance staff/support workforce and all scientific, therapeutic & technical staff/support workforce (NHS Digital, 2020a)

The regional data for the ambulance support workforce indicates that the Midlands has the largest workforce, followed by the North East and Yorkshire, and then the South East of England.

3.5 Limitations of mapping the allied health support workforce

The following limitations were identified with the data available to map the allied health support workforce:

- Communication with some of the allied health professional bodies, interviewees and NHS Improvement highlighted inconsistencies within the NHS Workforce Statistics collected through the ESR data. Although some NHS trusts and regions have recently cleansed their ESR data, it was suggested that there are still flaws with how some roles are coded and

therefore the data does not accurately capture the allied health support workforce. In particular, as noted in section 3.2, orthoptists and their support workforce are not explicitly recorded through ESR data. Also, it was suggested that the support to operating department practitioners can be recorded on ESR through different occupation codes: whilst some support workers are recorded under 'support to other scientific, therapeutic & technical staff' in the subsection 'operating theatres', other support roles might be recorded under 'nursing support staff'.

- Through reviewing the March 2020 quarterly workforce statistics (NHS Digital, 2020c), it was evident that data relating to 'area of work' was available for AHPs and the ambulance support workforce, but not for the support workforce across the other 13 professions. The data was recorded for all the main staff group 'support to scientific, therapeutic & technical staff', but it was not possible to extract the figures relating solely to those who support AHPs. Through discussions with NHS Improvement, it was suggested that the 'area of work' field is often overlooked during ESR data input. The completion of this data field would enable further mapping and provide a more detailed picture of the areas of work and specialisms within the support workforce.

- Although the HCPC, GOsC and some of the allied health professional bodies routinely collect data about the number of registered AHPs, the equivalent data is not collected about the unregistered support workforce.

- An original intention of this research was to record the number of support workers across each of HEE's seven regions (North West, North East and Yorkshire, Midlands, London, East of England, South East and South West). However, communication with AHP regional leads and NHS Improvement indicated that this would not be possible because the data was not routinely collated at a regional level. It is possible that the support workforce data might be available at a localised level through approaching each individual NHS trust and independent healthcare provider, but the collation of this data was beyond the timeframe of this project and would therefore be an area for further research.

4. Findings 2: qualitative interviews

This section will present the findings of the qualitative data collected through the 11 deep-dive interviews. As outlined in section 2.2.3 the data has been configured as *contexts, disabling mechanisms, enabling mechanisms* and *outcomes* to allow the identification of causal relationships across the data.

Figure 1 provides an overview of the main themes and configurations identified across the data:

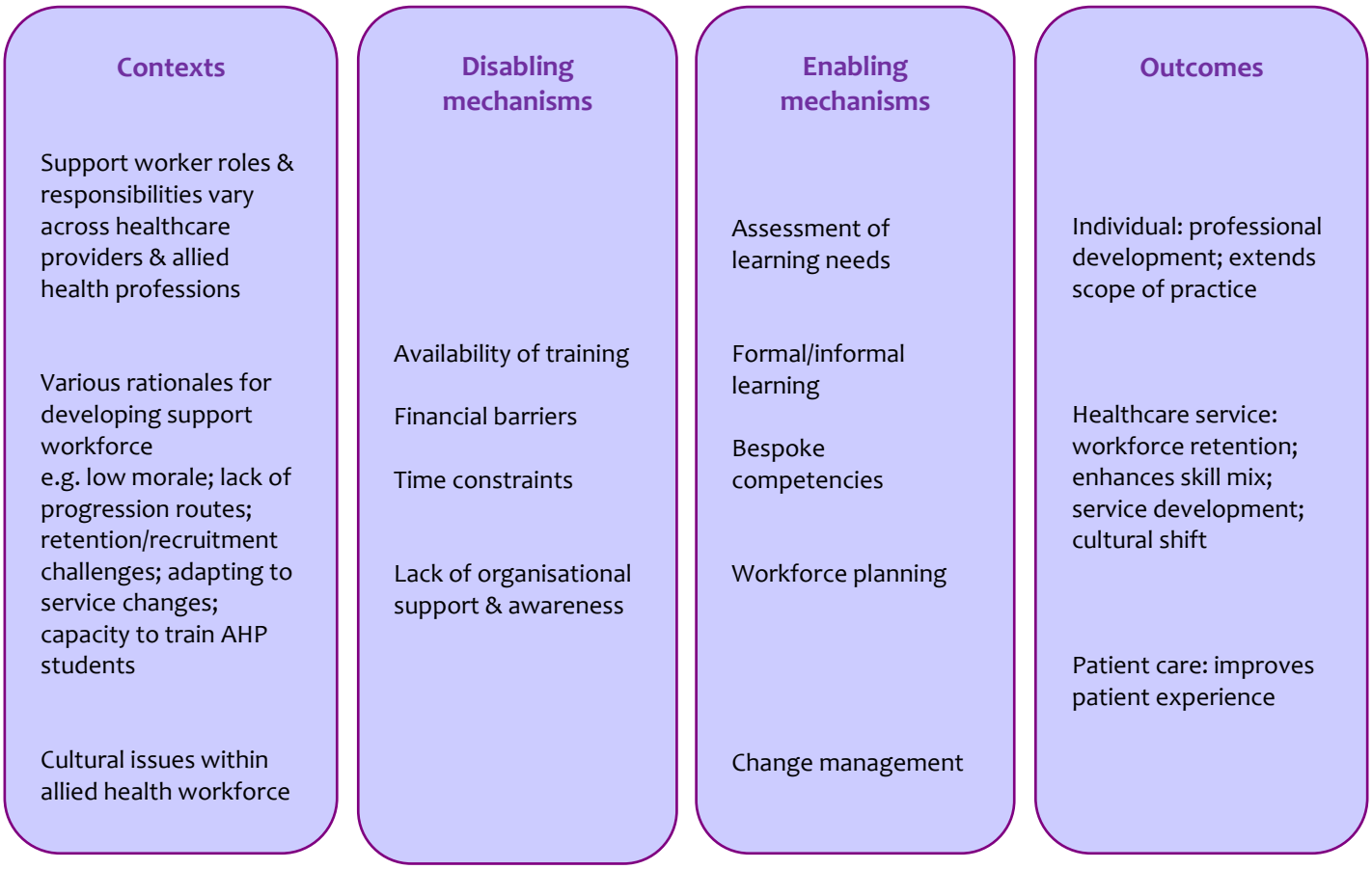

Figure 1: Context, mechanism and outcome configurations of the main themes

In order to demonstrate how causal relationships were identified across the data, five examples of the context (C), mechanism (M) and outcome (O) configurations are provided below:

- If new support roles or progression routes are created within the service, any cultural issues or misperceptions that historically exist within the workforce need to be identified (C) and then a process of change management can be undertaken with the whole team (M); this will raise awareness of the need for change and encourage acceptance, and create a culture shift amongst the workforce (O).

- If the band 4 assistant practitioner role is implemented as a progression route for the support workforce (C), the development of bespoke competencies can equip the support workers with the specialist skills for their area of work (M), which will extend the scope of practice for both the support workforce and AHPs by enabling the delegation of tasks so that AHPs can focus on more complex cases (O); this will also increase the skill mix within the workforce and enhance the level of care for patients (O).

- If healthcare providers want to utilise the apprenticeship levy to enable progression into registered AHP roles (C), organisational support can be gained through workforce planning which highlights the value of the progression route for the specific service (M); the implementation of the apprenticeship route provides career development for support workers, improves staff retention within the service, and ultimately increases the number of registered AHPs (O).

- A healthcare provider's capacity for AHP student placements (C) can be increased by formally training their support workforce about the placement process and how to support the AHP students effectively (M); this training increases the support worker's skills and confidence when supporting students, enables a greater number of support workers to be paired with AHP students during their placements, and encourages the registered AHPs to commit to taking on additional students (O).

- If healthcare providers identify specific tasks which can be undertaken by the support workforce (C), the support workers can be upskilled through informal training opportunities (such as shadowing or peer support) (M) or localised training provided by other departments within the organisation (M), which can enable the support workers to develop niche skills and expand their scope of practice (O).

4.1 Contexts

4.1.1 Support worker titles

The participants reported that a wide range of job titles were used to describe the various support roles across the allied health professions, which coincides with the literature in section 1.2.2. Figure 2 presents the 23 job titles identified in this research:

Assistant practitioner	Orthoptic assistant
Trainee Assistant practitioner	Physiotherapy support worker
Clinical support worker	Physiotherapy assistant
Clinical imaging assistant	Rehabilitation Assistant (abbreviated to rehab assistant)
Senior clinical imaging assistant	Support assistant
Exercise instructor	Senior support assistant
Healthcare assistant	Speech and language therapy assistant
Healthcare support worker	Senior speech and language therapy assistant
Housekeeper	Support worker in intermediate care
Occupational therapy assistant	Technical advisor
Occupational therapy technician	Technical instructor
Occupational therapy (OT) support worker	

Figure 2: Example of job titles for support roles across the allied health professions

Some of the job titles clearly explain exactly what the support worker does (e.g. occupational therapy assistant), whereas other titles are more generic (e.g. healthcare assistant). The lack of standardisation of support worker job titles was evident across all 14 allied health professions, as noted by Participant 7: "When I've done some research, I think there was something like over 70 different names for that band 3, band 4 healthcare assistant." At an organisational level, it was suggested that the various job titles can be attributed to "the time, what era or what initiative somebody was recruited under" (Participant 9) and also, "partly on history, partly on operational manager's direction and partly what's required from those services" (Participant 12).

This lack of standardisation can result in two support workers having different titles despite their jobs being exactly the same and conversely, they might have the same titles but undertake very

different roles. Participant 11 commented that over time, "I'm sure we'll be able to standardise that within our own house" in order to create equity, but felt that across the profession it would require a national approach to formally standardising job titles for the whole support workforce. However, it was also noted that some job titles are important to the support workers as they "hold that with pride" (Participant 11).

The participants confirmed that their support workers are typically paid at AfC bands 2 – 4. The assistant practitioner is a band 4 position, with trainees starting at band 3 and progressing to band 4 on completion of their training. Only one participant had AfC band 5 exercise instructors based within their pain team; this is an unregistered role which requires the support worker to have a degree in some element of sport science (Participant 9).

The band 4 assistant practitioner role had been implemented within the fields of operating department practice, podiatry, radiography, occupational therapy, physiotherapy and intermediate care (Participants 1, 2, 3, 9, 11, 12).

4.1.2 Deployment of support workers

Some of the participants indicated that their support workers are based solely within one allied health team (e.g. operating department practice, orthoptics, speech and language therapy), but others are deployed across multiple services. For example:

- Within radiography, clinical imaging assistants were deployed in computed tomography (CT) scanning, magnetic resonance imaging (MRI), ultrasound and general x-ray; assistant practitioners worked in general x-ray, breast imaging, ultrasound and the abdominal aortic aneurism screening programme.
- Within occupational therapy and physiotherapy, support workers were reported to work in the following areas: neurology, stroke, community settings, rehabilitation (including hospital environments and integrated community teams), paediatrics and musculoskeletal (MSK) services.

4.1.3 Support workforce roles and responsibilities

The findings indicate the roles and responsibilities undertaken by the support workers vary significantly across the different allied health professions and organisations. For example, Participant 3 indicated that the support workers based in radiography are responsible for

"proactively getting patients changed", helping "in interventional rooms" or with "ultrasound guided aspirations", and a small number are also skilled in cannulation: "Without having them on board and being able to cannulate as well as they can, we would be in a really tricky position as we cannulate probably more than 100 patients a day for our cross-sectional modality. So, they are an invaluable resource" (Participant 3).

Orthoptic assistants typically take responsibility for coordinating clinics, setting up equipment, liaising with patients, assessing visual acuity and doing taking bloods:

> "They do everything from the setting up of the clinic rooms, making sure that all the equipment is where it should be, to organising the clinic lists for today, making sure we know which rooms the doctors are going to be in. Any equipment which has to be borrowed from other departments, they are responsible for the signing in and signing out of that equipment. They oversee the general waiting room in terms of keeping patients informed of any delays or what's going to happen next in their pathway for their particular appointments. They hand out and talk to patients about patient satisfaction of their clinic visits and fill in questionnaires about that. That is as well as all of the assessing of visual acuity. They take bloods in particular clinics as well and that's a skill that they have learned whilst being on the job. It's very wide-ranging, what they do." (Participant 5)

Some of the speech and language therapy assistants in Participant 8's team are bilingual as they use spoken English in addition to languages such as Urdu, Punjabi, Mirpuri and Bengali, which are prevalent in the local population. The bilingual assistants have been with the service for over 20 years and were originally recruited specifically for their language skills and interpreting backgrounds in order to support the therapists in assessments by communicating in the patient's native language.

"When you lose an assistant who you have had for a number of years, you really feel it.... we just couldn't function without our assistant workforce, they are so invaluable, they are brilliant..." (Participant 11)

It was evident that some support workers had been employed within the same department for many years (Participants 3, 8, 11), which understandably expanded their scope of practice due to their extensive experience, as shown in this comment: "I would say we've probably got Assistant Practitioners who are as

skilled, if not more skilled, than some radiographers around the country, in that they've been here for donkey's years and are highly skilled professionals" (Participant 3).

The participants consistently reported that their band 4 support workers were more autonomous than those working at bands 2 and 3, for example:

> "The band 4s we are expecting autonomous working, independently managing -- when I say a caseload, obviously not making clinical decisions but managing a caseload themselves. Whereas the band 3s, we are very clear that they shouldn't be having direct clinical contact without somebody else, not necessarily there, but in the building within the day that they can go back to for support." (Participant 8)

> "...our band 4 workforce and those that are developing into that assistant practitioner... They can see some new patients and that is in the community as well as within an in-patient setting... In terms of what we would expect from the band 4, we don't ask that we have to speak to them about every new patient they've seen after the assessment. That is built into an end of week review. We would expect our band 3 staff to come back after the assessment and discuss it and just go through clinical reasoning, look at that treatment plan and then obviously review with us when they want to progress and then when they want to discharge..." (Participant 11)

Within occupational therapy and physiotherapy, it was noted that some of the support roles "won't be pure" as although the support workers' skills are based in a particular therapy, the trust expected support workers to have additional skills "around identification of the deteriorating patient, being able to do blood pressures, observations" (Participant 9). In addition, the support workers are responsible for conducting assessments and following treatment plans according to their skill level:

> "...the assistant practitioner role... that role can receive referrals within their own right within a specific framework and can deliver within that framework and that person's skills and competencies. So, they could do an assessment, implement a treatment plan and then discharge on conclusion of that treatment plan. That's still done under delegation but they will be the only person that will see that patient... Taking MSK, the band 3s and band 4s will

> see people following a knee replacement. The assessment and everything have been done within the acute setting, the person is discharged, they will be booked into a knee group which will be run by a band 3 or band 4 onsite in that area. So they will see the patient, do a basic assessment, put them through the programme and discharge them." (Participant 9)

Band 2 support workers in podiatry were described as working "entirely alongside the podiatrist and it's a repetitive thing", whereas the band 3s have slightly more responsibility and need to "use their initiative a bit more" (Participant 2). In contrast, the band 4 assistant practitioners work more autonomously by taking responsibility for "decision-making" and doing "more escalation". For example, the assistant practitioners regularly conduct home visits to follow the patient's treatment plan, which is then reviewed every four weeks by the podiatrist. Furthermore, there is a clear understanding of the scopes of practice for the unregistered and registered roles:

> "So, if it's task-based, a support worker can do it in whatever guise they are, 2, 3 or 4. If it's knowledge and skills based and you have to make a diagnosis, you have to come up with a treatment plan for that patient, then that's what our podiatrists are for" (Participant 2).

4.1.4 Rationales for developing the support workforce

During the data collection, the participants' motivations for developing their allied health support workforce were explored and a range of factors emerged: low morale amongst the support workforce; limited opportunities for progression; concerns about recruitment and retention; the need to adapt due to changes in service specification; and the desire to increase the organisation's capacity for supporting AHP students.

Participant 1 reported low morale amongst their assistant practitioners due to the role being unregistered and a lack of progression beyond band 4, which motivated the organisation to develop a degree apprenticeship pathway for support workers to train as registered operating department practitioners:

> "We had a lot of issues around the Assistant Practitioner because it allows them to be qualified at foundation degree level but it doesn't give them a registration... So this limits them on what they can do..." (Participant 1)

In addition, Participant 1 explained that they had an ageing workforce as many members were in their 50s and therefore, it was anticipated that they would retire in the next five to ten years. As the organisation had previously experienced difficulties when trying to recruit registered operating department practitioners due to a low number of applicants, the apprenticeship pathway was viewed as a pipeline for progressing their own support workers which would also hopefully fill the anticipated vacancies.

For professions with a small workforce, such as orthoptics[3], it was felt that staff retention could be enhanced through providing opportunities for personal development:

> "We recognise that in order to keep these members of staff within our team and stop them from looking elsewhere for a new role, we've got to keep them interested, we've got to develop them as far as we can within the niche role that they have. Because as I say, we're just very lucky in who we have recruited, and we don't want to lose them." (Participant 5)

Participant 3 experienced issues with the recruitment of the radiography support workforce due to the trust's processes and organisational structure which meant that all support workers were historically managed under the nursing team. This meant that they were recruiting "people who had potentially got aspirations to become nurses... and were expecting to work on a ward", rather than support workers keen to work in radiography settings. Within the past two years, the support workforce had moved back under radiography management, which enabled more appropriate recruitment and the rebranding of support workers as clinical imaging assistants.

"Clinically, we are so, so stretched... It's about balancing -- we want a very proactive, knowledgeable workforce..." (Participant 8)

Participant 4 felt that the support workforce development within their occupational therapy department had traditionally been "quite far behind"

[3] As detailed in section 3.2, in February 2020, there were 348 FTE orthoptic support workers employed by the NHS.

other allied health departments, so they recently established the band 4 occupational therapy technician role to develop an experienced member of their team who had been with them for 15 years.

Following the recent integration of services, Participants 11 and 12 were motivated to develop a pack of competencies and career progression routes, utilising the apprenticeship levy and assistant practitioner training, to develop the role of their physiotherapy-specific support workers.

A significant change in service specification resulted in the restructuring of a podiatry service to ensure that they could meet the specific needs of their patients. This required the upskilling of support workers in two key roles: clinical support workers (at bands 2 or 3) and assistant practitioners (at band 4). Participant 2 explained the rationale for developing their support workers:

> "We had support workers and then our service specification changed. Those support workers used to run skin and nail care clinics. They used to do mostly toenail clipping on the elderly patients that weren't necessarily particularly vulnerable, but just had mobility problems and couldn't get down.... We were decommissioned to provide that low-risk care and ended up providing high-risk treatment only. Mostly diabetic foot ulcers. So, we didn't really need those support workers in the same way, but we had to ramp up our activity in being able to deliver ulcer treatments on a weekly, sometimes twice weekly basis. We had to see a lot more in-patients, a lot more housebound patients that previously nursing teams were delivering some of this care. With diabetic foot, it was podiatry, we were commissioned to deliver that, we've now got to go out to the home. So we had to look at how we were going to increase our activity from a weekly to a high-risk patient caseload. We looked at those support workers and rather than just lose them, we were going to have to use them differently. So, what we did was set up ulcer clinics. We put a support worker in an ulcer clinic. Much like dental. Dentists work with a support worker; they work with a dental assistant. What we needed was a podiatry assistant of some description to support that, so we could keep contact time shorter and increase the throughput in our ulcer clinics that ordinarily used to take much longer. So you've got two people working on that patient at any

one time. We had to ramp up the sort of interventions we were doing." (Participant 2)

One participant explained that their organisation's aim to increase the placement capacity for students on allied health degree programmes provided a unique opportunity to develop the support workforce. After conducting a survey with the support workers to gauge their interest, a bespoke training course was developed to equip them with the skills to support the AHP students: "It's based loosely on the courses that qualified staff would attend at a university [but]... We've made it so that it is relevant for support workers" (Participant 10).

4.1.5 Cultural issues within the workforce

It is evident that cultural issues relating to role boundaries exist within the allied health professions, specifically between the unregistered support workforce and those in registered roles. Essentially, upskilling the support workforce "can still be seen as a little bit of a threat" to the registered AHPs (Participant 7).

"It can still be seen as a little bit of a threat, that we've got these very highly knowledgeable and skilled workers coming out and we don't like it..." (Participant 7)

As the range of tasks undertaken by support workers has increased significantly in recent years, some of the registered AHPs have questioned what this means for their own role:

> "...ten years ago there's no way that [assistant practitioners] APs or healthcare assistants would be taking bloods, doing blood pressures, doing catheterisation, all the huge clinical skills they do now. It was a bit - that's my job, that's what I've trained for. Now, you're seeing a progression where nurses and physios and OTs are doing more the jobs of specialists and doctors, and healthcare assistants and APs can therefore take on some of the roles of that. It is that challenge though - if I let go of that, then will I become surplus to requirements?" (Participant 7)

When organisations experience difficulties with recruiting for registered AHP vacancies, it can lead to role creep amongst the support workforce as they take on more tasks, as noted by Participant

11: "I think things were starting to move and it wasn't comfortable where things were moving to. So that was the need to really pin down what is 3, what's 4 and what's 5".

In particular, within the podiatry profession, the notion of scalpel work being conducted by newly qualified assistant practitioners initially raised concerns amongst some of the registered podiatrists:

> "We had some resistance, initially... from the podiatrists, the qualified staff... Their view was that if we've got band 4 assistant practitioners doing what they were doing before, or that they felt was their role, where does that leave them? My view was that actually, they've got a degree to become diagnostic practitioners. They work autonomously and they needed to be working to the maximum skills level that they've got, as opposed to doing some of this simple stuff... With the band 4s, that we haven't had in for quite so long, there has been a bit of, "They're taking on my job." They do scalpel work which the podiatrists feel is their unique selling point." (Participant 2)

In other organisations, where the band 4 assistant practitioner role had been embedded for a longer period of time, the role boundaries appeared to be clearer between the unregistered and registered roles, although tensions had historically been noted between the radiography support workforce and nursing teams:

> "...there have definitely been issues in the past. It's more about role boundaries between nursing and clinical imaging assistants. A lot of these have begun to be ironed out by having more stringent scope of practice. It's not necessarily about them overstepping, it's about them not thinking that they should be working in certain areas. Or not undertaking certain tasks based on banding....I would say that they definitely integrate really well into the general imaging team. I'd say where the clashes do come, it's where there's professional boundary issues between them and traditional nursing." (Participant 3)

4.2 Disabling mechanisms

The findings suggest that when attempting to develop the support workforce, the participants encountered several disabling mechanisms, such as: the availability of training for support workers, financial barriers, time constraints and a lack of organisation support or awareness.

4.2.1 Availability of training

Two of the participants highlighted the limited availability of training for support workers as a disabling mechanism to developing their workforce. For example, within small professions such as orthoptics, there are only a few courses "which are very pertinent to their role" and in some cases, the courses had not gone ahead due to not attracting enough applicants (Participant 5).

In addition, within the field of occupational therapy, Participant 4 noted that some course providers are not willing to accept support workers as the training is often only aimed at the registered AHPs, which is a missed opportunity for extending the skill base within the team:

> "...my argument would be that if you've got a static support member who has chosen to maintain and build their career in this speciality, it doesn't matter that they're not registered. That skill based would probably be much better retained in this team. The team then benefit from them attending the course more than they might one of the other registered members of staff who might not actually still be in this team in six to eight months. I think there is a huge inequality there." (Participant 4)

4.2.2 Financial barriers

Some of the participants reported financial barriers, such as the backfill of staff and the challenge of securing funding to access external training programmes.

The backfill of band 4 support staff who undertake degree apprenticeships can present a financial barrier for some organisations, along with paying the support worker's wages throughout their studies (Participants 1, 2). For example:

> "The challenge going through with the podiatry course under an apprenticeship scheme is that we've got to find the money to pay their salary and get access to the levy. We still have to deliver the same level of service, so they almost need to be supernumerary. That is going to be a challenge going forward for people." (Participant 2)

Two participants explained that they would temporarily need to lose a clinician (e.g. a band 5 position) whilst the support worker was undertaking their apprenticeship degree in order to have a band 5 position waiting for them at the end (Participants 2, 8); this can be particularly challenging for smaller teams who are essentially understaffed whilst the support worker is undergoing their training (Participant 8). Participant 2 described this as "playing with your financial envelope. It didn't cost any more but sometimes you would have less people on the ground whilst you were training them up."

Two of the participants reported that funding for external training was very limited within their organisations (Participants 4, 12). In particular, it was noted that funding limitations made it difficult to perform sustainable workforce planning:

> "Our CPD contract funded opportunities tend to be quite nursing-specific courses. There's a limited number of profession specific ones. Funding outside of our CPD contract is really hit and miss....and it's also quite short-term, we get very little notice. It's very difficult to plan the workforce training programme when you have year-on-year funding packages that are released with short turnaround and short timeframes. So, I would say that the funding mechanism doesn't really support a sustained programme of post-graduate or clinical development and that's across the workforce, that's not just the support workforce." (Participant 12)

In addition, it was suggested that gaining access to the apprenticeship levy funding can be challenging for some professions as organisations might designate the funding to other departments, for example: "If that levy has been earmarked to get 50 TNAs [trainee nursing associates] in post, then there isn't the money available for other apprenticeships" (Participant 7).

4.2.3 Time constraints

"...this idea that people don't have the time means that they sometimes don't always explore what roles are out there" (Participant 6)

The participants identified that a key barrier to developing the support workforce is a lack of time to release them for training and to support their learning in the workplace (Participants 3, 4, 8). This lack of time was attributed to the pressures of clinical work:

> "...the reality is that you have a caseload that requires everyone to be completely clinical and we are under pressure to discharge patients and get them out of hospital. So CPD, internal training, supervision and things, they do become a second thought because we're just very pressured to meet our clinical needs first and foremost." (Participant 4)

Participant 3 explained that having the capacity to train assistant practitioners can be particularly challenging within a large teaching hospital which already has a quota of at least 30 undergraduate radiography students per year:

> "It becomes a case of: is there enough space and time to be able to do their training well? The last thing you want is a department with three radiographers, two students and one trainee assistant practitioner on because that's just not an adequate level of staffing to be able to support them well. Especially if that department has then only got two x-ray rooms. You don't want to be in a position where everyone is having to just take it in turns, you want people to be able to just get stuck in. I think that is always a barrier when we talk about training within imaging. It's a barrier that I think often gets overlooked because people just assume that there's going to be somewhere for them to be." (Participant 3)

It was also suggested that the main difficulty with utilising the degree apprenticeship pathway is that the allied health team can struggle to manage the additional workload and time required to support the apprentice:

> "So, if somebody goes from assistant practitioner onto the next... through an apprentice pathway... you've got a 20 percent resource that you're not able

> to utilise. It's also taking away time from the registered team members in supervising, monitoring and training. So, it's a double hit. That's a challenge." (Participant 9)

4.2.4 Lack of organisational support and awareness

Some of the participants indicated that a lack of awareness of apprenticeships and the assistant practitioner role can hinder the development of their support workforce. For example, when implementing an apprenticeship pathway for operating theatre support workers to train as registered operating department practitioners, Participant 1 discovered a general lack of awareness about how apprenticeships work because "people don't really get the fact that they are studying at degree level".

Similarly, although the assistant practitioner role was first introduced in 2002, there appears to be a lack of awareness about what the role involves and how it can potentially enhance a team's skill mix, which can make some organisations reluctant to implement the role and embrace the apprenticeship programmes. It was suggested that this role has lost its momentum and "needs some sort of mass marketing of what an assistant practitioner can do and can be. Just like they did with the TNAs" (Participant 7). This lack of awareness is further complicated by the lack of standardisation in job titles and uniform colours across the support workforce, as assistant practitioners wear whatever colour is specified by the trust or allied health team, and are therefore not easily identifiable (Participant 7).

It was suggested that the lack of awareness about the scope of the assistant practitioner role is also exacerbated due to the role being unregistered (Participants 2, 6, 7). For example:

> "People see that this is not a registered workforce and therefore they just immediately go, "I'm not touching it." Because people have this perception that if you're registered, you're safe. The reality really is that you can still work unsafely whether you're registered or not... The registration doesn't make you safe. It's about how it's implemented, really, that makes you safe." (Participant 6)

Even in cases where the assistant practitioner role has been successfully implemented, its unregistered status can cause frustration due to a lack of recognition from the allied health professional body[4], as this podiatry example illustrates:

> "The Assistant Practitioners don't nationally feel that their role is recognised by our professional body. Because we are at the forefront of this, there aren't many Assistant Practitioners with a foundation degree out there wielding a scalpel. The scalpel-wielding technician, it's seen a little bit like it's a bit maverick. There's a bit of a rub between our professional body because they have lots of private members... They're not registered, they've got a foundation degree and they don't have that." (Participant 2)

Another disabling mechanism identified in the research was a lack of support from managers within the healthcare organisation, which impacted on perceptions of workforce roles and development. For example, Participant 8 had experienced three significant restructures in the last seven years which resulted in the service no longer having managers based within speech and language therapy: "And because of that, there's a lack of recognition of what we can do and what we should be doing." In particular, the restructuring meant that the bilingual skills of their speech and language therapy assistants were no longer being utilised in the same way, resulting in the assistants feeling deskilled. This had lowered morale amongst the support workforce and was also frustrating for the therapist who emphasised the value of having experienced bilingual assistants involved in the assessments: "...having the assistants there is so different from having an interpreter... They know what they're talking about, they know what they're doing" (Participant 8). The low morale amongst this support workforce was compounded by the trust's recent decision to make all staff wear uniforms with different colours for support workers and registered therapists: "they are fostering that us and them attitude with the assistants even more... I think it just undermines everything that we have tried to create and build" (Participant 8).

"That will be one of the barriers, people not understanding project management or quality improvement. Because if you don't understand them, you don't know the structure and the process to address the issues..." (Participant 1)

[4] See Mizzi (2020) for a detailed review of the current status of band 4 assistant practitioner roles within each allied health professional body.

Participant 9's organisation had recently encouraged the development of generic support workers in order to utilise their skills across all therapies. However, it was suggested that the generic support worker role can sometimes overlook the value of developing niche skills in a specific area:

> "The organisation would very much like the generic, the team members themselves find that there is -- you can delegate differently to somebody who is simply OT or simply physio than you can to somebody who is generic.... And they perceive that as adding the greatest value and won't perceive the fact that someone that is trying to stay competent in a vast range of different skills and competencies, then it tends to be at a lower -- a more diluted level, shall we say....And that somebody who only sees physio patients all the time tends to have more advanced skills in that area." (Participant 9)

4.3 Enabling mechanisms

The mechanisms that enabled the development of the support workforce will be presented under two main themes:

- The process of developing the support workforce: workforce planning, change management, the assessment of learning and training needs.
- Learning opportunities provided for the support workforce: formal learning, informal learning and the development of bespoke competencies.

4.3.1 The process of developing the support workforce

4.3.1.a Workforce planning

The findings indicate that the process of developing the support workforce required the participants to undertake detailed workforce planning in order to implement sustainable change and negotiate the infrastructure of their organisation (Participants 1, 2, 8, 12).

"You have to have a plan. Your workforce plan has to be really clear...."
(Participant 2)

For example, when implementing a career pathway for band 4 support workers to progress to an operating department practice degree apprenticeship, Participant 1 emphasised the importance of undertaking background research to understand the workforce and the available training and funding opportunities:

> "Get the data off the workforce analysis people. Have a look at the workforce, look at the age of the staff that are currently there. Look also at the turnover rate, as well, and address that. Look at that and then look at other opportunities where you could potentially get funding from." (Participant 1)

In addition, conducting a stakeholder analysis is a useful mechanism to engage relevant people within the organisation and help them to recognise the benefits of the development plan:

> "I had to do a stakeholder analysis because I wanted to know who to keep close to me, who to keep informed, who had the power. I even went up to

> the Chief Nurse and discussed it with her because she's the most powerful within our organisation." (Participant 1)

It is valuable to clearly communicate a long-term strategy for developing the support workforce so that the service can adapt to future changes and developments within the field, as explained here:

> "We also work really closely at my level with operational directors. So, we've got a consistent understanding from our operational senior directors about what we were trying to achieve, and that we were trying to deliver against the apprenticeship levy, support the support worker development, the workforce development. And also, then open the opportunities for future apprenticeship degree against the emerging programmes that we knew were going to be coming online and that we just weren't prepared for. In terms of the workforce getting up to a level for those who might be interested to take those opportunities. Operational managers, once they understood what we were trying to do, again I think they had buy-in. So, it is pre-empting it and trying to actually communicate your message and have a clear strategy about what you are trying to do. I think that really helped us." (Participant 12)

When restructuring the podiatry service, Participant 2 "undertook staff consultation and brainstorming sessions using traditional leadership and management tools" which focused on "where do we want to be, how do we get there, what does good/excellent look like, barriers" and also, "must, could and should prioritisation tools". They also "look[ed] at the Skills for Health site to evaluate the knowledge and skills they would need" and then "based a competency framework on the Skills for Health domains" (Participant 2).

In addition, Participant 2 had recently adopted an innovative approach to recruiting for the assistant practitioner training by advertising a "paid work experience role...for a school leaver or anyone who might want a career in podiatry". Two people were recruited on the pilot scheme and paid for 12 weeks, and then one person decided to continue to do the assistant practitioner course, supported by the organisation. This initiative involved significant planning and liaison with the organisation and trade unions, but was accepted as a potential mechanism for addressing the recruitment issues that are typically experienced by the smaller allied health professions.

4.3.1.b Change management

In order to address some of the cultural issues identified in section 4.1.5, some of the participants undertook change management with their allied health workforce to engage them in the process, manage their expectations, and alleviate some of the concerns about boundaries between unregistered and registered roles.

As Participant 2 explained in relation to the restructuring of their podiatry workforce, it was important to be "clear about what the expectations were of their roles". From a leadership management perspective, "you always get norming, storming, performing" when attempting to develop a team and this was addressed by engaging the workforce in discussion:

> "I always take it back to the team. Whenever we're doing some of this change management, what is best for our patients? Do you want them sitting on a waiting list and not accessing any care and deteriorating? Or do you want to change what we're doing within our financial envelope? Because that's a finite resource and I can't get any more money in these difficult times. Can we change what we're doing in terms of skill mix so that somebody else can do this task, to free you up to do the enhanced care that you need to deliver, so that patients can get in to see us quickly, get better quality of care and you can make a massive impact to them and improve their outcomes." (Participant 2)

It can be particularly important to manage the change within a workforce when implementing the more autonomous assistant practitioner role because "it can be easy for that role boundary to transgress" which can potentially put the support worker and AHP "in a vulnerable position" (Participant 6). Prior to implementing the trainee assistant practitioner role within their physiotherapy service, Participant 12 spent time preparing their registered workforce and reported that this was a very successful approach to managing the change:

> "... we did quite a lot of work anticipating some of the potential problems that we thought we might have when we developed the TAPs [trainee assistant practitioners]. We thought that there might be a level of anxiety from the qualified workforce around the fact that we were getting role creep in the support workforce. There was quite a lot of anticipation of that and in

> developing those competency frameworks, there was a lot of training that was put in at the time... There was also quite a lot of work in the qualified in-service training to make sure they understood the roles, the definitions and the expectations of our support workforce. So I think as a group we thought about that and did a really good job in preparing the workforce for where we were going. I think that was proactively dealt with. I think we could have had more problems had we not done that and not had that clarity of exactly what they were going to be doing." (Participant 12)

4.3.1.c Assessment of learning and training needs

The main mechanism for assessing the learning and training needs of the support workforce was through regular reviews or appraisals e.g. performance and development review, personal development plan, annual appraisal and annual review of competencies (Participants 1, 2, 4, 5, 8, 11). These reviews were typically conducted with line managers/supervisors, but some organisations also utilised their education and training departments when discussing the learning needs of their support workers. For example, the education and training department can oversee the initial assessment of English and maths to determine which NVQ level might be most suitable for the support workers (Participant 1). In addition, it was noted that education providers typically assess the support worker's English and maths skills prior to accepting them on a course (Participants 1, 6, 7).

"In terms of the development of clinical skills, it's very much around who is needed where in the department, which pathway they are working on and why..." (Participant 8)

An annual appraisal scheme provides the opportunity for support workers to share their career aspirations through their personal development plan (Participant 2). An annual review of competencies can also ensure that the support workers maintain the relevant skills (Participant 5). Participant 4 explained that the process of reviewing their occupational therapy support workforce, based in neurology, involves three key aspects – the individual's goal, the supervisor's observation and departmental objectives:

> "Speaking very much from our specific team, I think you often find that members of staff are very keen to learn specific areas that are relevant to a neuro patient or a neuro caseload. So often their objectives are based around

> improving their clinical skills or getting experience of working with different diagnoses. So no, we don't follow any sort of format, it's very much led by three angles. We have what the individuals want to focus on. A supervisor will carry out their IPR. It will be from their observation as to what skills they need to work on. We then also have to tie-in at least one objective if not two, to collaborate with department objectives. Every member of staff has to be involved in an ongoing department project and it has to adhere to Trust policies." (Participant 4)

Some of the support workers' skills are reviewed at more regular points throughout the year, for example: Participant 8 explained that all members of their speech and language team have an annual performance development review along with quarterly conversations "to make sure we're working towards those targets". In addition, the whole team has access to ad-hoc case-based supervision sessions, along with six-weekly management supervision and clinical supervision; the latter is "multi-disciplinary where possible, just to troubleshoot any problems you are having there and then" (Participant 8). Similarly, Participant 11's support workforce received an annual appraisal, which includes a personal development review, along with "somewhere between monthly and six-weekly supervision with a qualified physiotherapist, which will meet with them to discuss their caseload, patients, their development, to discuss training and development opportunities."

The decision-making about who to train, and on what topic, appears to be led by the specific needs of the department in which the support worker is based and the type of care they are providing. For example:

> "In terms of development of clinical skills, it's very much around who is needed where in the department, which pathway they are working on and why. Within that though, the same as any member of staff, whether assistant or not we would be looking at their interests and what they need, as part of their PDR." (Participant 8)

> "It's quite role-specific, so for some of that external training... we would train those staff that are working and delivering specific active balance classes or those that are delivering balance-specific treatments to patients. Those that aren't delivering that, we wouldn't necessarily look at those courses. It

> wouldn't be used, and it couldn't be developed. We would need to be able to use it." (Participant 11)

However, it was suggested that internal decisions about who to send on training can potentially be influenced by the fact that registered staff "are expected to maintain CPD and evidence for that" (Participant 4), whereas this does not apply to the unregistered support workforce.

4.3.2 Learning opportunities provided for the support workforce

4.3.2.a Formal learning opportunities

The formal learning opportunities mentioned by the participants included: the Care Certificate, level 2 and 3 qualifications, the assistant practitioner qualification, AHP degree apprenticeships and specific courses to develop niche skills.

Care certificate

Several participants reported that the Care Certificate had been completed by their support workers (Participant 1, 2, 9, 10, 11). One participant had not heard of the Care Certificate (Participant 4) and another stated that their service did not offer it (Participant 5). There was also evidence of inconsistency across one radiography service with some support workers having completed it, but not everyone, although it was acknowledged that this organisation had their own "mini Prepare to Care course" which was delivered as part of the induction process (Participant 3).

The Care Certificate contains 15 core standards and it was noted that 'fluids and nutrition' can be challenging for the operating department support workforce to complete "as we wouldn't deal with that within the operating theatre", but this was addressed through providing placements on wards (Participant 1).

Participant 11 explained that new starters are introduced to the Care Certificate during their corporate and clinical induction, and typically have 6-8 weeks to complete it, in addition to the competencies used within the physiotherapy department. However, it was felt that the "Care Certificate is quite nursing oriented" and "doesn't necessarily meet the competencies for our physiotherapy staff" (Participant 11).

As the Care Certificate is "only mandatory or supposed to be mandatory for new starters", Participant 7 pointed out that some of the assistant practitioner courses have mapped the 15 standards onto their programmes in case it has not been completed by support workers who have been in post for many years.

Level 2 and 3 qualifications

Some support workers had previously completed NVQs in health at levels 2 or 3 (Participants 2, 8, 9). It was suggested that the "Senior Healthcare Support Worker Level 3 Apprenticeship" was an appropriate training programme for band 3 allied health support workers (Participant 7), and Participant 1 reportedly trained their staff on this course. Both intermediate and advanced apprenticeships were utilised to train Participant 1's support workers, and the flexibility of the level 3 NVQ was highlighted as it contains elements that can be tailored to each speciality:

> "This is a generalised one, so it will cover all of the health and social care aspects for them... With the NVQ Level 2 they will go to college and normally attend a day either a week or every fortnight... When we get to Level 3 NVQ, it's more as an apprenticeship and we can pinpoint it more into the nursing environment. So a lot of colleges will put different modules together so that they cover the requirements to work in the operating department. It expands their knowledge greatly once they've done Level 3." (Participant 1)

Assistant practitioner qualification

Five of the participants reported that they had developed their allied health support workforce by formally training assistant practitioners (Participants 1, 2, 9, 11, 12). For example, Participant 2 commented that their assistant practitioners studied for two years on a level 5 "foundation degree in Health and Social Care". The assistant practitioners were based in the following professions: operating department practice, podiatry, occupational therapy, physiotherapy and intermediate care.

One participant stated that the assistant practitioner role had been implemented several years ago through an in-house training programme and their support staff worked "within the scope that's defined by both our local policies and the Society of Radiographers" (Participant 3). Although the

transferability of this in-house programme is limited as it "isn't nationally recognised", the assistant practitioners can get an accreditation through the Society of Radiographers (Participant 3).

Participant 9 highlighted the flexibility of the assistant practitioner apprenticeship route as the "second year...has got modules that can be more OT or more physio or more generic" (Participant 9). In addition, they had arranged with the education provider that in order to give the support worker the option of progressing to a registered occupational therapy role in the future, two of the assistant practitioner modules would be completed at a partner institution so that the support worker could join the second year of the degree programme.

In contrast, Participant 11 had recently utilised the apprenticeship levy to train three support workers as assistant practitioners, but felt the course was more generic than expected:

> "...this is my naivety when I first went into this actually, they could take that and be AP in any kind of field and it is the competencies that overlay the profession specific aspect. I think I was expecting, and we had anticipated there to be more physiotherapy training and treatment approaches, assessment skills, built-in to the practitioner programme. I don't actually think that's how it is ever delivered; I think we just assumed it was like that." (Participant 11)

Degree apprenticeships

Participant 1 had successfully utilised the apprenticeship levy to train three of their support workers on the operating department practitioner degree apprenticeship; at the time of data collection, one was in the first year of their course and two were in the second year. Although the "apprenticeship would say...that you only have 20 percent off your job", the organisation took a unique approach to show their commitment to developing the support workers as they "decided to put them in as students" (Participant 1). Essentially, this means that the support workers attend university the majority of the time but return to work in their department during the standard university holidays. Participant 1 highlighted the benefit of this arrangement as during the recent pandemic, the support workers returned to the department and were redeployed to support intensive care patients.

"...the apprenticeship levy is the piece of the puzzle that creates that sustainability..." (Participant 6)

As illustrated in this quotation, the apprenticeship levy has significantly enhanced access to allied health degree pathways for some support workers:

> "One of the things we recognised was that some of our support workers were eminently able to study at degree level but either never had the opportunity because they had children young or they had to go out to work early. They couldn't afford the tuition fees. The apprenticeship route has opened up a huge amount of opportunity for these people... we will be able to employ them and we'll be able to get access to the levy so we can pay their course fees. Then they'll be able to go on and study and they will still be employed, as opposed to giving up and studying for three years. It's opened up a wealth of opportunities for some people, which is brilliant". (Participant 2)

Participant 2 further explained that they had liaised with the education provider when implementing the assistant practitioner training to ensure that the foundation degree mapped onto the first year of the podiatry degree, to enable the accreditation of prior experiential learning (APEL); this clearly provides a progression route for the support worker and is also beneficial for the employer who has spent two years training the individual.

Participant 4 stated that their trust was currently monitoring the development of the occupational therapy degree apprenticeship. Similarly, Participant 3's organisation had not yet implemented the degree apprenticeship route for radiography, but it could be an option for the future as it "creates a pipeline that our Assistant Practitioners could move onto". However, at the time of data collection, the radiography degree apprenticeship was only available at one higher education institution and it was acknowledged that this might present logistical and funding issues as it was a significant distance from the organisation.

One participant felt there was no need to explore the degree apprenticeship route within their organisation as "it's just not financially viable for us to do that at the moment because we don't have the vacancy issue" due to their central location (Participant 10). Although it was acknowledged that the apprenticeship is funded through the levy, the organisation could not justify paying for "all of their expenses, their travel, any study time and then backfill them" (Participant 10).

Training for niche skills

The participants provided several examples of training (both in-house and external) that had been used to develop niche skills for the support workers in order to develop their role and fulfil the needs of the service they were providing. For example, band 2 and 3 support workers in orthoptics and podiatry were trained in how to take blood by the phlebotomy departments in their organisations (Participants 2, 5), and assistant practitioners in radiography had been trained to cannulate (Participant 3). Physiotherapy support workers received in-house training about the identification of the deteriorating patient (Participant 9) and clinical presentation of patients (Participant 11), along with external training about postural stability (Participant 9, 11), management of upper limb injuries (Participant 10) and cognitive rehabilitation (Participant 4). In order to equip their orthoptic assistants to conduct a scan which looks at the structure of the back of the eye, Participant 5 arranged for a specialist department to conduct the training and for the assistants to work with the other department for one session each week "just to keep their skill up", as they would not be practising that skill regularly in the orthoptic clinics (Participant 5).

The in-house programme available to the radiography support workforce was considered particularly relevant for their roles as they learnt about taking observations, basic life support, radiation protection and customer experience: "So the benefits of having an in-house training programme for them is that they can better serve our imaging departments" (Participant 3).

"[Our] in-house training programme is very bespoke to the needs of the department" (Participant 3)

Similarly, Participant 10 explained that their bespoke, in-house training course had been specifically designed to equip support workers with a range of appropriate skills to support AHP students. The course includes: the student journey and placement process; social styles; how to support students who are struggling; students with additional learning needs; and how to give feedback (Participant 10). It was emphasised that the support workers are ideally positioned to provide this support:

> "They know the Trust inside out and the workings of everything. They know the culture of the organisation; they know the local area really well. That's why they are really well placed to give that support because they just know everything... It makes such a difference. They are the ones that really help the students just settle in and feel like part of the team. Sometimes the pressures

> that the qualified staff are under clinically, they can't always give that time and that chit-chat, necessarily, but support workers can." (Participant 10)

4.3.2.b Informal learning opportunities

The findings indicate that some of the support workforce are provided with regular opportunities for informal learning through activities such as: shadowing colleagues, peer support meetings, department working groups, clinical interest groups for support workers, peer reviewed case discussions and journal clubs (Participants 4, 5, 8, 9, 11). For example, Participant 4 commented that their department working groups are usually attended by at least one support worker from each band and provide the opportunity to review "paperwork, models of practice, documentation, how we access community services and how we manage...our wheelchairs and specialist seating for our patients".

4.3.2.c Bespoke competencies

During the data collection, there were several comments about the development of bespoke competencies to ensure that the support workforce had the relevant skills to support the specific needs of the service and patients in their care. For example, Participant 9 reported that the competencies developed for their physiotherapy support workers are "very role-specific within the teams".

As noted by Participant 6, the work-based modules on the assistant practitioner course can be tailored for specific areas of practice:

> "Those work-based modules will be devised with the university, the student and the employer. They will come up with a specific piece of work that meets the requirements of the course but also meets that tailoring for the service. So, services have a real opportunity to almost bespoke part of the training, put the student to a piece of work that had maybe not been done due to capacity…" (Participant 6).

This was exemplified by Participant 2 who coordinated with the education provider to adapt parts of the assistant practitioner foundation degree to ensure that the support workers were equipped with the appropriate skills to "recognise a deteriorating foot" or the symptoms associated with sepsis or arterial disease, which were essential to the high-risk care they needed to provide:

> "So that band 4 foundation degree level training. We developed the competencies; we've said this is what we want our Assistant Practitioners to do. We invested in the training in them, put them on the course. They got a couple of days of academic study time and then we had to develop all of those clinical competencies. We had to put staff in place to do the training of them. We used our vascular podiatrists to train them on how to do these tests, to understand the blood supply. We had to develop written competencies and have some input into the academic studies and what sort of essays we wanted from them. So, they have a foundation degree in Health and Social Care… it was very generic because it was a nursing course initially. Then they did bespoke modules and bespoke competencies. But it's become much more tailored to podiatry...They've recognised that there's a lot more tailoring because we are very specific and specialist as a service… They are very receptive to saying, you know what you need, so you develop the competencies and let us know how well they have passed and failed" (Participant 2).

In order to define the different roles and responsibilities of their band 3 and 4 support workers, one of the physiotherapy teams had recently undertaken a project to develop a bespoke pack of competencies:

> "…we finished the development of our physiotherapy assistant competencies. That was a pack of competencies developed to support our assistant workforce. We had a pack for band 3 staff and band 4 staff. That was really derived from the need to differentiate what the differences are in those levels of staffing, to support their role and their development and to allow a progression for some staff from one role to another. And to define the differences. Those competencies were rolled out to the assistants with training and we trained our physiotherapy staff as well, in how to support our staff in completion of them… They are very similar, the 3 and the 4, but there are additional elements of practical skill built in. So, we've said that the knowledge needs to be exactly the same but the practical skill that the band 4 will show is different to the practical skill that you will see in a band 3. Then again, the supervision structure that supports that is slightly different for a 3 and a 4, in terms of the delegation they need to feed back." (Participant 11)

The pack of competencies was viewed very much as "a work in progress" because it was anticipated that more condition-specific or treatment-specific competencies might be added in the future (Participant 11). In addition, during the development process the team liaised with the Chartered Society of Physiotherapy (CSP) – their professional body - in order to benchmark the competencies and ensure consistency with other areas (Participants 11, 12).

> *"...it's shown how we value our assistant staff and how we are looking at their development and their progression...." (Participant 11)*

4.3.3 Role of allied health professional bodies in support workforce development

During the scoping phase of the project, communication with the allied health professional bodies indicated that some provide guidance, training and online resources aimed at supporting and developing the support workforce. For example, the CSP provides a position statement, practice competencies, clinical knowledge development, progression routes and guidance on delegating activities to support workers[5]. The Royal College of Occupational Therapists (RCOT) has published a career development framework[6] based on four pillars of practice, which is aimed at both the registered AHPs and their support workforce. The British Dietetic Association has a continuing professional development programme for support workers which includes communication skills, professional practice, nutrition and nutritional support. The Society of Radiographers has published an education and career framework[7] for the radiography workforce and a scope of practice[8] for the assistant practitioner role. The Royal College of Speech and Language Therapists (RCSLT) also designed a competency framework for support workers in 2002, but it was recently removed from the website to be updated (RCSLT; Participant 8); incidentally, both Participant 8 and the professional body commented that very few support workers are members of the RCSLT.

In contrast, it was reported that some of the allied health professional bodies (e.g. The College of Operating Department Practitioners and British Association of Art Therapists) generally have very little involvement with their support workforce.

[5] See: https://www.csp.org.uk/networks/associates-support-workers
[6] See: https://www.rcot.co.uk/sites/default/files/CAREER_FRAMEWORK.pdf
[7] See: https://www.sor.org/learning/document-library/education-and-career-framework-radiography-workforce
[8] See: https://www.sor.org/learning/document-library/scope-practice-assistant-practitioners

4.4 Outcomes

The participants reported a range of outcomes for three core groups: the individual support worker, the allied health service and the patients in their care.

4.4.1 Professional development for the individual support worker

Implementing training opportunities is clearly beneficial for the support worker's personal and professional development, extends their scope of practice and makes them feel valued as members of the team (Participants 2, 5, 7, 8, 9, 11). For example:

> "Because of what they do, the roles that they cover which is far exceeding what we thought they would be able to do, I think they have gained a lot of experience, grown as people themselves, learned things about themselves." (Participant 5)

In particular, the bespoke training course about supporting AHP students was reported to improve the support worker's confidence by reassuring them of the boundaries of their support role:

> "A lot of what we teach, they are doing it already... but it's just consolidating that knowledge that they already have. They have all this experience, but aren't always sure if they are allowed to help students out and give feedback... It's just putting some parameters on what their role can be and giving that permission and reassurance." (Participant 10)

The successful implementation of assistant practitioner training can create a progression route for support workers to move from band 3 to band 4 positions, expand the skill mix within the allied health team and enhance job satisfaction (Participant 7). The assistant practitioner apprenticeship route was viewed as a valuable pathway for developing the existing, "home grown" workforce:

> "It's definitely a valuable route for bringing people into healthcare that isn't challenging the way it is if you're bringing them in through a degree qualification. It definitely plays to the local workforce, locally grown route.

> That means that there is a more available core of people who would be willing to step in. So, they tend to be roles that are very attractive." (Participant 9)

In addition, the assistant practitioner apprenticeship was praised for providing support workers with a transferable qualification (Participants 9, 11) that can enable them to explore different fields, should they wish to do so. For example:

> "You can take the qualification and apply it to another completely different role and use those underpinning competencies to support you in that. So, their ability to work further afield within healthcare was opened up through that qualification as well. So that was quite a big selling point, that you could do other things with it." (Participant 11)

Participant 11 also emphasised that utilising the apprenticeship levy to fund the assistant practitioner course has opened up the career possibilities for some of the support workers who are interested in training to become physiotherapists by presenting a progression route that can be taken one step at a time, thereby enabling the support workers to gradually develop the necessary study skills:

> "This has opened up a whole new world really, to our assistant workforce, that's enabling them to look at something which they didn't think was possible in terms of their progression. Stepping up each level and taking it a piece at a time for their development. Going from a band 3 right through to university is a huge jump for a lot of people. If you can take it step by step with the assistant practitioner and then build on that into physiotherapy, that's been really key. I think it's shown how much -- even though I'm sure they know they are valued - I think it's given them that extra feeling that we value their input. It's enabled them to build up those skills in terms of study... It's the same as foundation degree, it's a level 5 apprenticeship... So, the writing that they are having to do is academic level. That's developing a whole different skill set for them. And I think it has opened more people up to thinking about being a physiotherapist. The gates aren't there anymore, it's opened that up." (Participant 11)

However, one participant pointed out that not all support workers aim to be registered AHPs and therefore, it is important to "value those roles in their own right and not just see them as stepping stones" (Participant 9).

4.4.2 Improving the allied health service

The findings indicate that developing the support workforce can bring improvements across four key areas: workforce retention, enhanced skill mix across the team, service development and a cultural shift within the whole team.

4.4.2.a Workforce retention

Although some participants reported a static support workforce with many years' experience (Participants 3, 4, 8, 10, 11), there was a general awareness that the retention of staff could be negatively affected by limited opportunities for progression or service developments that impacted on their roles.

"So, by enabling them to grow we can retain them." (Participant 2)

There was an emphasis on 'growing your own' by recruiting from within the existing support workforce and upskilling staff to meet the needs of the service in the hope of retaining them (Participants 1, 2, 3, 6, 9). This is particularly beneficial for smaller professions such as podiatry, which have "real challenges in terms of recruitment" due to having "a very low profile" (Participant 2). In addition, growing the existing workforce means that the service already has prior knowledge of the individual's capabilities and commitment:

> "If we want another band 4, we will put out an expression of interest to our band 2s and 3s and say, 'Is anybody interested in further development?'... With your support workers, you know what you've got, and you know they're capable of studying and you know they're going to stay with you because you've invested in them. They're keen to stay with you and they're committed to hard work. So, there are some benefits of growing your own." (Participant 2)

Implementing a degree apprenticeship pathway for support workers to study allied health degrees clearly has the potential to increase the number of registered AHPs (Participants 1, 11). Participant 1 explained that they were hopeful that the support workers currently undertaking the degree apprenticeship programme would adhere to their contract and remain with the operating department for at least two years so that the trust can benefit from their investment in the individual:

> "...they get the qualification but we also get members of staff. And because we have contracted them -- when they sign up to the apprenticeship it does state in it that our expectation is that you would stay with us for at least two years. Because potentially this is how much you've cost us. We're not sure on the output of that yet because we've not got to the three years, we haven't got them qualified at this time. So we can't really gauge that or measure it at this point... But these are members of staff who have worked with us before, so the chances are that they will stay with us. There's a high probability that they will stay with us because they live within our region..." (Participant 1)

"If you grow your own, people become integrated better into the team" (Participant 3)

Based on the experience of working in a large teaching hospital, Participant 3 believed that developing an in-house pipeline for training support workers can enhance retention as they tend to be based within the local area and want to stay there, whereas the undergraduate students on AHP courses pass through the organisation and are less likely to return to the service. Although the radiography degree apprenticeship has not yet been implemented within Participant 3's organisation, it was noted that this could potentially extend the in-house pipeline for support workers to "bring you out as a band 5 registered radiographer" which "would then mean that you retain your staff better, the people that have worked here already".

4.4.2.b Enhanced skill mix and scope of practice

A key benefit of developing and utilising the support workforce was that it enhanced the skill mix within the whole allied health team (Participant 2, 4, 5, 7, 9). As the support workers developed their skills and extended their scope of practice, the registered AHPs were able to delegate more tasks and focus their time on the more complex clinical cases (Participants 2, 4, 5, 9, 11). In

particular, the assistant practitioner role was reported to enhance skill mix as the support worker is able to work more autonomously and undertake a wider range of tasks (as noted in section 4.1.3) (Participant 2, 7).

Participant 9 suggested that the role of the support workforce has changed significantly in recent years, which has impacted on the ratio of registered to unregistered staff within allied health teams:

> "I would say there has been quite a significant shift, from say 20 years ago when it was a second pair of hands to actually having their own caseloads. I think there is greater responsibility that they hold now, significantly greater responsibility. They are hugely valued and very often it's a challenge for some teams to introduce newly qualified band 5s into the team because actually, they deliver less than the experienced band 3 and band 4.... the roles are expanding and understanding that as long as somebody has the skills and competencies to deliver a role, you can shape what that looks like... So, we've lost that very compartmentalised view of what somebody can and can't do. It's around skills and competencies and that assurance that they've got those skills and competencies and they know when to and when not to. I think that's given a lot of freedom, enabling us to maximise somebody's value to the benefit of patients. Which has enabled the ratio to change within teams." (Participant 9).

It is also evident that the efficiency of the healthcare team is enhanced by utilising a variety of skill mix across all roles and levels:

> "As a department, I don't think we would run anywhere near as efficiently if we didn't have support workers. Within our team specifically, we have a huge amount of respect and dedication into progressing and constantly reviewing our support workers' skill base... I would say from a registered perspective, all the other registered members of the team recognise their worth, their skills and their experience. With any banding in a team you need that variety of skill base for a team to function efficiently." (Participant 4)

There were several comments about how upskilling the support workforce can free up time for the AHPs to focus on more complex tasks, which can ultimately improve patient flow. For example:

"...our support workers are massively respected and massively appreciated, just for the amount of delegation we give to them" (Participant 4)

> "...one of the main roles of the orthoptic assistant is to assess vision, to assess visual acuity... So that's taking a chunk of work away from the orthoptists to allow us time to do other assessments." (Participant 5)

> "That is the key benefit of being able to utilise a support worker. Either in the more straightforward progressions or discharge planning, they can very much continue to progress your caseload with the therapist almost just reviewing from afar... with either band 3s or band 4s they are completely invaluable to us. If we didn't have our support staff, our team wouldn't work as well. From a therapist's perspective, our role is very much in the acute setting based towards assessment and then discharge. Our support workers are very much relied upon for the assessment and ongoing rehab interventions." (Participant 4)

> "I think it allows us more to use our qualified workforce for those more complex tasks. The assistant workforce really do support the ability for us to do a lot more assessing, a lot more being able to see a bigger caseload because we can carry on that rehab and it goes to our assistant workforce to continue it. So, I think they allow us to continue that flow and throughput of our caseloads, really." (Participant 11)

There was also an emphasis on utilising the support workforce to enable the registered AHPs to work to their maximum clinical ability: "We need our podiatrists to be working at their maximum, not doing something that can be done by a support worker in some guise" (Participant 2). Furthermore, Participant 9 commented:

> "...freeing up registered team members to do more complex work, that's the direction of movement and we're holding that and pushing that. Registered people working to the top of their license." (Participant 9)

However, it was noted that the ratio of time that a registered professional spends with patients "changes with the greater amount of activity for the skilled but not registered team members", which can result in some AHPs experiencing "less job satisfaction" or feeling that "their role has become very much assessment, care planning, delegating" (Participant 9). Consequently, it was suggested that registered AHPs might experience more burnout in the future, as the assessment and care planning involves a "highly intensive level of activity" (Participant 9).

4.4.2.c Service development

A key outcome of developing the allied health support workforce is that having more skilled staff members has enabled some of the organisations to expand their service provision. For example, the recent introduction of orthoptic assistants has reportedly enabled the "expansion of the clinics" (Participant 5). Also, Participant 2 recently extended their service to include non-medical prescribing: the podiatrists were trained to be non-medical prescribers and the band 2/ 3 support workers were upskilled to take bloods.

Participant 6 suggested that the assistant practitioner role has the potential to significantly develop health services by broadening skills mix and improving service delivery:

> "I think once they understand the role and how it fits and how it can cross those boundaries between say, primary care and GP [general practitioners], or IAPT [Improving Access to Psychological Therapies] services and GP or AHP speech and language into a community service, once you start to really formulate how it might work, people really see the value of it. I always think it's a bit of a win-win really because it gives employers the opportunity to broaden that skills mix and that diversity, bring people in with lived experience so then help drive services forward to provide the best service they can. It also offers opportunities to grow and retain staff as well." (Participant 6)

Two participants highlighted that utilising the support workforce to assist the undergraduate AHP student placements can increase the service's capacity to take on new students and also, enhance the experience for the students (Participants 10, 11). For example:

> "Our assistant workforce do support our students when they are on placement, in allowing us to have a few more students than we would if we just had physiotherapists working with them. So, they are a huge support for our students when we have them on placement as well... That local knowledge of our services and networks which when you're new into post or coming in for a short time is half the battle sometimes, isn't it? It's just knowing who and where to go to. Actually, their knowledge is super at that." (Participant 11)

Participant 10 explained that formally training their support workers in how to support the AHP students had given the clinicians more confidence that the support workers were equipped to escalate issues, which encouraged the AHPs to commit to more student placements despite their busy caseloads:

> "Some of our teams where they have very part-time staff struggle to take students because the students needed to be full-time. Then there's concern that there may be a day a week when there's no qualified around and what if they need support and there's no one there? But having the assistant come on our course, they feel a bit more confident about saying, okay, we can have a student now because although I'm not here, our assistant can support that student on that day, going through tasks I've set for them and delegated to them so they've got a remit to work within... Also, that side of it where we can look at increasing our capacity, as well. So, teams do feel like they've got more support there from the assistants... So that they can rely on that support if clinically, their caseloads are really high and they think, "I can't take another student because I haven't got the time to teach them." Actually, an assistant can do some of that teaching for them and help out a little bit and delegate some of that responsibility. That's a big help." (Participant 10)

In addition, it was evident that the support workforce can play an important role in supporting the newly qualified band 5 registered AHPs when they initially join the service:

> "I also think for the newly qualified band 5s coming in, although they can see more complex [cases], actually, the level of competence from our very established support workforce is really key in helping support and develop our newly qualified workforce... I think there is a juxtaposition where we are also relying on the knowledge and expertise of our support workforce, to help develop our qualified workforce when they are in their early stages." (Participant 12)

4.4.2.d Culture shift

"We very much see it as we are all working to the same end goal and we all just have different roles within the structure of that..." (Participant

Some of the participants clearly expressed that there had been a culture shift in their service since developing their support workforce. For example, Participant 1 had noticed improvements in morale through "giving people opportunities which can have an effect on the culture", along with enabling "a sense of ownership" amongst the support workforce. It was also acknowledged that "all of the staff have been very pleased that we've done this because they could see the potential in these staff" (Participant 1).

Since introducing orthoptic assistants into their service approximately three years ago, it was felt that the team had become "more integrated" as the support workers "have provided a link between the orthoptist and the ophthalmologist" (Participant 5). One participant felt there was no hierarchy within their physiotherapy team as everyone was included as equal members:

> "I feel we very much sit down as a team and if we have difficulties, we discuss them. They are always invited, and they are always part of our team meetings, they are always part of our governance feedback. They have exactly the same feedback that the therapists receive. It's exactly the same level for them." (Participant 11)

As explained by Participant 2, a significant cultural shift had occurred within their podiatry service whereby an initial resistance to developing the podiatry support workforce was replaced with acceptance and recognition of their valuable role within the team:

> "So initially, we got some resistance with our support workers working in the ulcer clinics. They almost felt that someone was over their shoulder watching everything that they were doing. They had to train these people to – this is how you take the dressing off, this is the dressing I want you to put back on. I want you to do this, I want you to do the test, swab them. So they had to do all that training, we came up with all the competencies for them. They were involved in the training and some of them said no, they didn't want a support worker. Now, if they don't have a support worker, there's merry hell... there's been a huge cultural shift. If a support worker is off sick and they haven't got one, you'd think the sky was falling in, it's dreadful." (Participant 2)

4.4.3 Improving patient care

It was evident that utilising and developing the support workforce had a positive effect on patients through reducing waiting lists, providing consistency and enhancing the quality of care.

"I would say that the quality of care is enhanced by having that wider workforce that you can draw on to deliver that care" (Participant 12)

Participant 1 explained that the implementation of a degree apprenticeship pathway within the perioperative environment has the potential to increase the number of registered operating department practitioners, which will ultimately increase their operating schedules; this will be beneficial for patients as it reduces the waiting time for operations.

Similarly, Participant 2 reported that they had a 12 month waiting list prior to developing their podiatry workforce, but they are now equipped to deliver a timely and enhanced level of care to their patients:

> "...the podiatry team are able to deliver an enhanced level of care because they've got more time to deliver it. They can do the things they need to do. We've been able to bring in prescribing, we've been able to send our team on courses and be innovative and do enhanced things because they've more time to do that. We've been able to prove that the healing rate has been enhanced." (Participant 2)

Within physiotherapy services, it was suggested that utilising the support workforce improves the quality of patient care because "you are drawing on and utilising to the maximum potential, a really expert workforce" (Participant 12). The patients can also access a greater number of therapy sessions than if they were solely treated by the physiotherapist, which can enhance the patient's physical progress (Participant 11).

In addition, the participants emphasised that the allied health support workforce is ideally positioned to provide consistent care for patients, which can increase patient satisfaction:

> "From the patient point of view, I think the patients have that very visible person within the waiting area who is there to be approached. As opposed to very busy orthoptists or ophthalmologists or reception staff. So, in that way they are very much increasing the patient satisfaction, I think." (Participant 5)

> "I think they are also really seen as face to face examples of our therapy department. Because they are probably the most consistent member of a team that a patient will come across because we try and maintain consistency with the caseload. So it will be the same tech seeing that same patient for continuity. They provide a great example of what our profession is and we're trying to promote that because from a registered staff perspective, we're probably a lot more ad-hoc with our face to face contact with patients because we're pulled across such a broader, larger caseload. They are essential to us." (Participant 4)

5. Theory of change

In order to support the future development of support roles, the findings presented in section 4 have been organised into a *theory of change*. This illustrates the process of developing the allied health support workforce. Figure 3 identifies the contextual factors and barriers that can affect the development of the support workforce, and demonstrates the process of change through four categories: *inputs, outputs, outcomes* and *impacts*.

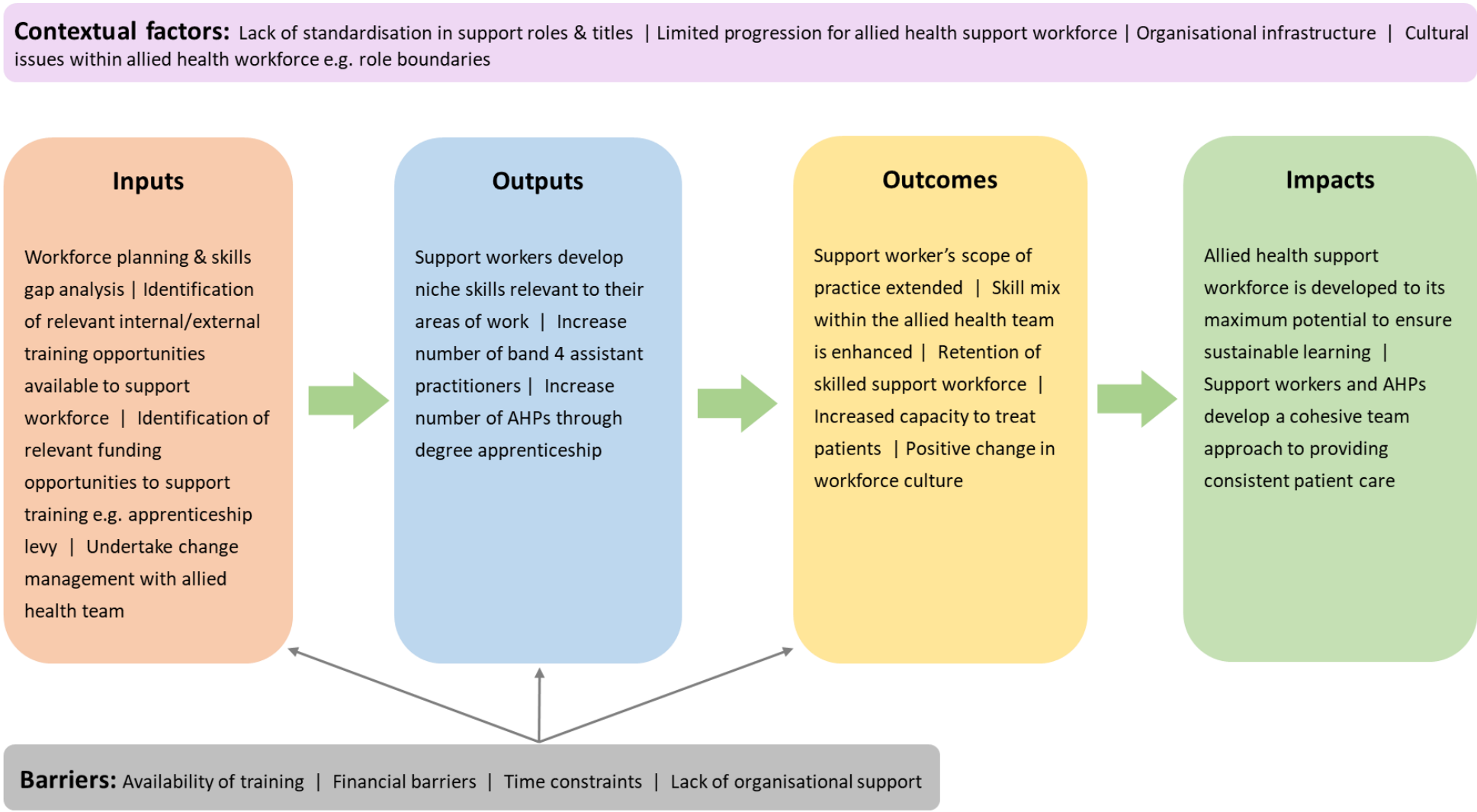

Figure 3: Theory of change for developing the allied health support workforce

6. Conclusions and Recommendations

The final section of this report will present the research conclusions and make recommendations to inform the future development of the allied health support workforce.

6.1 Conclusions

6.1.1 Mapping the allied health workforce

- The research findings indicate there are approximately 35,064 FTE support workers in the allied health professions across England: 34,358 FTE are employed in the NHS and 706 FTE are employed by independent healthcare providers. In February 2020, the 34,358 FTE support staff employed in NHS settings across England included: 17,773 FTE ambulance support staff, along with 16,585 FTE support workers in chiropody/podiatry, dietetics, occupational therapy, orthoptics, physiotherapy, radiography (diagnostic and therapeutic), art/music/drama therapy, prosthetics and orthotics, speech and language therapy, and operating departments.

- It is currently difficult to accurately map the size and scope of the support workforce due to the limited data available at both national and regional levels. The NHS workforce data collected through ESR appears to be the main source for estimating the number of allied health support workers across England, but inconsistencies were highlighted with the coding of some support staff which can skew the data. In addition, data relating to the support workers' specific areas of work and regional staff numbers was only available for the ambulance support workforce employed by the NHS, and not for the support workers across the other 13 professions. Although the research team attempted to collect data about the number of support workers directly from each of the seven HEE regions, it was evident that this data was not available at a regional level. It is possible that this data might be available at a localised level within individual organisations, but the collation of this was beyond the scope of the project.

6.1.2 Understanding the development of the allied health support workforce

- The findings highlight significant variation in the job titles of the allied health support workers, which can be attributed to the distinct development of each profession and organisational factors. The support workers have a diverse scope of practice that is very much determined by the allied health service in which they are based and the specific needs of the patients in their care.
    - Some of the allied health services have a relatively unchanging support workforce with many years' experience. The support workers are highly valued by their AHP colleagues and consequently, there is an emphasis on 'growing your own' in order to retain staff.

- The process of developing the support workforce can be hindered by a dearth of training aimed specifically at support roles, financial issues, time constraints and a lack of organisational support. In addition, the unregistered status of the assistant practitioner role can result in a lack of awareness about the scope of this role and the potential benefits for the whole allied health team.

- In order to successfully implement change, it is important to undertake detailed workforce planning, engage relevant stakeholders and articulate a clear vision to their allied health team. Undertaking change management with the allied health team can alleviate concerns about the blurring of boundaries between registered and unregistered roles, and raise awareness of the benefits of developing support workers.
    - The findings indicate that learning and training needs are typically assessed through standard mechanisms such as performance reviews and personal development plans. The decision-making about who to train, and on what topic, appears to be guided by the specific and localised needs of each allied health service.
    - The support workers' skills were developed through formal learning (e.g. the Care Certificate, level 2 and 3 NVQs, the level 5 assistant practitioner qualification, degree apprenticeships) and informal learning opportunities within the workplace. Collaboration with the learning provider can enhance formal learning, for example, by tailoring elements of the assistant practitioner programme to meet the specific requirements of the allied health service.

    - The apprenticeship levy has opened up opportunities for developing the support workforce, particularly to band 4 assistant practitioner roles and allied health degrees, for those who want to progress further.

- In particular, there was an emphasis on the development of niche skills (typically acquired through in-house training) to create sustainable learning for the support workers which enables role development and fulfils the specific needs of their service.
    - Through the development of bespoke competencies, support workers have successfully been upskilled to conduct a range of procedures and assessments which enable them to coordinate clinics and follow patient treatment plans. In addition, the support workers' skills have been utilised to support AHP students, which can increase capacity for student placements within the organisation.

- The implementation of the band 4 assistant practitioner role was a significant development for some services; this unregistered role provides a progression route for support workers and enables them to expand their scope of practice by working more autonomously. Furthermore, this role has a positive impact on the wider team as the AHP is able to delegate more tasks, which then frees up their time to focus on more complex cases; this enables all members of the allied health team to reach their maximum potential and also, improves patient flow.

- There is variation in the allied health professional bodies' engagement with their respective support workforce: whereas some professional bodies actively encourage the development of support workers, others appear to focus on the registered AHPs.

6.1.3 Enhancing practice through workforce development

- Overall, the findings show that developing the support workforce can be beneficial for the individual, the allied health service and the patients:
    - The support workers develop personally and professionally, expand their scope of practice and feel valued as members of the team.
    - The allied health service can improve staff retention, enhance the skill mix within the team, develop the scope of their service and experience a positive culture shift.
    - Patients can benefit from shorter waiting lists due to an increased capacity for appointments, along with a consistent and enhanced level of care.

- In this respect, the findings of this research can be represented in two figures. The first, Figure 4 below, shows how the current state of the workforce leads to something of a vicious cycle, where the localised significance of support roles do not translate into wider development opportunities to address population health needs.

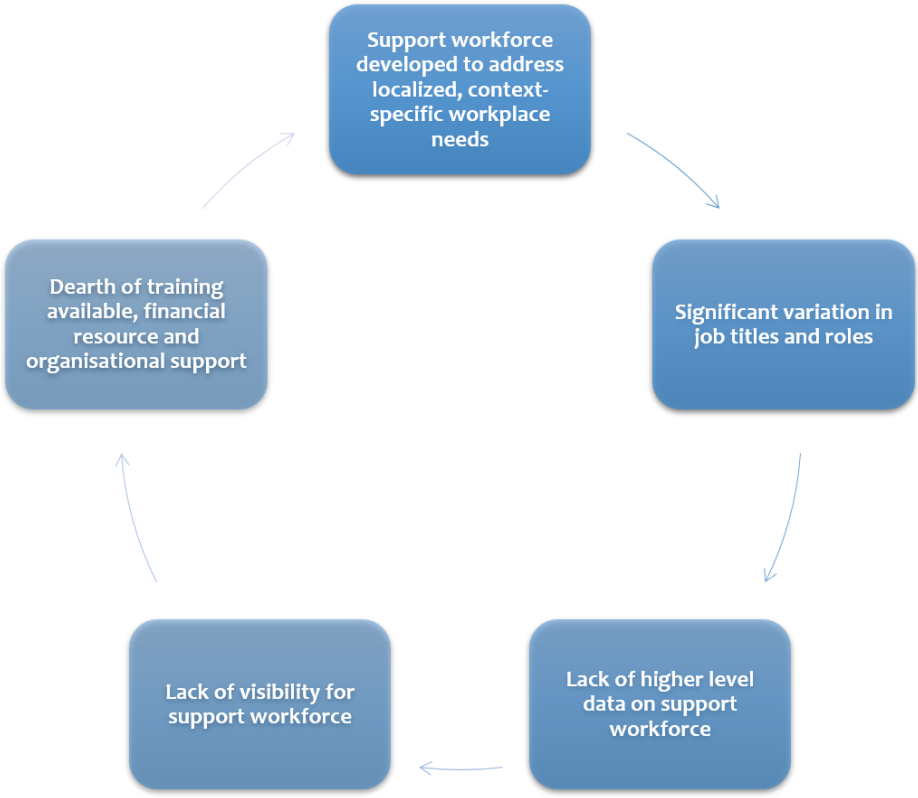

Figure 4 The Vicious Cycle of the Current Support Workforce

- At the same time, it is important to understand that the strength of the support workforce lies precisely in its responsiveness to the contexts of local need. As such, the challenge for the future is to turn this vicious cycle into a virtuous one, but improving the representation of support workers and their activities and establishing them more effectively within wider organisational strategies. This is shown in Figure 5 below.

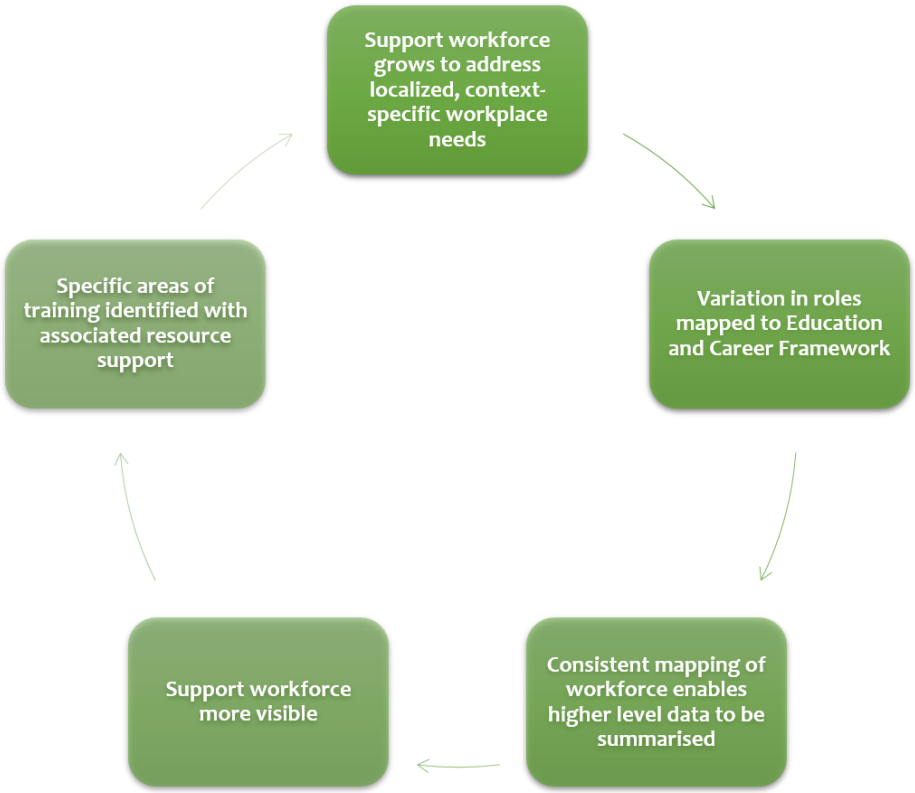

Figure 5 The Virtuous Cycle of the Support Workforce

6.2 Recommendations

- In order to ensure this shift from vicious to virtuous cycle, the following recommendations can be made:
    - Limited data was available for mapping the current allied health support workforce. Mechanisms for accurately recording the number of allied health support workers within each organisation/HEE region should be explored. In particular, the support workforce data needs to capture the number of employees, along with their job titles, qualifications and training. Adopting a standardised approach to documenting the support workforce will enable the data to be easily reviewed and provide an accurate picture of the workforce. A template for this document is provided in the accompanying Implementation Toolkit.
    - It would also be valuable to consistently record the 'area of work' for the support workforce within ESR data in order to provide a more detailed understanding about specialities across the allied health professions.

- It is recommended that mechanisms for standardising the various job titles across the allied health support workforce are explored. This is likely to require consultation across professional bodies.

- The assistant practitioner role has been around for several years, but remains a less visible path into allied health professions. It would be beneficial to promote the role in specifically in terms of its ability to enhance the scope of practice for the whole allied health team, and to clarify any misperceptions that still exist about this unregistered workforce.

- Although some of the allied health professional bodies are actively involved with their support workforce, this is not the case across all 14 professions. Therefore, it is recommended that the professional bodies should review their approach to engaging support workers and consider strategies for raising the profile of their support workforce, including professional development opportunities.

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Appendix 1: Schedule for deep dive interviews

1. Can you tell me about your role and responsibilities?

2. Can you describe your allied health support workforce?
   (E.g. number of support workers, demographics, job titles & pay bands, skill mix)

3. How have you developed your support workforce?
   (E.g. who/what/when/where/why/how)

4. What (other) opportunities for development/progression exist within your service and how do you decide who to train?
   (E.g. in-house or external training, progression routes, process for reviewing skills/learning needs)

5. Can you give me examples of how you utilise the support workforce in everyday practice?
   (E.g. tasks undertaken by support workers, scope of practice)

6. How would you describe the culture of your allied health support workforce?

7. What are the benefits of developing your support workforce in the way that you have?

8. What challenges have you encountered when developing your support workforce?