Healthcare Apprenticeships

Developed for the Community Education Provider Networks
Hosted on HASO which is sponsored by Health Education England

Skills for Health

SKILLS FOR JUSTICE

Transforming Services Together

Apprenticeship Development Plan

January 2018

Executive summary

1. This report has been produced by Skills for Health (SfH) for the Community Education Provider Networks(CPNs)across the Transforming Services Together footprint. Newham and Waltham Forest are hosted by the Clinical Commissioning Groups, whilst Tower Hamlets are hosted by the GP Care Group. It is the culmination of a project to support an apprenticeship programme for workforce development in primary care.

2. Apprenticeships are important for all employer groups. The apprenticeship agenda is a central plank of government policy including a new funding and delivery mechanism introduced to grow the number of apprentices across England. This report provides a full account of all the policy and practice issues relating to the development of an apprenticeship strategy and makes recommendations for a series of actions and initiatives.

3. The strategic aim of the project, from which this report comes, is to inform and support an increase in the range and number of apprenticeships available across TST for workforce sustainability though effective recruitment, retention and progression utilising apprenticeships. This report is a plan that provides:

    - An assessment of the current position in relation to apprenticeships
    - Information about relevant apprenticeship standards (including trailblazers in development and when they will be available)
    - Links to the existing workforce/apprenticeship strategies/analysis and opportunities to use apprenticeships to recruit and retain staff and address other workforce issues: this includes reference to occupations that are hard to recruit into and where workforce planning and refocusing of roles will alleviate these shortages
    - A review of relevant career paths
    - An overview of training and education requirements
    - Comments about transferability and progression
    - An assessment of potential for rotation across organisations, including small/single practitioner organisations in primary care (GP surgeries and community pharmacies)
    - A review of pay and conditions for apprentices and exploration of current developments and challenges
    - Recommendations to include “quick wins” and what can be done in the longer term.

4. This apprenticeship development project does not stand-alone. It aligns with a number of other plans, including for example, the East London Heath and Care Partnership (ELHCP) that recognises local providers will need to adapt service models, and ensure workforces are supported and trained to deliver services in new ways, flexing organisation priorities to embrace a new approach to planning and contracting services. The current workforce is not sufficient to meet the challenges of growth in demand and system transformation. Workforce transformations are needed to respond to changing service needs. A key aim is to attract, encourage and train staff in working across integrated health and social care systems.

5. There are at least 20 active partners in the ELHCP, making for a diverse and varied context. Within this complex stakeholder landscape employers must consider why they might engage with the apprenticeship agenda. While there are clear benefits for all stakeholders, given the complexity of the relationships between these stakeholders, (employers themselves, training/education providers, the apprentices, other employees/team members and patients/service users), there are challenges that require the reconciliation of different interests and the careful consideration of costs and benefits.

6. A well-designed apprenticeship system is attractive to potential candidates whether as entry to employment, or for personal development or progression within their chosen career. This can create value for employers not just by creating new efficiencies in the system, but also by being able to recruit engaged and committed apprentices as part of an investment in the future workforce. Apprenticeships can contribute to the local health economy through effective service provision and local employment. This can only be done through a partnership approach.

7. The rationale for the partnership approach is to ensure the most efficient use of resources locally to deliver the training of both new and existing staff through new apprenticeship standards and together fill workforce gaps in current and future provision of services. There is recognition that partners are at different stages of readiness to address this agenda.

8. Engagement with the apprenticeship agenda differs across the TST. The research showed that there is a consistently high level of knowledge and understanding of apprentices among the apprenticeship leads, and an awareness of the barriers to and opportunities for apprenticeship expansion, but this is not always the case with service leads. The variability of the employment of apprentices across the TST indicates the need to share knowledge and experience. However, the drivers are understood (existing skills gaps and recruitment difficulties), and there is a perceived potential to expand apprenticeship numbers across clinical staff and where there are particular roles that are hard to recruits to.

9. The apprenticeship landscape is changing very quickly, with new standards and endpoint assessments being approved. All health-related apprenticeship standards can be found on the dedicated Skills for Health website Healthcare Apprenticeship Standards Online. The portfolio of apprenticeship roles available to GP practices is growing, and approvals for standards are being processed. The status of some of the standards indicate that recruitment to some new roles may need to be medium to longer-term aims of partners although this is a changeable state.

10. One advantage of many of the clinical and non-clinical apprenticeship standards that have been approved is that role development could be undertaken to develop the multi-disciplinary team to support primary care providers. Opportunities do exist for developing priority areas to help fill current gaps in the workforce, using available apprenticeship standards across both clinical and non-clinical roles. Examples for short-term developments include healthcare

assistant roles, trialling nursing degree roles, and adapting business administration and customer service roles for non-clinical tasks that can ease the workload of clinicians.

11. It is acknowledged that, for primary care providers, there is a need to balance the challenges, costs and benefits of apprenticeships. The challenges relate to the cultural context and the willingness of organisations to support a strategy. Development of an apprenticeship 'culture' requires a set of 'management capacities' within employer organisations that allow them to make effective use of apprentices. Practical issues include the costs of salaries and setting up the structures and systems. There are specific physical practicalities associated with placing apprenticeships in primary care organisations in what are, in some cases, essentially family businesses. The administrative load associated with the management and delivery of an apprenticeship strategy is considerable. Some specific areas that require financial consideration relate to the HR issues associated with employing apprentices include:
    - Managing time out for training
    - The contribution of apprentices to productive work in the practices
    - The apprentice's wages
    - The cost of trainers and mentors
    - The context in which the apprenticeship is provided, (the characteristics and size of the practices as well as regulation and NHS statutory and mandatory requirements).

12. Some of the costs associated with training are the same as for any other employee, but the cost-benefit balance for apprenticeship development may require more skilled supervisors and trainers to make apprenticeships profitable for an employer. The analysis of costs to practices should:
    - Acknowledge that the benefits may be non-financial, such as a more flexible and efficient and productive workforce
    - Take into account the costs of paying salaries
    - Consider how and where the apprentice can fill gaps in the workforce
    - Relate activity to the local labour market; how difficult it is to find skilled recruits
    - Manage the risk that fully-trained employees might be poached by other employers
    - Consider the effect of an apprenticeship on retention of staff.

13. Apprentices must have a contract of employment, which is long enough for them to complete the apprenticeship programme, and have a job role (or roles) that provides them with the opportunity to gain the knowledge, skills and behaviours needed to achieve their apprenticeship. The Apprenticeship standard suggests a time for completion. Pay rates for apprentices should be considered within the National Living Wage and the National Minimum Wage frameworks. In recent weeks, HENCEL have drafted guidance for partners across the footprint for a shared apprenticeship policy in the hope of developing a common agreement on pay and conditions within the STP. This will be of interest to partners and may provide a good benchmark and a starting point for discussions for primary care providers to work within.

14. Information gathered during the research confirmed that the majority of GP practices across the TST will not pay the mandatory apprentice levy because their wage bill/number of employees is too small. In effect, non-levy paying employers will share the cost of training and assessing their apprentices with government - this is called 'co-investment'. These changes around apprenticeship funding should be considered as an opportunity to access subsidies for training the workforce. Non-levy payers (those with a wage bill under £3 million) negotiate a contract with an apprenticeship training provider that has successfully tendered for public funding, after which 90% of their apprentices' training costs will be covered.

15. All apprenticeship standards must include a minimum of 20 per cent off-the-job training. This does not necessarily mean that apprentices must attend college, or be away from the employer's premises, but they must undertake some sort of training/development activity away from their day-to-day job, in order to learn and practice their skills and knowledge.

16. The NEL area has some specific characteristics that may hinder progress with developing apprenticeships strategies: the demographic characteristics of people living and working in the area, but also the size and nature of the GP practices. This will necessitate the consideration of a range of options for managing and employing apprentices. There is a clear desire to explore how non-levy payers in the partnership might be able to access the funding in partnership with levy paying partners.

17. It is important to contextualise the aspirations for this project. Any appraisal of the current situation must take into account key threats and weaknesses within the partnership approach as identified within the report, in particular, to address the different levels of organisational readiness and engagement of the Small and Medium Enterprises in the constituency.

Key Recommendations

1: Workforce Intelligence and Planning

To develop and use a single workforce planning and intelligence tool across the three CEPNs. This would facilitate a TST footprint wide identification of gaps in the workforce that can be filled by apprentice roles, using supporting information on standards and the requirements of individual practices to allow informed decisions to be made.

Identified areas of work for consideration to deliver this recommendation

- Workforce intelligence and planning Information should be shared and collated to inform discussions and support the decisions about the numbers of apprenticeship roles to be commissioned using a specific standard and single education provider across the footprint.
- This work should feed into development and opportunities for role developments across the two nursing super hubs that cover the CEPNs.
- There should be a named clinical lead in each CEPN who can make objective judgments about clinical need, including role developments in the context of safe clinical practice and safe clinical staffing levels.
- There should be a named person in each TST area responsible for updating workforce information and sharing the intelligence with partners.
- Information should be gathered concerning training capacity and ability to support placements.

2: Develop Collaborative agreements, Recruitment, Pay, Terms and Conditions

The three CEPNs should work together with stakeholders collaboratively to agree and make recommendations on a sole recruitment process and the level of pay that apprentices will receive for different standards used in Primary Care across TST. Develop and adopt a common approach to recruitment, contractual and employment terms and conditions and managing apprentices.

Identified areas of work for consideration to deliver this recommendation

- To meet and determine strengths, identify the opportunities and the aspirations to developing apprentices across TST.
- Memorandum of understanding to ensure and agree parameters on the recruitment pay and conditions to be agreed and implemented with stakeholders, CEPNs, GP Federations and CCGS. (Reference should be made to existing Apprentice Pay Policies that have been developed to support this in North Central London).
- To trial one of the options for managing and employing apprentices outlined in part 3 of this report. Growing the model through:

    - take up from individual employers
    - Sharing apprentices with a network or a sole GP Federation the employer
    - Use an Apprentice Training Agency model where they will source and employ trainees.
    - To facilitate these options each CEPN should have a co-ordinator to develop and support implementation.

3: Infrastructure to Develop and Implement Apprenticeships

To acknowledge the need for, and develop the infrastructure requirements in order to take this work forward, including the appointment of an apprenticeship lead across the three CEPNS to develop roles.

Identified areas of work for consideration to deliver this recommendation

- Scoping of the requirement and resource required to develop a case for the infrastructure required to grow apprentices in primary care and to co-ordinate the view points from CEPNs.
- A communications strategy on the use of apprentices to engage all stakeholders, linking in with the marketing of careers work being undertaken across TST and being expanded to the ELHCP.
- The post employed by Newham CEPN to work with SMEs to support and increase apprentices developed across all three areas to deliver this.

4: Choosing Standards available and Career Pathways

To use existing standards for clinical and non-clinical roles in primary care and consider developing apprentices at scale across TST in specific areas. The priority areas to be identified by the workforce planning process.

Identified areas of work for consideration to deliver this recommendation

- To use existing apprentice standards in the short-term to develop them within primary care.
- In the short term the recruitment of healthcare support workers and customer service apprentices would offer opportunities to local people and enhance the careers of existing staff.
- In the medium-term, use of the nurse associate standard; this can be supported and referred into working together with providers.
- A more long-term ambition would be the introduction of the nursing apprenticeship role.
- To consider that if any other roles without apprentice standards are required, that standard development is undertaken.
- To use the existing standards set out in Appendix 7, it is recommended that the level 2 and 3 roles for healthcare support workers are developed along with the nursing associate role.
- Development and use of the registered nurse standard when it becomes available.

5: Working Together with Providers & Social Care to develop Integrated Apprenticeships (rotational posts)

To work with providers and hosts across the care pathway to develop integrated care apprentices building on learning from existing pathways.

Identified areas of work for consideration to deliver this recommendation

- The learning derived from earlier projects should inform the development of any integrated care apprentice roles. These should be developed in the context of Care Closer to Home and feature on the agenda of workforce planning as the Accountable Care System develops.
- Skills for Care have trialled integrated H&SC roles and further information relating to a local authority initiative across City and East London boroughs is available from Skills for Care.

6: Collaboration within the East London Health Care Partnership

To work with the ELHCP so that learning from the parallel project allows the development of progression pathways and working together on strategies to utilise the levy across care pathways.

Identified areas of work for consideration to deliver this recommendation

- There is an appetite to work collaboratively between the NHS Trusts and the primary care providers particularly joining up Care Closer to Home developments and out of hospital care support.
- There is an appetite to change the profile of community nursing and the development of the Nursing Associate apprenticeship roles could be an opportunity for more joint working in general and mental health care.
- Building on the work the Apprenticeship leads have done with HENCEL around training provider (TP) procurement, identifies the need for enhanced relationships with local TPs to improve quality and especially with local FE Colleges and HE institutions. It will be important that the TST requirements feature in any collaborations addressing these issues.
- There may be opportunities for joint work on recruiting cohorts of apprentices into nursing pathways. TST should ensure they are included in any opportunities for this and will require creative and approved agreements on how these will be managed.

Introduction, context and methodology

This project report has been produced by Skills for Health (SfH) for the Community Education Provider Networks (CPNs) across the Transforming Services Together footprint. Newham and Waltham Forest are hosted by the Clinical Commissioning Groups whilst Tower Hamlets are hosted by the GP Care Group. The aim is to support an apprenticeship programme for workforce development in primary care across the Transforming Services Together footprint. The acronym TST is used throughout the report to refer to the client.

A similar report has been produced for secondary and specialist care providers in the East London Health and Care Partnership (ELHCP) footprint . The two reports are distinct and separate but the concept of partnership and alignment on behalf of the NEL stakeholders is pivotal to the overall success of the apprenticeship programme and its impact on all stakeholders and so the reports can be used in conjunction with each other.

The project is underpinned by the North East London Sustainability and Transformation Plan (STP) 'Collaborative Approach to Apprenticeships Programme' Plan supplied by Andrew Attfield (Barts Health NHS Trust) and the scoping paper relating to Apprenticeship Development for the partners in the Transforming Services Together Clinical Commissioning Groups (CCGs) and CEPNs in Tower Hamlets, Newham and Waltham Forest, supplied by Gareth Noble (TST Workforce Programme Manager).

The strategic aim of this project, which has been carried out by Skills for Health, is to inform and support an increase in the range and number of apprenticeships available across TST for workforce sustainability though effective recruitment, retention and progression utilising apprenticeships. This report is a plan that provides:

- An assessment of the current position in relation to apprenticeships
- Information about relevant apprenticeship standards (including trailblazers in development and when they will be available)
- Links to the existing workforce/apprenticeship strategies/analysis and opportunities to use apprenticeships to recruit and retain staff and address other workforce issues: this includes reference to occupations that are hard to recruit into and where workforce planning and refocusing of roles will alleviate these shortages
- A review of relevant career paths
- An overview of training and education requirements
- Comments about transferability and progression
- An assessment of potential for rotation across organisations, including small/single practitioner organisations in primary care (GP surgeries and community pharmacies)
- A review of pay and conditions for apprentices and exploration of current developments and challenges
- Recommendations to include "quick wins" and what can be done in the longer term.

Methodology

The project took place between May and October 2017. The production of the report has involved:

- Desk based research of national policy
- Desk based research on the local context
- Primary research
    - Baseline information on apprenticeships in the TST partnerships
    - Workforce data from NHS digital relating to each partner
    - Focus groups with each TST on perspectives around apprenticeships
    - Individual interviews with selected stakeholders
- Scrutiny of current and emerging Apprenticeship standards.

A list of consultations is provided at Appendix 4

Structure of the report

This report is in four sections plus appendices:

- Section 1 provides a full explanation of the background and context of the Apprentice Development Project, including the identification of relevant stakeholders
- Section 2 provides a workforce analysis and explores the different apprenticeship opportunities that might inform future strategy
- Section 3 reviews the operating context for deploying apprentices within primary care
- Section 4 proposes a number of recommendations

The project has involved a significant review of national/local drivers and policy influencers to inform the recommendations. Supporting information that informed the research is therefore provided in the Appendices:

1: Local health and social care initiatives

2: Significant health economy concerns in North East London

3: Stakeholders in the TST Apprenticeship Development

4: List of consultations

5: Apprenticeship funding bands

6: Standards Approval Process

7. Summary of the current status of Apprenticeship Standards

8: Illustration Comparing Salary Costs for HCSW Apprenticeships

9: Example of progression pathway for Clinical and Non-clinical apprenticeships.

Section 1: Context for the report

This section provides a full explanation of the background and context for the Apprentice Development Project. It explains how apprenticeships are now funded and how the policy aligns with the NEL health economy. It identifies relevant stakeholders and notes the potential value of using apprenticeships.

Apprenticeships: The current apprenticeship system

Apprenticeships are not new, but, in their revised and extended format, are at the cornerstone of learning and skills policy. Following an extensive reform programme after the Richards Review of Apprenticeships, they are seen by government as a significant way of addressing skills shortages and improving productivity across all sectors by, essentially, providing "off the job" training, alongside a "real job". The overall principle of the Apprenticeship programme is to incentivise employers to recruit apprenticeships, providing employment with skills training.

The coalition government manifesto of 2010 aimed to have achieved 3 million apprenticeship starts by 2020. The Government set a target of 3 million new apprenticeships by 2020 and in the 2015 Queen's Speech and the Welfare Reform and Work Act 2016 placed an obligation on the Government to report annually on its progress towards meeting this target, which remains in place.

Public sector employers with a headcount of more than 250 are expected to achieve a target of 2.3% of the workforce being apprentices. This will be recorded on 31st March each year. This is not 2.3% of all new recruits, rather an average to be achieved over a longer period of time. While many of the organisations within the TST will have fewer than 250 members of staff, this figure may be a useful indicator.

What are apprenticeships?

Apprenticeships are a structured programme of training, consisting of paid employment and learning. They give people the opportunity to experience working for an employer, learn on the job, build up knowledge and skills, and gain recognised qualifications within a specific occupation or skills area. An apprentice should therefore be defined as falling into one of more of the following categories:

- Someone in a newly created role, or
- Someone in a job role that has changed and requires the post-holder to develop new knowledge and skills following, for example, a restructure or a job evaluation
- Any age, as there is no age restriction
- Undertaking a degree as part of the apprenticeship without incurring any fees.

An Apprenticeship programme:

- Must be associated with a new job role
- Must include the development of transferable skills
- Must differentiate new training and tasks in the case of an existing member of staff in an organisation
- Is not simply a training programme: it requires sustained and substantial skill and competency development that will lead to progression and should be developed over an acceptable time frame.

Quality Assurance

Apprenticeships are now designed to bring enhanced quality assurance by giving them the same legal treatment as degrees, and the term “apprenticeship” is protected by law. The new Apprenticeship programme is centred on **standards**, and not frameworks as before. Apprenticeships are targeted at individual sectors and employer groups, known as trailblazers, develop the standards. Each apprenticeship must have a job description covering the knowledge, skills and behaviours required for a role. The standards may be written at any Level of learning from 2 to 7. During the programme, the apprentice must demonstrate that they have met each area of the standard through the development of a portfolio of evidence and the completion of a project. When they are ready they will go to the ‘endpoint assessment’, which is conducted by an Apprentice Assessment Organisation.

The Institute for Apprenticeships (IfA) has been established to quality assure apprenticeship standards and provide advice on funding. The process from submitting a proposal for developing a trailblazer to approval for delivery of the standard is fairly complex as the trailblazer goes through 3 gateways for approval. A diagram illustrating the process is in APPENDIX 6.

The funding of apprenticeships

The way that Apprenticeships are now funded marks a significant shift in policy. The new apprenticeship legislation set up a levy scheme designed to reward employers that create apprenticeship places. Employers who pay into the levy fund need to ensure they take advantage of it to pay for training that brings new ways of working and fills skills gaps. Full details are regularly updated, and are provided by the Department for Education (DfE). In summary, the DfE funds off-the-job education and training, while employers take responsibility for the supervision and training of apprentices during their work placements.

The Apprenticeship levy was introduced on 6th April 2017. Money is taken from employers with a salary commitment of at least £3 million by HMRC, based on 0.5% of the wage bill following a £15,000 allowance. This money can be reclaimed if it is spent on apprenticeships. Employers who do not pay the levy will make a 10% contribution to their apprenticeship costs and government will make a 90% contribution. This is particularly significant for the small organisations that feature very heavily in the primary care landscape.

Some of the stakeholders within the TST partnership will pay the levy, including the CCGs and possibly GP groups, although data on this is to be confirmed.

The IfA also oversees the Apprenticeship Service, the digital interface to services designed to support the uptake of apprenticeships. The service will help employers by providing an account to access funding, select apprenticeship types and training providers.

A summary Step-by-Step guide to the Apprenticeship service for levy payers is available from Skills for Health. Health Education England (HEE) has a well-developed policy for supporting the development of Apprenticeships and Health England North Central and East London Health (HENCEL) has developed a Toolkit with a range of resources that are helpful for service providers to download and use within their organisations.

Employers may be sceptical that the levy is a tax on the business, but there is some evidence from the OECD that, when reviewing the costs and benefits of apprenticeships, consideration should include the need to take account of the cost of apprenticeship training, how tight the labour market is, how difficult it is to find skilled recruits and the risk that fully-trained employees will be poached by other employers. One of the significant features of the new apprenticeship policy is that although it relates to a training post, because there will be an expansion of a wide range of clinical and non-clinical roles, existing staff, as apprentices, will be able to access the training offered. The levy approach *can* be beneficial as the training subsidy provides employers with the option of controlling the workforce areas they want to fund the training in. This is an important issue and will be referred to in Sections 2 and 3.

Funding Caps

All apprenticeship frameworks and standards are placed within a funding band that sets an upper limit and caps the maximum amount that can be spent on an individual apprenticeship. The funding system

includes a set of 15 funding bands that range from £1,500 to £27,000. The Funding Bands are listed in APPENDIX 5**.** Further details of the actual roles are provided in Section 2 of this report.

NEL Health Economy

The East London Heath and Care Partnership (ELHCP) outlines the local plans for services including proposals for changes to estates, to service provision and the workforce. A Local Workforce Action Board (LWAB) has been established to deliver the workforce plans for the partnership.

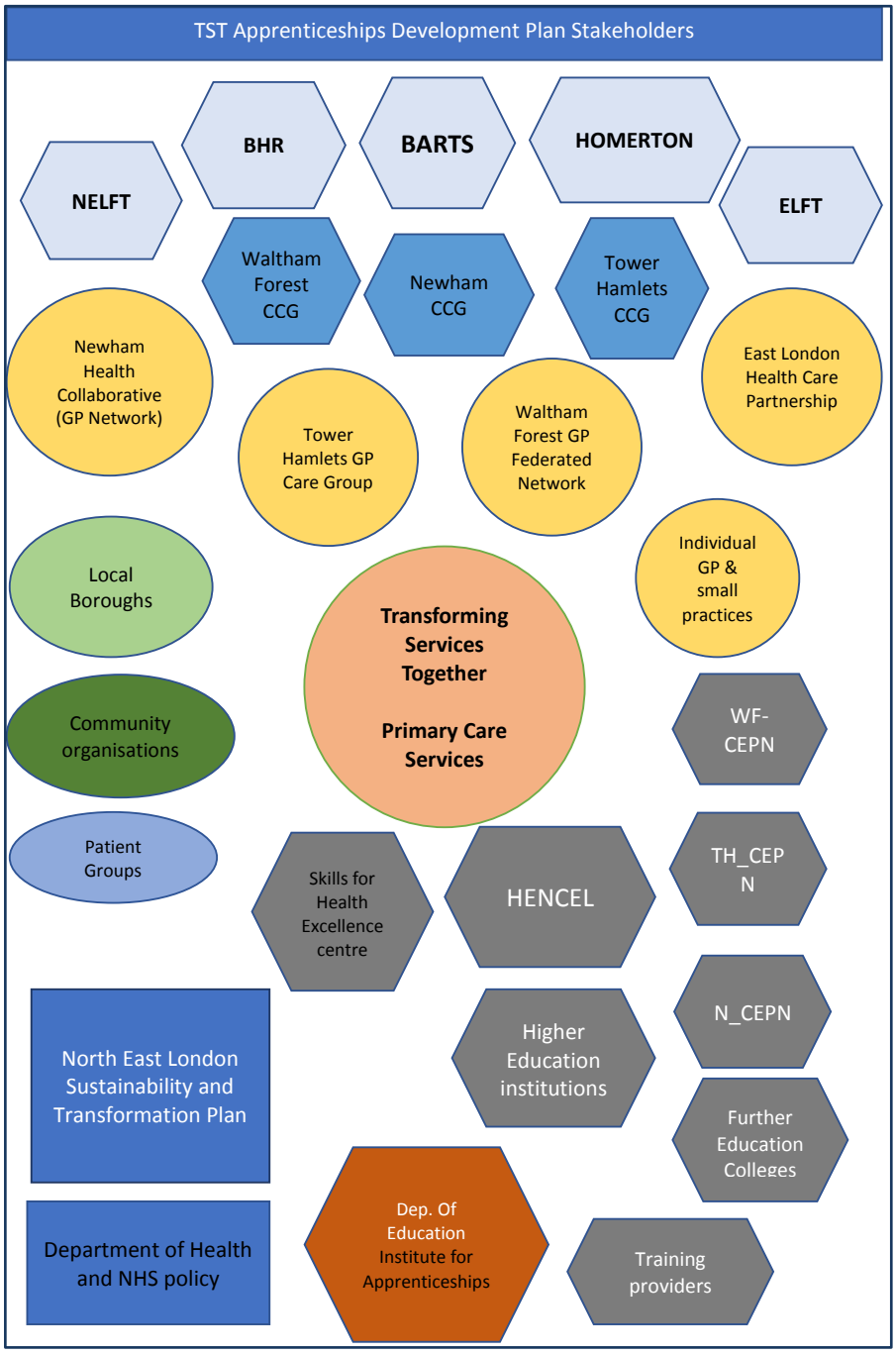
The plan recognises local providers will need to adapt service models, and ensure workforces are supported and trained to deliver services in new ways, flexing organisation priorities to embrace a new approach to planning and contracting services. The current workforce is not sufficient to meet the challenges of growth in demand and system transformation. Workforce transformations are needed to respond to changing service specifications and a key aim is to attract, encourage and train staff in working across integrated health and social care systems.

The ELHCP plan is an active programme of work that incorporates a range of different policy initiatives both nationally and local to North East London. Reference to these are outlined in APPENDIX 1 and include the national Five Year Forward View, London focussed plans such as Healthy London, the London Workforce Strategic Framework and specific primary care policies such as Transforming Primary Care. Specific health concerns influencing partner services are summarised in APPENDIX 2. Ongoing initiatives and test beds including Vanguard, Devolution and Place-based Care innovations are noted.

Stakeholders in TST apprenticeship developments

There are at least 20 organisations that are active partners in the ELHCP. For the purpose of the Apprenticeship development project significant partners are illustrated here. APPENDIX 3 provides a more detailed overview of stakeholders for the TST programme.

Diagram 1: Key stakeholder Map - NEL TST Apprenticeship Development Project



Within this complex stakeholder landscape employers need to consider why they might engage with the apprenticeship agenda. While there are clear benefits for all stakeholders, given the complexity of the relationships between these stakeholders, (employers themselves, training/education providers, the apprentices, other employees/team members and patients/service users), there are challenges that require the reconciliation of different interests and the careful distribution of costs and benefits.

However, a well-designed apprenticeship system is attractive to potential candidates whether as entry to employment or for personal development or progression within their chosen career. This can create value for employers not just by creating new efficiencies in the system, but also by being able to recruit engaged and committed apprentices as part of an investment in the future workforce. Indeed, apprenticeships can contribute to the local health economy through effective service provision and local employment. This will be explored in greater detail in Section 2.

Apprenticeships also have a role in the widening participation agenda and could be used to develop a pipeline for the future workforce. There is evidence from partners across the STP footprint that apprenticeship development is being managed as part of the Talent for Care agenda and features as a coherent workforce planning strategy to recruit and retain support staff (Get in Get on Go Further).

Summary

TST reflects a complex operating context with a plethora of stakeholders with diverse needs.

The new apprenticeship agenda, with its radical changes and new initiatives, offers an opportunity to reflect, take stock and plan what aims and aspirations may converge.

A key challenge will be developing apprentices to work across a range of health and social care settings in order to meet the "care closer to home" objective.

Overall the evidence provided asserts that, within an often turbulent operating environment, changing the *competence mix* within the workforce is more significant than increasing the size of the workforce.

Section 2: Workforce Analysis

This section comments on workforce analysis data and explores the different apprenticeship opportunities that might inform future strategy. It has been noted in Section 1 that the need to introduce more apprenticeships into the health and social care workforce is influenced by a number of national and local drivers. This project builds on existing partnership working to provide high quality teaching and learning for health care staff employed in the North East London area and draws on workforce data to provide evidence of need.

The rationale for the partnership approach is to ensure the most efficient use of resources locally to deliver the training of both new and existing staff through new apprenticeship standards and together fill workforce gaps in current and for future provision of services. There is recognition that partners are at different stages of readiness to address this agenda.

The development of more apprenticeships in acute, primary and community health and care services will be one contribution to ease the growing pressures on services and could help address some of the five key priorities identified in the ELHCP plans to transform the workforce. These are listed below.

Priority	How apprenticeships could help
Retention of existing staff	Recruit existing appropriate staff to apprenticeships to develop skills and competence to meet service needs and create career pathways
Promoting NEL as a place to live and work	Create career opportunities and recruitment of apprenticeships engaging local business partners to develop shared opportunities. Through CEPN support engagement with local communities, schools, colleges to market apprenticeships and future employment opportunities.
Workforce integration to support new models of care	Standardise and promote new 'integrated' roles through development of appropriate apprenticeship standards and working in collaboration with secondary and social care providers. Apprenticeships development could support new roles and provide opportunities for rotation and flexible workers.
Whole systems organisation development	Shared understanding of apprenticeships, training education, employment, pay and conditions and career progression.
Primary care transformation	Consider how apprenticeships can support new role development e.g. care navigators and physician associates and new ways of working. Development of existing staff to work in multidisciplinary teams across care pathways.

Apprenticeships within the TST: baseline information

This section of the report establishes a baseline from which to measure current apprenticeship activity across the TST area, and provides workforce analysis to determine potential priority areas for apprenticeship development.

An online survey was carried out in June 2017. This was distributed to apprenticeship leads across the 3 CEPNs:

- Waltham Forest CCG
- Waltham Forest GP federated network
- Tower Hamlets CCG
- Tower Hamlets GP care group
- Newham CCG
- Newham health collaborative.

The survey aimed to obtain an initial baseline and overview of recent apprenticeship activity and to explore the barriers to and opportunities for apprenticeship expansion in the short to medium term. Not unexpectedly, there are both similarities and differences across the TST members:

There is a consistently high level of knowledge and understanding of apprenticeships among the apprenticeship leads, but this is not always the case with service leads

Apprenticeship take up in the 12 months to June 17 is lower across primary care in TST than in acute services. The variability of take-up across the TST indicates the need to share knowledge and experience

The drivers identified in the STP submission are reflected across the TST (existing skills gaps, recruitment difficulties, and positive experiences of apprenticeships).

There is a potential to expand apprenticeship numbers across clinical staff groups, but less in administrative and managerial roles within primary care

Baseline workforce information for each member of the TST was collated in July 2017. It was derived from NHS Digital, General and Personal Medical Services, England September 2015 - March 2016, Provisional Experimental statistics, released on 29 March 2017. The data for all of England can be accessed from this link. The data available provides a detailed view of the General Practice workforce including GPs by type and their practice staff. The data is published every year and details GPs in England along with information on their practices, staff, patients, and the services they provide.

Data was shared with the same 3 CEPN organisational groups and each one was asked to check and amend the workforce data and to provide information relating to vacancies, recruitment, retention and future workforce change.

The baseline data highlighted significant similarities and differences within TST. Significant findings are:

- Waltham Forest CCG is the smallest of the CCGs in terms of overall GP Practice Staff with 360 FTE, Newham has 510 FTE and Tower Hamlets has 630 FTE
- As a proportion of the total workforce, Registered Nursing staff make up 7% of the workforce in Waltham Forest, 9% in Newham and 12% in Tower Hamlets
- As a proportion of the total workforce, Healthcare Support Workers make up 2 % of the workforce in Waltham Forest, 6 % in Tower Hamlets and 4% in Newham
- As a proportion of the total workforce, Admin & Clerical staff make up 40% of the workforce in Waltham Forest, 50% in Tower Hamlets and 61% in Newham
- Retirement profiles reveal that in Newham and Waltham Forest a significant proportion of GPs and Registered Nurses are approaching retirement age
- Tower Hamlets has a younger than average age profile

	% of workforce aged over 55				
	Newham CCG	TH CCG	WF CCG	HEE North, Central and East London	England
GPs	30%	16%	33%	25%	20%
Registered Nurses	42%	24%	52%	41%	31%
Admin & Clerical	18%	16%	31%	29%	34%
Direct patient care in GP surgery*	13%	8%	22%	20%	27%
Total Workforce	**23%**	**16%**	**34%**	**29%**	**30%**

- Higher levels of turnover were highlighted in Practice Nurses, Practice Managers and in lower-level clinical roles

- GP and Practice Nurse roles were described as difficult to recruit to within Newham and Tower Hamlets, although retention is often more of an issue, and Waltham Forest report more difficulty retaining and developing lower level clinical roles

Newham	***General Practitioners*** *- both permanent and locum. It is thought that the large number of small practices, high workload, the population profile and high churn makes Newham a less positive environment for young GPs who may have a preference for a more collegiate environment.*
	Practice Nurses *are also considered to be difficult to recruit; however, the experience of Newham Together (the CEPN) indicates that if provided with support, the issue is more around retention than recruitment.*
Tower Hamlets	***General Practitioners***
	Nurses
Waltham Forest	*As we understand it,* ***lower level clinical roles*** *are quite difficult for the practices to recruit to. It is not that roles cannot be filled; it's keeping these people at the practice but also developing current staff where possible.*

Anticipated changes with Clinical Roles

Expansion of posts over the next 36 months is anticipated in a range of clinical and non-clinical roles including Practice Nurses, HCAs, Salaried GPs, Clinical Pharmacists, and Care Navigators

Reductions of staff over the next 36 months is anticipated in higher-level clinical and administrative roles including GPs, Nurses and Practice Managers

Opportunities to transfer work from GPs to other roles within the GP Practice, including Physiotherapists, Medical Assistants, Advanced Nurse Practitioners, Physician Associates and Clinical Pharmacists

Increased use of Pharmacists across a range of settings in order to enhance services across primary care

Workforce planning: what has been done to date?

The stakeholders appear to be at different stages of preparation/readiness. For example, there is clear evidence of robust and rigorous workforce planning within Waltham Forest, where the CEPN has produced an online Primary Care Workforce Catalogue, and has indicated that is prepared to share this resource with partners. This is supported by a Workforce Planning Tool Kit that holds a variety of data to support planning and identify gaps in the current workforce. A three-stage process is followed:

1. Engagement via a guided conversation with each individual business or GP practice
2. Identification of needs through deployment and analysis of the toolkit
3. Recruitment: support is given to select roles/recruit workers (internally or externally) and to determine the training required.

The catalogue is not simply an apprenticeship prospectus as it extends to a variety of roles. However, it provides ample information about apprenticeship standards, both ready for delivery and in development, and it should be rolled out and replicated across the TST. If all organisations adopted this it would provide continuously updated information about vacancies, recruitment and turnover issues and skills gaps and match these up with available roles. It would also provide a vehicle for identifying roles for development as trailblazers. It should be reviewed on a twice-yearly basis.

The Newham CEPN has appointed a consultant to examine the wider General Practice workforce from a perspective of succession planning and gap analysis; with the aim of matching up training with practices in order to drive up training standards and support career development. A target of 37 apprentice starts by March 2017 has been exceeded. An ambition is to facilitate the GP Federation to host some of the apprenticeship roles, so the career pathway of health care assistant to nurse could be shared in terms of learning and placement opportunities. There is recognition of the benefit of offering apprenticeship opportunities to existing staff.

Workforce analysis appears to be less detailed in Tower Hamlets, but there is an interest in primary care development, multidisciplinary training, integrated care, and education and networking as an enabler. The work of the CEPN has extended beyond health and moved into care, mental health schools, enforcement and transport for London. It is anticipated that there may be an opportunity for the CEPN to become a training provider for specific roles.

Summary

Overall there are particular roles that are hard to recruit to and gaps where a focus on apprenticeship development could provide a solution, namely:

In Waltham Forest, there is a need for non-clinical roles: leadership and management skills and mentoring and in clinical areas, practice nurses and lower level clinical roles

In Newham, all roles across the workforce are needed to fill gaps, especially GPs and nurses

Nothing specific was reported in Tower Hamlets, although it was noted that some recruitment practices have led to a "revolving" door of new starters and leavers.

Identifying need and determining roles

The apprenticeship survey of June 2017 indicated that interest was focused on role developments for Practice Nurses, HCAs, Salaried GPs, Clinical Pharmacists, and Care Navigators. Although some of the roles identified and debated do not yet exist, they do indicate a need, which suggests that there has been some exploration of skills gaps. However, there is evidence that data gathering is not consistent across all TSTs and that there is not a clear picture of all apprenticeship opportunities either approved for delivery or currently in development.

The focus groups with identified practitioners held in July 2017 in the 3 TST CEPNs, explored further the data returned by the desk-based surveys. Respondents noted issues and barriers associated with the development of specific apprenticeship roles. These included:

- A distinct lack of career progression opportunities within primary care, especially in non-clinical roles
- An urgent need for cultural change in order embrace the apprenticeship agenda
- A current position where there are both numbers gaps and skills gaps acknowledged across the TSTs, however, the way that data is gathered and interpreted is not consistent and varies in its depth and robustness
- There are differential experiences of recruiting and there is churn within organisations.
- Where apprentices have been used, there has been an experience of a "revolving door" caused by low levels of pay, a lack of understanding of the roles by the apprentices themselves, and the recruitment of unsuitable applicants. (It should be noted that in the main respondents were referring to apprenticeship frameworks not to the new standards)
- Standards need to be clearly linked to roles with the identification of clearer pathways; practices need to understand that undertaking apprentice training does offer the prospect of employment within the same practice, network or federation.

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"Understanding about apprenticeships depends on the maturity and understanding of the GPs"

"There are very, very few progression opportunities in primary care"

"People underestimate the need for clinical leads and nurse leads to develop their competence"

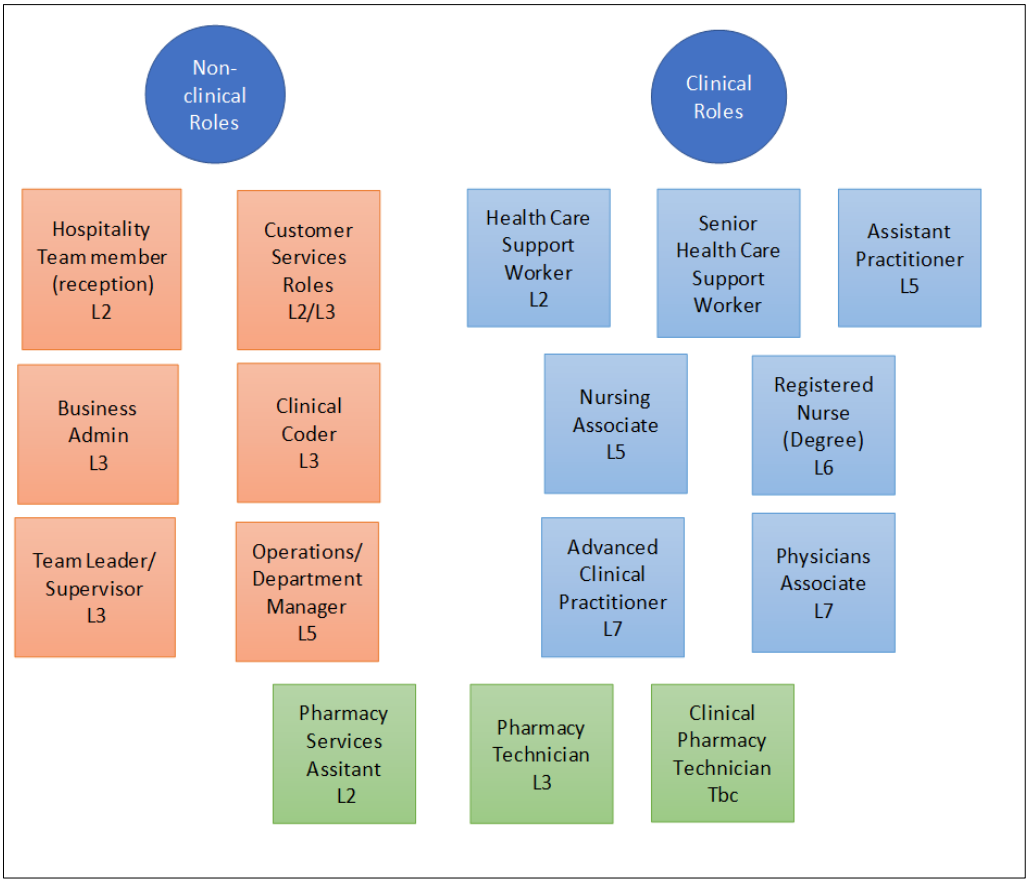
The apprenticeship landscape is changing very quickly, with new standards being approved and endpoint assessments being agreed. All health-related apprenticeships can be found on the

dedicated Skills for Health website. Information about apprenticeships approved for delivery is correct at the time of writing. Up to date information is available from the Healthcare Apprenticeship Standards Online website.

The approval process for apprentice standards is at APPENDIX 6. There have been changes to approval criteria for standards, leading to delays and concern expressed in the sector that the agreement of assessment plans following approval is too lengthy[1]. In the academic year 2015-16, there were 509,400 apprenticeship starts, of which just 0.2% were degree apprenticeships. One issue may be that there are 240 standards still in the pipeline and the greater scrutiny that is being applied by the Institute for Apprenticeships is likely to slow down the process of approval. Juggling development of apprenticeships that take account of the timeframe for standards approval and requirements for utilising levy is challenging some NHS organisations.

Taking into account the snapshot from both the surveys and the focus groups, the tables in APPENDIX 7 reflect the drawn-out process of readiness for delivery relating to the Apprenticeships of interest for TST partners: it is correct as of September 2017.

Diagram 2 below summarises the potential apprenticeships standards that could provide opportunities for TST partners as potential areas for further development. (Where directly related apprenticeship standards are not available or level of apprenticeship has not been specified, alternatives are suggested.)



[1] http://feweek.co.uk/2017/06/09/employers-slam-inordinately-long-development-time-for-apprenticeship-standards/

Diagram 2: Summary of potential Apprenticeship roles of benefit to primary care Providers across TST

Opportunities for developing the Multidisciplinary Team (MDT)

One advantage of many of the clinical and non-clinical apprenticeship standards is that role development can be undertaken to support the primary care service needs. The current approval status of some of the standards indicates that recruiting to some new roles may be medium to longer-term aims of partners. However, the roles could be beneficial in developing a multi-disciplinary team to support primary care providers.

Nursing apprenticeships

All partners indicated an interest in developing more clinical apprenticeship roles. Health Care Support and Nursing roles are in various stages of approval. The advantage for local partners are that the new clinical roles such as the Nursing Associate have been piloted by partners in the wider ELHCP with the support of a HEE working group. For the Nursing Degree apprenticeship, the standard is approved for delivery but there may be some technical issues to address. It would appear that recruitment to the nursing degree apprenticeships nationally might not start in selected Higher Education Institutions until 2018. Further information is awaited.

Physician Associate roles

A pilot of PA roles with Queen Mary's University London with placements in primary and secondary care is underway across the ELHCP. The focus groups indicated interest in the role. Converting the role into an apprenticeship is at an early stage of development and it is expected the standard development and approval process will pick up pace towards the end of the year.

Comments in the focus groups indicated that there are requirements for more trial and evaluation of the new PA roles as there is a cultural change required by patients and staff before full approval of the role can be made.

The learning gained from rotational placement models being trialled as part of both the nurse associate and physician associate pilots could benefit future apprenticeship development

Pharmacy roles

Stakeholders noted the increasing use of pharmacists in GP practices. The role of pharmacy service assistant is seen as helpful to patients and to ease pressure on GPs, especially when working with patients with chronic health conditions who require support with medicine. The development of pharmacy technician and clinical pharmacy technician roles is being considered. Pharmacy technicians play a part in the management of medicines as pharmacy and multi-professional team members and the Clinical Pharmacy Technician role will be embedded in patient facing clinical pharmacy services across all settings and sectors. These roles are being investigated in a separate research project addressing requirements for developing apprenticeships at the interface between community pharmacy and primary care.

Non-clinical roles

Some apprenticeship standards provide an opportunity for creating bespoke roles for businesses and therefore for more effective support within MDTs. The focus groups identified that some practices employ staff as Medical Assistants, and Patients' Assistants. The groups also indicated an interest in Care Navigating roles or Social Prescribers. In effect, these are non-clinical roles but do involve patient/client-facing activities. For example, in Tower Hamlets a GP practice has developed a Patient Assistant role; this assists other team members' communications directly with patients. The role is not an apprenticeship, but such roles could be developed using the Business Administration standard or Healthcare Assistant apprenticeship standards.

Currently there are no Apprenticeship Standards for Medical Administrator/GP Assistant/medical assistant roles approved for development. It is considered that new GP assistant apprenticeship roles could be developed at level 4 but currently the trial for these roles is limited. A role outline being developed in the North West is identified on the HEE website. Until future approval, the Level 3 Business Administrator standard could be used to underpin education and training for this role, particularly as it relates to non-clinical duties, by contextualising the delivery of the standard to match the specific requirements of the GP practice.

There was some concern expressed that there is no Level 2 Business Administration standard. Discussions about this standard were closed after DoE turned down the request for approval, however existing Level 2 apprenticeships could provide the structure for developing required roles in the primary care sector as noted above including:

- Business Administrator standard at Level 3
- Customer Service Practitioner at Level 2
- Hospitality Team Member at Level 2 (which includes Reception duties)
- Healthcare Support Worker at Level 2 (if also offering clinical care)

The focus groups identified the need for better-developed clinical coding roles. A level 3 apprenticeship standard for clinical coding is going through the development process; it will be of interest to the partners.

Leadership and management

Leadership and management apprenticeship standards are developed across employment sectors but provide an opportunity for professional accreditation from LMI and CMI and can be underpinned by learning within the context of employment. The standards for Operations/Departmental Manager and Team Leader apprenticeships may be of interest for developing practice managers and supervisors. Medical secretary (AMSPAR) qualifications can form a part of the apprenticeship. NHS Employers and HASO indicate senior leader/management apprenticeships for local government and the public sector are under discussion but no further details have been provided. A degree apprenticeship could be helpful for any practices wanting to develop practice manager roles or for GP Federations or Networks requiring coordinating roles.

Integrated Health and Social Care roles

One area that was not referred to by participants in this research was integrated apprenticeships, with health and social care employers operating a rotational programme. However, the ongoing work in the Vanguard sites and as part of the approval for a future Accountable Care System would appear to provide the opportunity for further development of such roles to ease pressures on acute and community health services and provide more responsive patient facing roles. While there are challenges (complexities of partnerships, the time and resources needed to support the apprentices and issues arranging rotations and sourcing placements), the potential of such roles is supported by HEE and there is evidence of successful pilots across the country, with a high concentration in London.

HEE working across North Central East London has developed a three-tiered Care Navigation competency framework, which describes the core competencies for people providing care navigation across a wide range of health, social and voluntary care sectors. It may be that the Senior Healthcare Support Workers apprenticeship standard would provide an opportunity for such roles, should the clinical competencies be required within them. At this time, there is no clear guidance. Such roles do exist however and East London Foundation NHS Trust (ELFT) employs integrated health and social care navigator roles. A pilot of Care Navigator roles has identified the benefits to primary care providers.

A social prescribing role allows the GP to refer an identified patient to a facilitator or co-ordinator who then works with the patient to identify needs or issues that may undermine patient wellbeing. The social prescriber can then refer onwards or draw on community resources to address patient needs. Within the NEL locality the Bromley by Bow Centre provides social prescribing to local medical practices: Bromley by Bow Health Centre, St Andrew's Health Centre, St Paul's Way Medical Centre, Stroudley Walk Health Centre, Merchant Street Practice and XX Place Health Centre (at Mile End hospital) but these involve social services, the voluntary sector, community services, hospitals, informal support networks and GP surgeries. An apprenticeship role could be developed for the coordinator/facilitator but this is more likely be one element of a Senior HCA apprenticeship role.

Summary

The portfolio of apprenticeship roles available for GP practices to develop is growing and approvals of standards for these are at variable stages in the process.

Opportunities exist for developing priority areas that can fill current gaps in the workforce using the standards on the shelf across both clinical and non-clinical roles

Examples for short-term developments include:

Health Care Assistant roles

Trialling Nursing Degree roles and

Adapting Business Admin/ Customer service roles for non-clinical tasks.

Example of primary care apprentices

HEE Yorkshire and the Humber has piloted a clinical healthcare apprenticeship scheme, and this is being extended in 2017/2018. GP practices are invited to apply to participate in what is part of a wider programme of primary care initiatives including physician associate, advanced clinical practitioners, practice nurses and pharmacists. The aim is to promote a standardised regional programme which will be completed in 12 to 18 months.

The learning and development includes a level three diploma in health care support, the care certificate, level 2 Maths and English if appropriate, and dementia awareness training. In addition, there are primary-care specific bolt-on modules, including for example e.g., venepuncture, wound care, first aid (non-CPR) and motivational interviewing and health promotion.

The individual practices, who must employ the apprentice, are responsible for providing other key training including chaperoning requirements, the necessary medical terminology, and cold chain practice and process. Each apprentice must be employed for a minimum of 30 hours per week at minimum wage of £5.60 per hour for the first 12 months, followed thereafter by the age related national minimum wage. An employment bursary is being provided by HEE. These apprentices have to be over 18 years of age. While this is a useful example of a practical approach, it should be noted that the new arrangements, together with funding reductions in HEE, preclude bursaries to support apprentices.

Guidance on the scheme issued by HEE can be found here. Early information about the scheme identifying the CCGs involved and the coordinating role by training hubs (CEPNs) can be found here.

Other **case studies** of successful primary care apprentices have been provided by South Warwickshire GPs and a range of videos showcasing initiatives has been prepared by the National Skills Academy and can be found at https://www.nsahealth.org.uk/video-case-study-apprentices-are-the-talent-pool-of-the-future

Section 3: Managing Apprenticeships in Primary Care

This section explores the challenges and opportunities for primary care providers in recruiting apprentices and managing an apprenticeship strategy. It reflects on ways to overcome barriers and considers how an apprenticeship strategy might be operationalised, by exploring how to access funding, identifying the costs and addressing how to manage learning and development. It is acknowledged that, for primary care providers, there is a need to balance the costs and benefits of apprenticeships.

Cost-Benefit Balance

The challenges associated with managing an apprenticeship strategy in primary care relate to the culture and willingness of organisations to support a strategy as well as the practical issues, including costs of salaries and setting up the structures and systems. Development of an apprenticeship 'culture' requires a set of 'management capacities' within employer organisations that allow them to make effective use of apprentices.[2]

The data gathering exercise for this project raised awareness that apprenticeship developments need to support GP practices by seeking increased flexibility within the workforce; how working patterns can be configured to free up the time of GPs and other senior clinicians; and how an apprenticeship strategy can support these concerns.

There are specific physical practicalities associated with placing apprenticeships in primary care organisations in what are, in some cases, essentially family businesses. These include:

- A lack of organisational readiness
- Issues with supporting learning out of the workplace
- Organising rotation
- Recruitment and selection
- The physical space needed to accommodate apprentices.

The administrative load associated with the management and delivery of an apprenticeship strategy is quite considerable. This involves identifying the numbers of apprenticeships, arranging learning of the appropriate quality, keeping records, and monitoring that will take time and resources; it is likely that there will be a need to have

[2] Kuczera, M. (2017), "Incentives for apprenticeship", OECD Education Working Papers, No. 152, OECD Publishing, Paris.
http://dx.doi.org/10.1787/55bb556d-en

a dedicated individual or team with an understanding of apprenticeships to carry out this function.

Some specific areas that require financial consideration relate to the HR issues associated with employing apprentices:

- Managing time out for training,
- The contribution of apprentices to productive work in the practices,
- The apprentice's wages,
- The cost of trainers and mentors, and
- The context in which the apprenticeship is provided, (the characteristics and size of the practices as well as regulation and NHS statutory and mandatory requirements).

Some of these costs associated with training are the same as for any other employee. The cost-benefit balance of apprenticeships may require more skilled apprentice supervisors and trainers to make apprenticeships profitable for an employer. The analysis of costs to practices should:

- Acknowledge that the benefits may be non-financial, such as a more flexible and efficient and productive workforce
- Take into account the costs of paying salaries
- Consider how and where the apprentice can fill gaps in the workforce
- Relate activity to the local labour market; how difficult it is to find skilled recruits?
- Manage the risk that fully-trained employees might be poached by other employers
- Consider the effect of an apprenticeship on retention of staff.

With regard to retention, there is some general evidence that an apprenticeship can create loyalty between the employer and the apprentice in post-training employment. The most recent government evaluation on apprenticeships indicated that apprentices are often with the same organisation 12-18 months after the apprenticeship and this can be enhanced with the opportunity not only for employment but also providing progression opportunities to higher level skills training.

Apprenticeship Pay, Terms and conditions

Contract of Employment

Apprentices must have a contract of employment, which is long enough for them to complete the apprenticeship programme, and have a job role (or roles) that provides them with the opportunity to gain the knowledge, skills and behaviours needed to achieve their apprenticeship. The Apprenticeship standard suggests a time for completion.

On completion, an apprentice should remain with their employer where a job opportunity continues to exist. Where this is not possible, they must be supported to seek alternative opportunities.

Apprenticeship agreements form part of the apprentice's contract of employment as well as for the learning aspects. Apprenticeship agreements must include a statement of the skill, trade or occupation for which the apprentice is being trained. Apprenticeships for job roles within the scope of the Agenda for Change(AfC) agreement will normally be employed on contracts incorporating the NHS Terms and Conditions of Service Handbook. This however does not apply to General Practice where AfC conditions may not be applied, so any upward salary trend must be addressed.

Government guidance (England) states all apprentices must be offered the same conditions as other employees working at similar grades or in similar roles. This includes:

- Paid holidays
- Sick pay
- Any benefits offered, such as childcare voucher schemes
- Any support offered such as coaching or mentoring.

All apprenticeship standards must include a minimum of 20% off-the-job training. This does not necessarily mean that apprentices must attend college, or be away from the employer's premises, but they must undertake some sort of training/development activity away from their day-to-day job, in order to learn and practice their skills and knowledge. It is acknowledged that there will be capacity issues within General Practice to achieve this, so strategies to manage the requirement will be needed.

Apprenticeships are a learning route to achieve a recognised qualification, but they are not a qualification in themselves. For example, a nursing degree will be the same qualification whether gained via higher education, or through an apprenticeship.

Traineeships

In the NEL area, where education achievements are low, and unemployment is high, especially among people **under 25 years**, some people may not immediately be capable of fulfilling a job role, and an apprenticeship will not be suitable. An alternate approach is to put them on a traineeship to provide underpinning basic skills and employability skills development as a stepping stone into an apprenticeship. Employers will work closely with training providers in supporting such individuals by providing access to work placements.

A high-quality work experience placement with an employer is central to the traineeship. This supports work preparation while the training provider enhances English and Maths if needed. It could provide entry to health care and address the requirements of the Care Certificate if negotiated with the training provider. The Skills for Health Excellence Centre in Barts could provide advice on this. The work experience element should last for at least 100 hours (a maximum of 240 hours for benefit claimants) over a maximum of six months alongside other training. This time frame is to allow for skills development and work-related learning to give confidence to step into work. The scheme is designed to be flexible to meet the needs of employers and the young person. Training costs are met by government funding. Employers are not required to pay the young person taking part in the traineeship but may support trainees with expenses such as transport and meals. Undertaking a traineeship does not impact on a young person's benefit entitlement.

Traineeships have the potential to provide a pipeline to support recruitment into hard to fill vacancies and can be a significant feature of a Talent for Care policy. Traineeships as pre-employment programmes in NHS organisations have been developed with training providers and organisations such as the Princes Trust, and JobCentre plus. Cambridge and Peterborough CCG has had such a scheme. The latter has encouraged participation by primary care providers through a Health Ambassadors scheme. An entry into the programme is through providing work experience opportunities. The steering group for this project has discussed the coordination of opportunities being developed with schools across the region and, for example, NELFT promotes its work experience programme to schools.

Some NHS Trusts provide a pre-apprenticeship scheme through a traineeship model and an illustration of the costs of a traineeship is included in APPENDIX 8**.** The main principle for employing anyone is to pay with respect to age and national minimum wage requirements.

Apprentice Salaries

Pay rates for apprentices should be considered within the National Living Wage and the National Minimum Wage frameworks.

These are the current rates for the National Living Wage and the National Minimum Wage.[3] The rates change every April.[4]

Year	25 and over	21 to 24	18 to 20	Under 18	Apprentice
April 2017	£7.50	£7.05	£5.60	£4.05	£3.50

The government's national apprenticeship website notes apprentices are entitled to the **apprentice rate** if they're either:

- Aged under 19
- Aged 19 or over and in the first year of their apprenticeship

Example: An apprentice aged 22 in the first year of their apprenticeship is entitled to a minimum hourly rate of £3.50

Apprentices are entitled to the **minimum wage** for their age if they both:

- Are aged 19 or over
- Have completed the first year of their apprenticeship

Example:

An apprentice aged 22 who has completed the first year of their apprenticeship is entitled to a minimum hourly rate of £7.05

The apprentice must also be paid for time spent training or studying for a relevant qualification, whether this is while at work, attending a college or training organisation.

From April 2016, employers are not required to pay employer **National Insurance Contributions** for apprentices under the age of 25 on earnings up to the upper earnings limit.

[3] The minimum wage a worker should get depends on their age and if they're an apprentice. The National Minimum Wage is the minimum pay per hour almost all workers are entitled to. The National Living Wage is higher than the National Minimum Wage - workers get it if they're over 25.
[4] https://www.gov.uk/national-minimum-wage-rates

NHS Apprenticeships

The NHS has considered fair pay for apprenticeships. The NHS Staff Council has reached agreement and joint guidance covering the pay and conditions of apprentices under Agenda for Change. [5][6]

The key features of the agreement are:

- Apprentices should be employed on Agenda for Change contracts
- Pay should be determined in accordance with the Agenda for Change agreement section on trainees in the NHS
- Shorter apprenticeships should have a job description that goes through job evaluation, while higher apprenticeships over several years can apply percentages of the band maximum for the job role they are working to qualify for
- The absolute minimum that can be paid under this part of the AfC agreement is the 25yrs+ national minimum wage in England, Wales and Northern of £7.50/hour.

The NHS Terms and Conditions of Service Handbook Annex 21 (previously Annex U) sets out the options for the pay and banding of trainees.

Annex 21 paragraph 4 states that application of a percentage of the qualified band maximum cannot be applied if it would take the starting rate of pay for any trainee below the rate of the main (adult) rate of the National Minimum Wage. It should be noted that the Agenda for Change agreement does not make provision for age related pay rates. It is acknowledged that primary care providers have the option of paying Agenda for Change pay and conditions. In reality many have moved away from this; however the details provided above demonstrates agreed good practice.

In recent weeks, HENCEL have drafted guidance for partners across the footprint for a **shared apprenticeship policy** in the hope of developing a common agreement on pay and conditions within the STP. This will be of interest to partners and may provide a good benchmark and a starting point for discussions for primary care providers to work within. In general salaries are being proposed that are 70% of the top of the AfC pay rate.

[5] https://www.unison.org.uk/news/article/2017/07/apprentices-protected-new-pay-guidance/
[6] http://www.nhsemployers.org/news/2017/07/apprenticeships-in-the-nhs-staff-council-guidance

Illustrative examples of salary costs of apprentices

The salary costs of apprenticeships need to be considered in comparison with recruitment costs for established or new staff roles. In APPENDIX 8 salary costs are illustrated for employing Health Care Support Workers. The figures here have been developed by Skills for Health and are based on the NHS Employers Service Handbook. The figures are based on the recruitment of staff members at Band 2 and Band 3 comparing these with the alternative models for employing Apprentices, taking into account national guidance on the minimum wage and the Living wage. In primary care employees may not be recruited onto NHS Agenda for Change pay bands and this is taken into consideration in the examples. The recent HENCEL guidance is also included to see how salaries at 70% of the top of a pay band plus London weighting are calculated.

The costs are worked on a 37.5hour week, including 20% on-costs of employment to the organisation over 52 weeks, which is the training period for a Level 2 Apprentice. This does not include any unsociable hours' payments, National Insurance and NHS Pension contributions. Other additional costs not illustrated. but should be taken into account include:

- High Cost London weighting adjustment
- Other non- pay benefits offered by the employer e.g. Childcare Vouchers, travel vouchers.

The need for rigorous workforce planning in developing an apprenticeships strategy cannot be overemphasised. In terms of the apprenticeship levy funding, the salary and training costs need to be carefully considered. For example, training two Assistant Practitioners at Level 5 will cost as much as training eight Level 2 Health Care Support workers, so it is important to explore costs as well as numbers and this can be done through a very detailed workforce development strategy based on roles and potential vacancies.

Financial support for employing apprentices

Information provided by the CEPNs during the focus groups confirmed that the majority of GP practices across the TST will not pay the levy. In effect, non-levy paying employers will share the cost of training and assessing their apprentices with government - this is called 'co-investment'.

The changes around apprenticeship funding should be considered as an opportunity to access subsidies for training the workforce. From May 2017, they pay 10% towards the cost of apprenticeship training and government will pay the rest (90%), up to the funding band maximum.

Non-levy payers will not be able to access the apprenticeship service to pay for apprenticeship training until at least 2018. They will have to agree a payment schedule with a training provider and pay them directly for the training. Non-levy payers (those with a wage bill under £3 million) negotiate a contract with an apprenticeship training provider that has successfully tendered for public funding, after which 90% of their apprentices' training costs will be covered.

There are additional incentives employers should take into account when reviewing their options for the role apprenticeships could help fill:

- There will be an incentive for the employers if they recruit a young person aged 16-19. This will be a minimum of £1000 and there will also be additional funding to pay for their training. Smaller employers that recruit 16-19 year olds will not have to make any contribution to the Apprentice's training. Larger employers will contribute 10% of the cost of the Apprenticeship training. The government will contribute the rest of the cost (90%). The payments will be made directly to the training provider.
- This would also apply to 19-24 year olds who were formerly in care or who have an Education and Health Care plan.
- Providers will receive an additional £600 for training on an Apprenticeship standard, an apprentice who lives in the top 10% of deprived areas (as per the Index of Multiple Deprivation), £300 for any apprentice who lives in the next 10% of deprived areas (the 10-20% range), and £200 for those in the next 7% (the 20-27% range). This may be applicable in Tower Hamlets and possibly Newham as outlined in the Department for Communities and Local Government 2015 Indices of Multiple Deprivation reviewed in the London data store, and therefore should be promoted in those areas.

Learning and development/career paths

All apprenticeship standards include an option to achieve a recognised qualification as well as meet the core competences for the job role. These competences have been developed nationally with the approval of employers and professional bodies.

All apprenticeship standards must include a minimum of 20 per cent off-the-job training. This does not necessarily mean that apprentices must attend college, or be away from the employer's premises, but they must undertake some sort of training/development activity away from their day to day job, in order to learn and practice their skills and knowledge.

Apprenticeships are a learning route to achieve a recognised qualification; they are not a qualification in themselves. For example, a nursing degree will be the same qualification whether gained via higher education, or through an apprenticeship.

When setting up an apprenticeship, it is important that employers select and establish effective and constructive working relationships with a training provider (either a local further education college, higher education institution or an independent provider). The National Skills Academy for Health have a directory of providers but the CEPNs have developing knowledge of quality assured providers who should be on the approved ESFA register of apprenticeship training providers (RoATP).

It is important to consider what to expect from a training provider and to remember that the employer is the commissioner of the service i.e. the provision of off-the-job training for the apprentice.

The apprenticeship should be considered as a stepping stone on to a career pathway. An example summarising potential progression routes is in APPENDIX 9**.** This model is based on an example outlined by a partner organisation and illustrates how clinical support workers can progress to registered practitioner, or non-clinical personnel may eventually progress into clinical roles.

Options for managing and employing Apprenticeships

The NEL area has some specific characteristics that may hinder progress with developing apprenticeships strategies: the demographic characteristics of people living and working in the area but also the size and nature of the GP practices as noted earlier from the survey results. There may be a need therefore to consider a range of options for the CEPNs to consider when developing a TST strategy. Some of the benefits and risks identified in the options appraisal for managing and employing apprentices are outlined in the tables below:

Option One: Individual employer	Benefits	Risks
An individual GP practice advertises and recruits an Apprentice into a recognised role within the business. The apprentice may be an existing employee transferring into an apprentice role or a newly recruited member of staff.	The GP or Practice Manager takes on the role of supervisor and organises opportunities for the apprentice to meet the Core standards. The role can be adapted to meet the service need. The apprentice can be paid a salary at minimum/living wage levels outside of the AfC guidelines. A training provider will be commissioned to manage the learning elements of the programme and the End Point Assessment.	The apprentice may not get enough experience to meet the requirements of the standard. May be more challenging with clinical apprenticeship roles. Managing/supervising and mentoring the apprenticeship may be difficult in time - challenged context. The practicalities of hosting an employing an apprentice may be difficult in smaller practices. Offering a lower salary than employers covered by AfC may result in a smaller candidate pool.

Option 2: Sharing the Apprentice	Benefits	Risks
A group of GP practices/Federation develop a Memorandum of Agreement for managing and supporting apprenticeships across a partnership. One business will be the lead partner and employ the apprentice(s) and other partners agree to provide work experience on rotation to support the individuals to achieve the standard.	A Group practice, Federation or Network can share the burden of providing the relevant work experience for an apprenticeship. All partners take on a minimum role as supervisor or mentor. Only one lead partner to bear the cost of the training and applying for co-investment for the training. Across the partners expertise could be developed with particular apprenticeship standards, so each can participate where willing. Build on local experience with Nursing Associate and Physicians Associate pilots. Could be trialled before wider roll out.	There is a need to set up a coordinating forum and evaluation group of the model to ensure targets are met. Apprentice may have a Mixed experience. Practices have little time for support or commitment. Tracking achievements and supervising of skills development becomes fragmented with no coordination. Benefits for all are not shared or understood.

Option 3: CEPN apprenticeship Coordinator	Benefits	Risks
GP Networks/Federations individuals invest in an Apprenticeship Coordinator /Project Manager role for each CEPN. (The role itself could be funded from CCG levy as a Leadership and Management or Project Manager apprenticeship if appropriate). Activity is underpinned by a Memorandum of Understanding and financial contribution by stakeholders to support project management and employment costs as a risk sharing measure.	Building on a combination of activity undertaken by the CEPNs: • Assessment of workforce needs. • Support individual GPs to identify opportunities for apprenticeship recruitment. • Establish a framework for managing and supervising apprenticeships. • Where relevant coordinate the provision of work experience, learning/training and EPA including rotations across the practices. • Commit to recruitment beyond the apprenticeship. • Levy paying partners within the TST footprint could be invited to contribute to the costs of particular apprenticeships to benefit the health economy (developing a model for ACO?). • Facilitation of working across care settings.	The future status of the existing CEPNs. Commitment to funding the role. Commitment from a lead partner (possibly the CCG?) to employ the apprentices and the associated on-costs and salaries HR issues. Commitment from project members to support apprentices in their training. Managing competition and incentives for recruiting to full employment.

Option 4: Apprenticeship Training Agency	Benefits	Risks
An organisation set up by a group of employers to create a pool of apprentices they can hire. The ATA employs the Apprentice. All members of the group contribute to the apprenticeship pot and can 'hire' an apprentice for particular activities. The National Skills Academy for Health (Locally based in the Excellence Centre in Barts) can provide this role.	A small practice may not be able to employ an apprentice full-time, but could use them for particular activities e.g. phlebotomy or weekly child health clinics. GP provides the work experience/supervise training on-the-job, but the ATA manages the rest. Employers choose to pay a negotiated amount into the Apprentice pool and 'take out' a commensurate amount in apprenticeship time. ATA acts as a recruitment agency and hires out the apprentice weekly, monthly and so forth. ATA manages the programme. The pot of money supporting the Apprentices should be sufficient to pay them all the year round.	The ATA has to break even, which can be difficult because margins are tight. In addition to the daily, weekly, monthly charge out rate (including administration / /management costs) may include such ideas as charging a 'finder's fee', also known as temp. to permanent arrangement fee. The trainee doesn't understand the set up. There is a risk of reduced loyalty/commitment to the practices as apprentices have to move around providers. Employers do not get the chance to fully assess capabilities of apprentices and may not convert to employment.

Collaborative options

The options list is not exhaustive and will be influenced by local conditions. The further development of any of these options requires input from practitioners to provide a realistic outcome of success, but could form the basis of a business case. The costs associated with setting up any of these options is beyond the parameters of this report.

Further information to take into consideration includes:

- **Apprenticeship Training Agency**: The option of working with a third party or create an ATA could be attractive, especially to SMEs. The National Skills Academy for Health runs an Apprenticeship Training Agency (ATA) which supports employers who are considering taking on an apprentice. The service is available for employers across the health sector – large or small. The TST may wish to explore using this service for the development of part of its strategy

- **Rotations between providers**: Learning from the experiences of managing the Nursing Associates and Physician Associates pilots, which have training placements in primary care. Drawing up clear Memorandums of Understanding and having senior manager sign off of on these.

- **Coordinating Roles**: a trial of these options could be set up as a project to be carefully managed including an evaluation framework for measuring success. Partners could sign up and contribute to the creation of a project manager role within each CEPN, with supporting administration and researcher facilities to ensure the activities are carefully managed. There is a need to establish a lead employer who is prepared to employ the apprentices or find an alternative way of employing them. The future of the CEPNs in their existing form may be a challenge.

Accessing the Levy

An exploration of accessing levy funding is essential.

The research found some evidence that the levy paying partners will not meet their spending targets in the first years of the scheme. Most attention was paid to Barts, but this is likely to apply to the other secondary provider NHS trusts. There is a clear desire to explore how non-levy payers in the partnership might be able to access the funding in partnership with levy paying partners.

However, it must be noted from this research, that one issue for non-levy payers is that there is no incentive to focus on apprentice development when there are other sources of funding available. The HEE supported programme to upskill nurses to become GP practice nurses was warmly welcomed and take up has been excellent. Although levels of uncertainty were expressed about when/if this funding stream ends then developing an apprentice pathway substitute would be time-consuming, slow and by no means certain to be improved.

There have been fears expressed nationally about apprenticeship funding for SMEs, suggesting there will be a drop in the number of small businesses taking on apprentices and, by extension, a drop in the total number of apprenticeship starts.

It appears that some non-levy employers cannot absorb the requirement for 20% off-the-job training, particularly when potential apprentices are existing staff. There does seem to be an understanding among small businesses that hiring an apprentice is a major commitment in terms of the wage bill.

SOAR Assessment

An analysis that draws together the key themes emerging from the research has implications for the apprenticeship strategy. It is important to contextualise the aspirations for the project. Any appraisal of the current situation will take into account key threats and weaknesses within the partnership approach as identified within the report particularly to address the different levels of organisational readiness and engagement of the SMEs in the patch.

A partnership review that can be used by partners is to take a SOAR approach that identifies the Strength, Opportunities, Aspirations and Results of the project. This appreciative inquiry approach is a strategic planning framework that focusses on the strengths of the project and identifies results that all stakeholders can share. Based on findings to date, the table below identifies some key issues:

SOAR Assessment

Strengths • Commitment to cooperate • Robust data analysis tool developed by Waltham Forest • Evidence of successful use of apprenticeships and examples of good practice to draw upon • Engagement with General Practice on workforce initiatives • Good knowledge of local health economy and socio-economic drivers	**Opportunities** • Sharing costs and other liabilities • Establish worthwhile career opportunities through collaboration, use of rotations etc. • Use partnership to demand appropriate learning and development opportunities • Role of Federations developing as an employer • Work with local authorities and other providers to develop integrated care roles • Use existing models (for example across mental health providers) for approaching rotations and shared apprentices • An opportunity to establish develop host employers across a number of sectors
Aspirations • Become employers, individually or collectively, supporting apprenticeships for training and development of staff • Implement an apprenticeship strategy to meet organisational needs • Make an impact on the local health economy, reflecting the values of primary care providers • Use apprenticeships for recruitment and retention of staff in key areas of need to benefit local service users and patients • Create new approaches to developing multi-disciplinary team working supporting transformation in primary care • Develop new approaches to health and social care integrated roles • Become employers of choice for local people	**Results** • Meet a target number of apprenticeship starts across the partnership over 3-year period • Set target and achieve number of local people employed post-apprenticeship into quality jobs • Develop and retain talent pool of people working at different levels in different roles to fill skills gaps and improve retention • Identify progression opportunities • Marketed success stories • Create target number of new integrated roles working across the partnership • Create structured and measurable approach to managing apprenticeships across the TST

Section 4 Recommendations

These recommendations have emerged from the research undertaken and take into account the complex and multifaceted nature of the partnership. They acknowledge that there are diverging agendas and different operating contexts. The recommendations are arranged thematically and offer a baseline for further negotiation and development:

1. Workforce intelligence and planning

- Skills for Health recommends that all the TSTs should adopt the same workforce information system, most likely extending and developing the Waltham Forest toolkit to engage with practices and promote the apprenticeship agenda.
- Workforce intelligence and planning Information should be shared and collated to inform discussions and support the decisions about the numbers of apprenticeship roles to be commissioned using a specific standard and single education provider across the footprint.
- There should be a named person in each TST area responsible for updating workforce information and sharing the intelligence with partners.
- There should be a named clinical lead in each CEPN who can make objective judgments about clinical need, including role development in the context of safe clinical practice and safe clinical staffing levels.
- Hard to recruit to posts should be converted into apprenticeships following intelligence sharing and coordination.

2. Develop collaborative agreements, recruitment, pay, terms and conditions

- The three CEPNs should work together with stakeholders collaboratively to agree and make recommendations on a sole recruitment process and the level of pay that apprentices will receive for different standards used in Primary Care across the TST.
- In order to provide equality of access, a Memorandum of Understanding should be developed to establish parameters and procedures including a common approach to recruitment, contractual and employment terms and conditions and management of apprentices.
- Working practices relating to apprentices should be aligned across the TST. This can be enhanced by the adoption of a “toolkit” by all partners, which provides a template for activity from understanding the business case, identification of roles, through recruitment, selection and employment, to training and progression. Such a toolkit is available from Skills for Health.
- Time should be given to bring partners together to reflect on the strengths within the partnership, identify the opportunities and the main aspirations of partners with

regard to apprenticeship developments. Working together in this way will uncover how ideas can be implemented effectively.

- A decision should be made to select and trial one of the options for managing apprentices identified within part 3 of this report.
    - take up from individual employers
    - Sharing apprentices with a network or a sole GP Federation the employer
    - Use an Apprentice Training Agency model where they will source and employ trainees.
- Each CEPN should have a co-ordinator to develop and support implementation

3. Infrastructure to develop and implement apprentices

- Skills for Health recommends a dedicated coordinator for apprentices across entire TST is appointed. The volume and complexity of work associated with recruiting, employing and training apprentices is considerable. This could be an associate or consultancy role in the first instance, rather than an established substantive post, to offer flexibility.
- The need for culture change, communication, information sharing and marketing the apprentice message is an imperative. The Newham CEPN provides an example of good practice and should be replicated
- To achieve a long-term strategy, a decision should be made about locating the employment of apprenticeships and management in one place.
- Where rotation or sharing of apprenticeships is an option, this should be managed via the Memorandum of Understanding. The Skills for Health Apprentice Toolkit would be a useful resource to use to determine precise arrangements.

4. Develop protocols utilising funding and financing agreements

- Some partners within the TST membership pay the levy and others do not. This requires an exploratory and flexible approach to determining if and how to access the fund by non-levy payers. It could be possible to deploy the levy within a supply chain - one partner could employ the apprentices and sub contract them out to others. Here, the comprehensive Memorandum of Understanding should be used to set out all aspects of the contract of employment and how the costs of employment and training are shared and risks mitigated.
- Partners should consider a formal agreement for TST partners for signing up to the HENCEL shared protocols for apprenticeships pay and conditions.

Choosing apprenticeship standards and career pathways

- There is a clear appetite for certain roles and these should be formalised and prioritised. In the short term, the recruitment of healthcare support workers and customer service apprentices would offer opportunity to local people and enhance the careers of some existing staff.
  In the medium term, progression through an apprenticeship framework to Nursing Associate
  In the longer term, Nursing Degree apprenticeship should be considered.
- If a role for which there is no standard (for example care coordinator) is deemed to be a priority, the partnership should consider applying for a trailblazer project to initiate the apprenticeship standard.
- New standards are coming online frequently and for updated information partners are encouraged to engage with Skills for Health's website and for guidance and support for workforce planning.
- Support with marketing apprenticeships can be obtained from NHS employers Think Future and Step in to the NHS. This should feed into the existing marketing Careers in Health and Social Care project.

5. Working Together with Providers & Social Care to develop integrated apprenticeships

- To work with providers and hosts across the care pathway to develop integrated care apprentices building on learning from existing pathways.
- The learning derived from early projects should inform the development of any integrated care apprentice roles. These should be developed in the context of Care Closer to Home and feature on the agenda of workforce planning as the Accountable Care System develops.
- Skills for Care have trialled integrated H&SC roles and further information relating to a local authority initiative across City and East London boroughs is available from Skills for Care.

6. Collaboration within the STP

- To work with the ELHCP so that learning from the parallel project allows the development of progression pathways and working together on strategies to utilise the levy across care pathways.
- There is an appetite to work collaboratively between the NHS Trusts and the primary care providers, particularly joining up Care Closer to Home developments and Out of Hospital Care support which should be encouraged and supported.
- There is an appetite to change the profile of community nursing. The development of the Nursing Associate apprenticeship roles presents an opportunity for more joint working in general and mental health care. Skills for Health recommend that a partnership approach to developing this should be considered.
- Building on the work the Apprenticeship leads have done with HENCEL around training provider (TP) procurement, identifies the need for enhanced relationships with local TPs to improve quality and especially with local FE Colleges and HE institutions. It will be important that the TST requirements feature in any collaborations addressing these issues.
- There appear to be opportunities for joint work on recruiting cohorts of apprentices into nursing pathways. TST should ensure they are included in any such opportunities; these will require creative and approved agreements about management.
- The learning from the parallel project led by the NHS Trusts for the STP should be taken into consideration when decisions are made for developing particular progression pathways for apprentices, as well as strategies for utilising the levy

APPENDICES

Appendix 1: Local health and social care initiatives

The STP references a range of influences on the local area. London has exceptional health and social care challenges and this has been recognised by the development of the Healthy London Partnership formed in April 2015, in response to the NHS Five Year Forward View (FYFV) and the London Health Commission's report Better Health for London to improve health services and deliver changes to health in the capital. Specific health concerns identified as priorities for action are outlined in the STP. These socio-economic and well-being indicators require changing responses from local health and social care services and form the core of how services are delivered and available and the workforce implications associated with transformations.

In response to FYFV, the London Workforce Strategic Framework has been produced. This is a collaborative workforce transformation programme involving London's clinical commissioning groups (CCGs), NHS England (London Region) and Health Education England, through the Healthy London Partnership has provided a focus for workforce transformations.

The 2017 Five Year Forward Next Steps report outlined key changes required for specific work groups, not least the development requirements for staff progression such as those in the support workforce and the introduction of flexibility in the training and employment of nursing staff. Flexibility of roles will be required to meet any changes in places of work and the shape of health care in local communities. The emerging apprenticeship routes into health services has been recognised and supported. Ambitions in the STP reflect these requirements.

Specifically related to primary care, Transforming Primary Care in London: A Strategic Commissioning Framework has been developed by the London Primary Care Transformation Board and Collaborative partners and outlines the requirements for primary care teams to work in new ways in support of a population health model with other health, social, mental health, community and voluntary organisations. This aligns with the TST Strategy and Investment Case with its 3 clusters of Care Close to Home, Strong sustainable Hospitals and Working across Organisations. The Health Education England Primary Care Workforce Commission 2015 report into the future of primary care identifies that recruiting more doctors, nurses and allied health professionals although required may not be the most effective or cost-effective way to provide some types of care in primary care settings. The suggestion was for reviewing the place of new roles working in primary care settings such as physician associates, healthcare assistants and possibly paramedics.

Initiatives emerging from the FYFV to trial new models of delivering services within and across health and care services are influencing service delivery in local provision. The apprenticeship programme is peripheral to these, but any development could be incorporated into workforce changes as a result of these initiatives. These include the development of Vanguards and 2 of these have been funded in the North East London area: Tower Hamlets Together is a partnership that includes commissioners and providers of acute, community, mental health, social care and primary health services, including partners in the apprenticeship initiative. The GP federation involved comprises 37 General Practices in Tower Hamlets. Tower Hamlets Together is coordinating new approaches to care; the Barking and Dagenham, Havering and Redbridge System Resilience Group vanguard is looking at the efficiency of sharing communication systems to transform local urgent and emergency care services, removing barriers between health and social care and between organisations. The learning from this vanguard in local Foundation Trusts may influence content of new education programmes for staff.

A further initiative developed by CCGs in London include pilots of new Devolution models for integrating health and social care services and these are underway within the NEL footprint including: Hackney: a health and social care integration pilot, aiming for full integration of health and social care budgets and joint provision of services and Barking & Dagenham, Havering and Redbridge, a pilot to develop an Accountable Care Organisation, where primary and secondary care are closer and patient pathways are redesigned. Both BHRUFT and NEFLT acute care provides are partners in these local initiatives.

Apprenticeship development that could support integrative initiatives between primary and community health services and social care providers may be relevant here and recent findings of activities supported by Skills for Health and Skills for Care may be of interest. A partnership of 4 LAs, (City of London, Hackney, Newham & Tower Hamlets) supported by the Skills for Care Area Officer, have worked together to develop a collaborative health and social care apprenticeship programme, using the former framework model. The LAs pooled their resources and expertise to offer an infrastructure that enabled social care employers in the area to employ an apprentice (from their local area) for the first time. The training element was delivered by Tower Hamlets local authority who had several years' experience of training social care apprentices and were able to use their SFA contract to fully fund the training with the City using theirs to fund the training for the over 25s. The training has rotated around the boroughs with venues being supplied by the partners.19 Apprentices were recruited by 6 employers & started in early March 2013.

A further project relating to innovation in health and care is Care City, a joint venture between NELFT and the London Borough of Barking and Dagenham. Again, partners within the footprint of this project are involved in these initiatives and these new approaches to Place-based Care may encourage the demand for apprenticeships in roles for new approaches to care delivery that may emerge.

Appendix 2: Significant health economy concerns in North East London

Demographic changes including:

- An anticipated growth in the local population of 6.1% in five years and 18% over 15 years.
- Population highly mobile, with residents who frequently move within and between boroughs.
- Deprivation (five of the eight STP boroughs are in the worst Index of Multiple Deprivation quintile).
- Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- Significant health inequalities across NEL and within boroughs, in terms of life expectancy and years of life lived with poor health, diabetes, dementia and obesity all disproportionately affecting people in poverty.

Well-being:

- NEL has higher rates of obesity among children starting primary school than the averages for England and London and generally high rates of physically inactive adults.
- An increased risk of mortality among people with diabetes in NEL and an increasing 'at risk' population. The proportion of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is variable. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- Cancer screening uptake is below the England average and emergency presentation is 5% higher than the national average.

Mental Health:

- Ageing population, continuing work towards early diagnosis of dementia and social management
- Access to Psychological Therapies (IAPT) variable
- Issues relating to Acute mental health
- There is a low employment rate for those with mental illness.

Appendix 3: Stakeholders in the TST Apprenticeship Development

The Apprenticeship agenda forms one element of the workforce development plans identified in the NE London Sustainability and Transformation Plan. The STP involves:

- 5 NHS Trusts (Barts Health; Barking; Havering and Redbridge University Hospitals; Homerton University Hospital FT; East London FT; NELFT) providing both hospital and community services across the locality and
- Local CCGs in Barking and Dagenham; City and Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest.
- Local Authorities covering the area are also involved: City of London; Barking and Dagenham; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest.

For this collaborative apprenticeship development project, the NEL NHS Hospital Trusts and the CCGs covering Tower Hamlets, Newham, Waltham Forest and their associated Community Education Provider Networks are key stakeholders.

Health Organisations (Acute and Community	Services provided	London Borough
Barts Health NHS Trust	St Bartholomew's Hospital (Barts) Local and specialist services for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions.	London City
	The Royal London: teaching hospital providing local and specialist services; children's hospitals; dental hospital, stroke and rental units.	Whitechapel
	Whipps Cross Hospital: A large general hospital with a range of local services.	Leytonstone
	Newham Hospital: district hospital with innovative facilities such as its orthopaedic centre	Plaistow
	Mile End hospital & Community services: a shared facility in Mile End for a range of inpatient, rehabilitation, mental health and community services	Mile End
East London Foundation Trust	Mental health services from three former community trusts in Tower Hamlets, Newham, The	Newham Tower Hamlets City Hackney

	City and Hackney. Community health services provider	
North East London Foundation Trust	Provides an extensive range of integrated community and mental health services for people; Emotional Wellbeing Mental Health Service for children and young people across the whole of Essex.	Barking & Dagenham, Havering, Redbridge and Waltham Forest; South west Essex areas of Basildon, Brentwood and Thurrock
Homerton University Hospital NHS Trust	General health services at hospital and in the community with staff working out of 75 different sites.	Hackney
Barking Havering and Redbridge University NHS Trust	King George Hospital in Goodmayes and Queen's Hospital in Romford. (Also serve clinics across outer north-east London and run some services from Barking Hospital.)	Goodmayes, Redbridge Romford
The Transforming Services Together (TST) in partnership with Barts Health NHS Trust.		
Waltham Forest CCG	GP, Primary Care	Waltham Forest
Newham CCG	GP, Primary Care	Newham
Tower Hamlets CCG	GP, Primary Care	Tower Hamlets

There are additional stakeholders who have an interest in the workforce developments in the North East London area including:

- Health Education Central and North East London (HENCEL)
- Local Education institutions and training providers such as Bromley and Bow
- Higher Education institutions including South bank university, City University
- Community Education Provider Networks related to the three TST partners but also CEPN in nearby communities such as those in City and Hackney CEPN
- The Capital Nurse network within the Healthy London initiative
- Skills for Care
- Local authorities
- Skills for Health National Skills Academy Excellence Centre

There is also a range of stakeholders within the TSTs with whom engagement is critical. These include:

- Senior managers/GPs/business owners
- Front line staff who might be involved in managing/supporting and/or mentoring apprentices
- Pharmacies
- Service users

- Voluntary and statutory service providers and referral agencies
- Community centres

Appendix 4: List of consultations

Contributors to this report have included partners from the ELHCP involved in the collaborative apprenticeships development and other stakeholders who have contributed to information on local and national policy. The list here is not exhaustive:

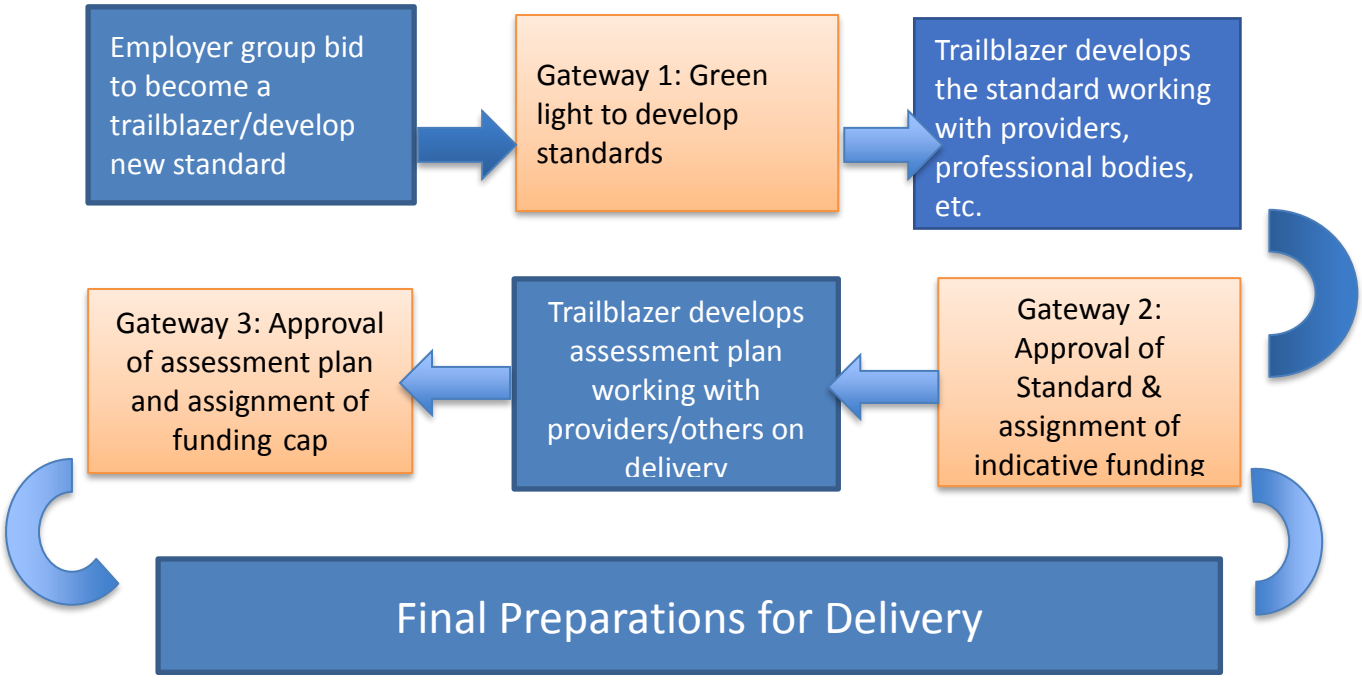
TST partners		
Gareth	Noble	Waltham Forest CCG
Toyin	Ajidele	Waltham Forest CCG
Ruth	Amertey	Waltham Forest CCG
Loretta	Okoh	Waltham Forest CCG
Christina	Anderson	Waltham Forest CCG
Naila	Hassanali	Waltham Forest CCG
Saleema	Abdin	Waltham Forest CCG
Ekramul	Hoque	Tower Hamlets (TH) CEPN
Elaine		Practice Manager, TH
Shaheena	Begum	Reception manager, TH
Liz	Delauney	Newham CCG
Anna	Byers	Newham CCG
Nessa	Khoyrun	Newham CCG
Shuhela	Hannan	Newham CCG
Moshin	Patel	Newham CCG
Prenotti		Practice manager, Newham
NEL partners		
Andrew	Attfield	St Bartholomew's Hospital (Barts)
Debbie	Dzik-Jurasz	Barts
Lois	Whittaker	Barts
Liam	Slattery	Barts
Kevin	Garay	Barts
Basit	Abdul	Barts
Maureen	Finneran	Barts
Sadia	Ahmed	Barts
Sultan	Wahid	Barts
Daniel	Waldron	Homerton (University Hospital Foundation Trust)
Natalie	Moyanah	Homerton
Jill	Sluman	Homerton
Alan	Wishart	Barking Havering & Redbridge University Hospital Trust (BHR)
Jennifer	Garvey	BHR
Jennifer	Stone	BHR
Sandra	Drewett	East London Foundation Trust (ELFT)
Chris	Tyson	ELFT
Princess	Kabba	ELFT
Bob	Champion	North East London Foundation Trust (NELFT)
Neera	Dhir	NELFT
Angie	Singer	NELFT
Health Education England North Central London		
Lucy	Hunte	HEE
Jenny	Halse	HEE

Other		
Ali	Rusbridge	Skills for Care
Ben	Derham	Education & Skills Funding Agency
Jan	Parfitt	Skills for Health
Lorraine	Yeomans	Skills for Health
Lynn	Atkins	National Skills Academy for Health
Angelo	Varetto	Skills for Health

Appendix 5: Apprenticeship funding bands

Number	Band limit
1	£1,500
2	£2,000
3	£2,500
4	£3,000
5	£3,500
6	£4,000
7	£5,000
8	£6,000
9	£9,000
10	£12,000
11	£15,000
12	£18,000
13	£21,000
14	£24,000
15	£27,000

Appendix 6: Standards Approval Process



Appendix 7 Summary of the current status of Apprenticeship Standards

Role	Level of learning	Apprenticeship Funding Band	Current Status (NB 15.09.17)	Comments
Clinical Roles				
Health Care support worker	Level 2	Band 4	Approved for Delivery	Clinical (with non-clinical tasks) support role. Can be adapted and advertised to meet specific jobs across every healthcare discipline. Usually Band 2 on AfC pay system. Progression route to Level 3 and/or pre-registered nursing learning programme
Senior Health Care support worker	Level 3	Band 4	Approved for Delivery	More experienced support worker, carries out a range of clinical and non-clinical healthcare tasks, under direct/ indirect supervision of the registered healthcare practitioner. Usually Band 2/3 on AfC. Progression to AP role or direct to pre-registration nursing.
Assistant Practitioner	Level 5	Band 10	Approved for Delivery	Assistant Practitioners work at level above Healthcare Support Workers and have more in-depth understanding about factors that influence health and ill-health (e.g. anatomy and physiology). Can take on specialist responsibilities such as assisting in total patient assessment, coordination of care (including referrals to other practitioners) and higher clinical skills such as catheterisation, wound care and discharge planning. Can progress to Reg Nursing sometimes with APEL. Usually Band 4 on AfC.

Nursing Associate	Level 5	TBC	Standard approved and assessment plan submitted.	The Nursing Associate is a highly trained support role to deliver nursing care in and across a wide range of health and care settings. The skills and knowledge for the role are taken from the Nursing Associate Curriculum Framework (HEE, 2017). Role can be specialised to meet needs. Usually Band 4 on AfC. Progress to Registered Nurse (APEL).
Registered Nurse (Degree)	Level 6	Funding Band 15	Approved for Delivery	The apprenticeship follows the route to becoming a Registered Nurse. The programme is approved by the Nursing and Midwifery Council (NMC) with standards comprising a common core of skills and knowledge. **Further local information on piloting the role to be confirmed but training programmes are expected to commence in 2018**
Physician Associate	Level 7	TBC	Approved for development- no documents available yet. First meeting held July 2017	Physician Associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician Associates are dependent practitioners working with a dedicated medical supervisor, but are able to work autonomously with appropriate support. Pilots of Physician Associate roles are underway in the NEL area. However, the Apprenticeship standard for this new role is at an early stage of development with further information on the standard expected soon.
Advanced Clinical Practitioner	Level 7	TBC	Approved for development – no documents available yet.	Advanced Clinical Practitioners are non-medical practitioners operating at a level beyond the level and scope of their registered status and typically becoming competent in areas that have traditionally been the remit of medical practitioner. Role provides opportunity for delivery high level practitioner tasks across 24/7 health care delivery model.

Pharmacy Roles				
Pharmacy services assistant	Level 2	TBC	Approved for development but on hold	**An additional research project is being undertaken to assess demand for these roles**. Development awaiting outcome of General Pharmaceutical Council review of standards The role of pharmacy service assistant is seen as helpful to patients and to ease pressure on GPs, especially when working with patients with chronic health conditions and who require support with medicines.
Pharmacy Technician	Level 3	TBC	Approved for development but on hold	Clinical Pharmacy Technician role awaiting outcome of General Pharmaceutical Council review of standards. Will be embedded in patient facing clinical pharmacy services across all settings and sectors.
Clinical Pharmacy Technician	TBC	TBC	EOI submitted – no further documents available.	The Clinical Pharmacy Technician role will be embedded in patient facing clinical pharmacy services across all settings and sectors. Play a fundamental role in enhancing information flow along patient pathways. [7]

[7] http://psnc.org.uk/sheffield-lpc/wp-content/uploads/sites/79/2013/06/EOI_23-pharmacy.pdf

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Non-clinical Apprenticeships				
Hospitality team member	Level 2	Funding Band 7	Approved for delivery	This is a generalist but adaptable standard that could be beneficial in a busy GP practice. The role is very varied and hospitality team members tend to specialise in an area, such as receptionist.
Hospitality supervisor	Level 3	Funding Band 7	Approved for Delivery	Hospitality supervisors work across a wide variety of businesses providing vital support to management teams and are capable of independently supervising hospitality services such as front office supervision.
Business Administrator	Level 3	Tbc	Standard approved, assessment plan in development	Business administrators have a highly transferable set of knowledge, skills and behaviours that can be applied in all sectors. The role may involve working independently or as part of a team and will involve developing, implementing, maintaining and improving administrative services. Tis role can be adapted for any setting/organisation. The focus groups identified that some practices employ staff as Medical Assistants, and Patients Assistants and this standard could cover these needs
Customer Service Practitioner	Level 2	Funding Band 6	Approved for delivery	Another generic role that could be adapted to suit primary/community requirements. Also at Level 3. Core responsibility to provide high quality service to customers which will be delivered from the workplace, digitally, or through going out into the customer's own locality- cover a wide range of situations and can include; face-to-face, telephone, post, email, text and social media.
Clinical Coder	Level 3	Tbc	Approved for development – no documents available yet.	The focus groups identified the need for better-developed clinical coding roles. There is a level 3 apprenticeship role developed – information on the proposal which provided a summary of the role which is to abstract, analyse, translate and data enter Clinical Coding on patient records in

				accordance with National and International Coding Standards, and Trust guidelines.
Leadership and Management				
Team leader/supervisor	Level 3.	Funding Band 7	Approved for delivery	A team leader/supervisor is a first line management role, with operational/project responsibilities or responsibility for managing a team to deliver a clearly defined outcome. A generic role for supporting, managing and developing team members, projects, planning and monitoring workloads and resources, delivering operational plans, resolving problems, and building relationships internally and externally.
Operations/Departmental Manager	Level 5	Funding Band 9	Approved for delivery	An operations/departmental manager is someone who manages teams and/or projects, and achieves operational or departmental goals and objectives, as part of the delivery of the organisations strategy. They are accountable to a more senior manager or business owner. Generic role for all sectors but knowledge, skills and behaviours needed will be the same. Key responsibilities: creating and delivering operational plans, managing projects, leading and managing teams, managing change, financial and resource management, talent management, coaching and mentoring.

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Appendix 8: Illustration Comparing Salary Costs for HCSW Apprenticeships

Table provides an illustration comparing Salary costs for Health Care Support Workers employed under a variety of contracts

Job Role	**Health Care Support Worker** (HCSW) **AfC Band 2 point 2**	**Senior Health Care Support Worker** (SHCSW) **AfC Band 3 point 6**	**Health Care Support Worker (Not on AfC conditions)** Aged 21-24 years+ **National Living Wage**	**Health Care Support Worker** (Not on AfC conditions) Aged 25 years+ **National Living Wage**	**Apprentice HCSW** (16-18yrs) or (19+ in first year of training) **National Apprenticeship rate**	**Apprentice HCSW** 25years + **National Living Wage**	**Trainee (AfC)** (up to 12 months prior to completion of training: 75 per cent of the pay band maximum of the fully qualified rate- **adjust for age**) Standard Recruitment Band 1 Point 2 **(75%)**	**Apprentice HCSW** Paid at 55% of top of Band 2 Pt 8 **Local Example (55% of £18,157)**
Hours per week	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5
Standard Recruitment	£15,404.00	£16,968.00	£13,747.50	£14,625.00	£6,825.00	£14,625.00	£11,553.00	£9,986.35
On-costs 20%	£3,081.00	£3,394.00	£2,750.00	£2,925.00	£1,365.00	£2,925.00	£2,310.60	£1,997.00
Annual Salary	**£18,484.00**	**£20,362.00**	**£16,497.50**	**£17,550.00**	**£8,190.00**	**£17,550.00**	**£13,863.60**	**£11,982.00**
Hourly pay	£9.48	£10.44	£7.05	£7.50	£3.50	£7.50	£7.11	£6.14
Weekly pay	£355.50	£391.58	£264.38	£281.25	£131.25	£281.25	£266.61	£230.42

Additional Costs to be taken into account include:

- High Cost London weighting adjustment

- Other non- pay benefits offered by the employer e.g. Childcare Vouchers, travel vouchers;
- National Insurance adjusted for age
- All employees including Apprentices included in NHs Pension Scheme requiring employer Contributions

HENCEL Shared Apprenticeship Policy Proposal: Illustrated

Apprentice Salary

2017/2018				
	Basic Max Point	70%	HCAS	LLW
Band 2	£18,157.00	£12,709.90	£4,200.00	£19,012.50
Band 3	£19,852.00	£13,896.40	£4,200.00	£19,012.50
Band 4	£22,683.00	£15,878.10	£4,536.60	N/A
Band 5	£28,746.00	£20,122.20	£5,749.20	N/A

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70% of Band + HCAS			LLW Difference		Per week	Per hour	LLW Hour	LLW Weekly
Band 2	£16,909.90		-£2,102.60		£325.19	£8.67	£9.75	£365.66
Band 3	£18,096.40		-£915.60		£348.01	£9.28	£9.75	£365.66
Band 4	£20,414.70		£1,402.20		£392.59	£10.47	£9.75	N/A
Band 5	£25,871.40		£6,858.50		£497.53	£13.27	£9.75	N/A

Appendix 9: Example of progression pathway for Clinical and Non-clinical apprenticeships