

RCSLT assistant practitioner professional framework (APPF)

Part two: towards a new framework for professional training and development

1. Introducing the RCSLT Framework (APPF)

The RCSLT APPF is about guiding good safe practice, through supporting the training and development of APs.

Professional practice in any role can be difficult to quantify. Fish and Coles (1998) used the image of an iceberg to represent the 'invisible elements of practice' which are below the surface.

This element of 'invisible' practice is especially difficult to quantify in an evolving professional role such as AP.

This RCSLT APPF for professional learning is based around competencies. In October 2021 Health Education England (HEE) published their [Allied Health Professions' Support Worker Competency, Education, and Career Development Framework](#) with the intention of 'maximising the contribution of the AHP support workforce to delivering safe and effective care.'

This gives AHP support workers a shared foundation framework of wider profession competencies with three levels of development.

HEE recognised that each AHP needs to build upon the generic competencies in their framework with more specific uni-professional guidance. Therefore, the project group has developed a specific speech and language therapy professional Framework as part of this project. This clinical competencies framework will be part of the Toolkit.

There are two profiles of competencies:

- A foundation framework of wider professional competencies based on the AHP Framework (three profiles of increasing complexity)
- A specific speech and language therapy clinical competencies framework

The clinical competencies framework augments the foundations of the AHP framework, with the intention that both competency frameworks are used by

APs and those who support them, to identify training and development needs and track progress over time.

1.1 Competency based learning

The visual model of the RCSLT APPF for professional training and development shows how the foundation competencies form the base, extending upwards into clinical competencies. There is a ladder of support and supervision to give each practitioner scaffolding support, in building a set of individual competencies as they move up through the APPF.

As the role of the AP varies significantly across services, each practitioner will follow a slightly different route through the structure. As experience is gained, the practitioner reaches a 'platform of safe practice' in their role, and over time, the scaffolding support for delegation changes, to become more flexible with wider parameters for decision making.

The AHP Foundation Framework gives a firm base of wider professional competencies needed for competent practice. At this stage of development, likely close to entry into the role, an AP is supported by experienced clinicians who give them direction within narrow parameters, e.g. for undertaking routine clinical or administration tasks. Working through these generic competencies gives a firm grounding in the values, attitudes and interpersonal skills needed in healthcare support roles. Knowledge of healthcare policies and legal frameworks, alongside practical skills such as making case note entries, are also included.

We have devised a more specific speech and language therapy clinical competency for APs to strengthen their competency development. This might be used after completion of the basic AHP Competencies.

However, there is flexibility, for example, one practitioner might work through the [core competencies](#) before commencing the clinical competencies, while another practitioner might be working on core competencies and clinical competencies in tandem. Some practitioners might complete a basic level of foundation competencies then move on to the next level of the foundation framework.

It is anticipated that irrespective of grading, many speech and language therapy services will need all practitioners to work up to Level 3 in some domains of AHP competencies.

The clinical competencies focus on what is required of APs in their job roles, or the skills which are needed to do the job with confidence. There are also indications of how the type of support and supervision changes, as an AP gains experience in their role.

The level of scaffolding support on the ladder of support and supervision needs to be dynamic. For example, if an experienced AP was embarking on learning skills in a different clinical area then initially the support would be tighter, with more specific direction. The onus in the RCSLT APPF is on APs and their supervisors/managers, discussing the type of support/supervision needed for the different competencies identified as required for the job role.

Guidance on this reflective process is given in the Toolkit.

1.2 What are competencies and competence?

"Competencies are statements about what needs to be carried out within the workplace and therefore form part of how professional practice can be described. Underpinning these competencies is all the knowledge, understanding and skills we have as individual practitioners, together with our professional values and beliefs." (RCSLT, 2002)

Competence is evident:

- within an individual's professional practice, how they carry out their role and responsibilities
- in the way an individual critically reflects on their practice.

Essentially, it is about an individual's ability to: *"effectively apply all their knowledge, understandings, skills, and values within their designated scope of professional practice."* (RCSLT, 2002)

Building competencies through a structured framework is the way to confident competency in our professional roles.

1.3 Clinical competencies: a model of practice

The clinical competencies were developed to strengthen CPD. This is a framework of clinical/professional competence which focuses on those specific tasks/roles which are within the scope of practice for APs. The competencies cover the process of therapy, moving from identification of need through to discharge from service.

In the RCSLT survey (detailed in section one) one of the strongest themes to emerge was that APs would like to learn more 'background theory' i.e. the 'why's' behind the therapy they deliver and a structured model to enable this learning. In this framework there is more emphasis on the 'practitioner in the field', learning and developing as they reflect on experience and the decisions they make when working with clients.

1.3.1 Professional 'know how'

Once a practitioner has acquired a set of competencies linked to their job role then the focus changes to how capable they are in carrying out their role. This is about the wider practical application of competencies and involves factors like individual style, confidence and the ability to make judgements and decisions in a work situation.

Eventually practitioners reach a stage where the focus is on the intuitive application of professional knowledge and skills in day-to-day work.

This has been described as professional 'know how' (Schön 1991) and it is more difficult to measure than acquisition of specific competencies. It is how the practitioner applies knowledge and acts in their daily work and so develops their competent practice. Ghaye (2007) comes at this from an interesting angle and says that there is a point in our professional development where we begin to 'think like' a Lawyer, a teacher or an SLT.

"Professional practice is far greater than the ability to deliver a service through a predetermined care plan or pathway. A therapist is constantly facing unique situations and practice dilemmas not just in relation to individual clients."
(RCSLT, 2002)

In simplest terms this is about being an assistant practitioner and having acquired the professional 'know how' to undertake the job role with confidence. It is also about developing individual practice and being successful in a role and it is more difficult to measure.

Sometimes we utilise observation and feedback by colleagues as tools to support practice development. Certainly, the practitioner at this stage needs to be able to access an identified colleague (manager/supervisor) as a competency coach with opportunity to meet for reflective learning.

At a basic level all practitioners need to have conversations about their experiences and 'unpick events'. Decision making in a session might be retrospectively explored with questions such as:

- What went well
- Would you have done anything differently
- Would you do the same again in a similar situation

A skilled, experienced colleague can guide the conversation through a reflective learning cycle and through this process jointly identify new learning points.

Schön's work set the scene for later research on the reflective practitioner in both education and healthcare. By doing the job we acquire this professional 'know how' and in becoming experienced practitioners, we shape our

professional skills and develop our individual style as practitioners. We eventually become 'expert' practitioners in our field of expertise.

Schön writes of the very technical acquisition of competencies necessary for a particular job. He then writes about the 'art of practice' and how the most successful practitioners progress to this stage not only by working 'in the job' but through feedback and reflection on daily actions. There is an accrual of learning in practical practice settings.

Eventually we have a store of knowledge, built up through our experience of professional practice and Schön calls this 'professional wisdom'. This may sound a little soft, but it is about how we develop in our professional role and that learning encompasses more than 'ticking off those competencies'. It is about how we engage with others, share our knowledge in supporting clients and carers and interact (think) in everyday clinical situations.

The RCSLT Model of Professional Practice in Speech and Language Therapy (2002), focuses on the crucial importance of judgement and decision making. This was one of the most crucial competencies in speech and language therapy professional practice. We can acquire isolated competencies but success in our professional role hinges on how we think and make decisions within a coherent professional framework.

"Developing expertise with a given client group relates not just to the development of knowledge and practical skills, but to the making of increasingly fine-tuned, appropriate, accurate and speedy judgements and decisions."
(RCSLT, 2002)

There are skills and knowledge which underpin the tasks that need to be carried out, as well as skills and knowledge that underpin the process of doing the task and then how we monitor, adapt, adjust (use our judgement and make decisions). Interestingly, it was this type of knowledge which APs said they were keen to learn more about in the survey.

"It is suggested that an extended notion of competencies is appropriate, one that accepts that the competencies of judgement and decision-making lie at the heart of professional practice. This aspect of practice, informed by a therapist's cumulative knowledge and skills, tends to be hidden from normal view and is correspondingly hard to measure" (RCSLT 2002).

The busy clinician does not have time to scrutinise learning and development theory and this project intends to ensure that the information is there and accessible for those who are 'juggling casework' and need to access information which they can then apply practically to support APs.

There is a recognisable stage when we become 'established' in our role. We are confident. In the visual representation of the RCSLT APPF we have reached a

'safe platform'. In the words of Ghaye we are 'thinking like' an AP at work. We know our job. We are keen to continue learning, developing and building on an established level of skills and expertise in our role. This is when we have that professional 'know how' and competence in dealing with everyday situations in clinical practice has been described as 'problem infested' (Tripp 1993).

Schön described an expert practitioner as a 'walking set of theories' based on practical experience over time. He maintained that when a practitioner with expertise, developed over many years, leaves a team there is a significant gap which is often only recognised when the person leaves that team. If an experienced AP has worked in a team for many years, then they are an expert practitioner in their field of work. This needs recognition and respect and as Schön pointed out, we don't always recognise this expertise until the practitioner leaves.

Knowledge and skills develop over time. As APs 'do the job' they develop a store of individual experience and a 'clinical style' or approach in how they carry out their role. The practitioner develops their professional 'know how' plus individual style in their job role.

This is difficult to set out in a learning and development framework, but colleagues will recognise this level of experience with respect. This is equally true of a Band 3 AP as it is of a Band 6 Specialist SLT. It is true of all professional roles. The theory and knowledge about how we develop in our individual professional practice is relevant across all roles.

1.3.2. What does this mean in terms of supporting development of a practitioner?

Professional competence is difficult to measure. Potentially are most usefully gauged by 'engaging' with the practitioner in analysing their casework and the observations, decision making and the effects of chosen actions in terms of outcomes, caseload demands and all the 'unexpected happenings'.

"Professional competence is therefore most usefully estimated by engaging with the therapist in analysing the judgement and decision-making processes as they relate to designated responsibilities, and further by analysing the effects of action in terms of a range of outcomes, caseload demands and all the unexpected happenings" (RCSLT 2002)

At this stage the "quality of professional practice will be achieved and improved on primarily by individual professionals working with integrity in a critically reflective way." (RCSLT 2002)

There seems to be consensus that the key to individual practice development, after a basic level of competency has been achieved, is through reflective clinical conversations 'about the job'.

Using the core or clinical competencies as a focus for conversations about strengths and gaps, while identifying objectives for learning is a good starting point. As are regular reflective conversations with colleagues and supervisors, to share experiences, look back at what happened and learn from experience.

1.4 Reflective learning

The RCSLT APPF has its foundations firmly in reflective learning. Reflective practice is a researched tool which is easily available, and which works if implemented consistently with quality support and supervision. This approach to learning for professional development is advocated by RCSLT and HCPC.

We know that reflection can enable practitioners to:

- analyse complex and challenging situations
- consider the way we make decisions
- make connections between previous cases and current practice
- make it more likely that we will put what we have learned into practice
- improve our problem-solving skills
- identify future learning needs

(CPD statement, Health and Social Care Professional Advisory Group, HSE 2017).

Reflective practice is long recognised as an important aspect of good practice, and is seen as integral to how professionals integrate learning and experience into their development and into improved practice throughout their careers. (*Argyris & Schön 1978, Kolb 1984, Gibbs 1988, Rolf 2001*).

2. RCSLT Framework (APPF) for professional training and development

This RCSLT APPF has the [HEE AHP Support Worker Competencies for Education and Career Development](#) as its foundation as 'core competencies'.

The approach to learning is through acquiring these core competencies in a planned, tracked way and engaging in reflective practice about development in the role. The RCSLT Toolkit includes three separate profiles for each level of competency. The RCSLT core competencies are based on the HEE competencies.

The Toolkit also has a sign-off sheet for accrediting prior learning by experienced APs. In addition there is the more advanced and speech and language therapy focused Clinical Competencies devised by the project group.

2.1. Core competencies (AHP Framework) aka wider professional competencies

The project group considered whether the AHP competencies should be adapted and decided only minimal changes were required. These changes are primarily around the suggested formal education programmes as these tend not to be relevant in speech and language therapy.

These foundation (or core) competencies can be found within the Toolkit.

The AHP Competencies are grouped into [eight domains](#) for education and competency development.

The [NHS Scotland Induction Standards' four Pillars of Practice](#) could easily be substituted here. The four Pillars of Practice help practitioners identify areas for development in clinical practice, facilitating learning, service improvement and leadership.

We are specifically looking for further information from Wales and Northern Ireland so please add in your comments anything you think is useful.

We will add any resources and information from across the UK, to the final RCSLT assistants webpages.

There are resources but no specific competency statements, so the AHP Framework should bridge this gap for practitioners in Scotland. It is envisaged that the RCSLT Clinical Competencies will be relevant in Scotland in enhancing the Pillars of Practice.

2.2. The learning structure of the RCSLT APPF

Through the scaffolding structure of the support and supervision ladder the AP gradually builds and extends their competencies. This may be a rapid or gradual progression and will be individual to the practitioner and the team context.

The AP then moves on to focus on extending clinical competencies linked to their specific job role and a set of specific clinical competencies can be selected with their manager. Some practitioners might begin working on clinical competencies in parallel with wider professional competencies in the foundation framework, but this would be a decision for each service.

After initial training and development, the support and oversight changes from close directive support to 'sheltered practice support'. Competencies are built through planned work-based learning with the support of an experienced clinician, a competency coach (supervisor or manager). Where an AP is working in a team the reality is that all clinicians who are delegating casework to the practitioner will be involved in guiding and coaching an AP's development, though it is advisable to still have an identified competency coach co-ordinating the learning.

Once the AP becomes experienced in their role the focus will be on practice development with more individual and specialised competencies linked to 'working near the top of their scope of practice' (HEE 2021). They should have reached a safe platform of professional expertise in the role. More specialist competencies in areas such as supervision, leadership and more advanced clinical skills become part of the skillset.

Over time there is more focus on being a reflective practitioner with each AP identifying their own learning from experience. At this stage of development, the scaffolding provided by the ladder of support and supervision is through reflective conversations, sharing practice experience through a professional relationship with colleagues and a specific clinical/professional supervisor. The level of support and supervision becomes negotiated and increasingly 'arm's length'.

2.3. Evidence of learning

The usual Performance and Development Review (PDR) paperwork used by the service might be all that is needed to plan learning in role once this 'platform of safe practice' is reached. In the Toolkit there is a profile which can be used to plan and record learning where the focus is on more specialized, individual clinical competencies. It will depend on the job role as to whether the clinical competencies framework is still relevant in the identification of competencies for development at this stage.

The clinical competencies are designed to be flexible enough to cover the different specialist areas in speech and language therapy and continue to be relevant for experienced APs.

The RCSLT APPF covers the progression up the ladder of supervision and support. Variability in responsibilities delegated and the style of delegation was a strong theme in the survey. The support begins at the lower rungs of the ladder where there is a need for specific, directive supervision to assure safe practice in delegated work. As the practitioner becomes established and experienced towards the higher rungs of the ladder then the support is less specific and more flexible.

The RCSLT CPD Diary is accessible as a log of reflective learning for those who are RCSLT assistant/associate members. There is also signposting to other portfolio based approaches in the Toolkit.

Ideally there would be opportunities for a clear career progression as an AP. We know from the survey, plus NHS Scotland and Health Education England (HEE) that this is not the case and opportunities are often limited. However, the aspiration for the future is that there should be a career ladder for AHP Support Workers which moves from a basic entry role through to senior and specialist AP levels.

2.4. Entry requirements

There are currently no specific entry level qualifications for APs, although some organisations will specify essential and desirable criteria within job descriptions. APs can enter employment through various routes and with a diverse range of experience and qualifications. In 2020, the RCSLT surveyed APs about their role and asked about educational attainment. The responses to the survey illustrate just how diverse the range of qualifications is with:

- 50% of respondents having GCSE qualifications
- 48% A Level qualifications
- 39% an undergraduate degree
- 6.7% a postgraduate degree

In addition, 39% of respondents said that they have other qualifications such as a National Vocational Qualification (NVQ).

This is positive in terms of encouraging wider diversity and skill sets on entry. Everyone in the survey and project group regarded this flexibility about entry requirements as positive for speech and language therapy. However it does increase the need for a framework to guide development in the role.

Many APs will have already acquired their competencies in the AHP Foundation Framework. This should be recognised with a 'sign off' so that this level of

competence is validated and recognised. There is a sign off sheet which can be used for this in the Toolkit. Throughout this project the group have consistently agreed that it is essential to value accrued experience and skills.

2.5. Clinical competencies

Clinical competencies need to be central to a practitioner's development. Surprisingly they can often be overlooked when frameworks focus on generic 'across professions' learning competencies. Clinical work is what motivates SLTs and assistants. Clearly planned, supported learning within a clinical competency framework reduces risk and assures safe practice.

This is about acquiring those competencies which are necessary to work clinically in a role as an AP. The core competencies are an important foundation, but roles are predominantly designed to support the clinical care provided by a speech and language therapy service, whether that service is in the NHS, independent or third sector.

Clinical work is why people enter this career and it is essential that there is planned quality training and development in the acquisition of specific clinical competencies. Some tracking of development via a profile gives a focus for learning conversations and an assurance that there is quality training and development. There will come a point where the AP becomes an experienced expert in their job role and professional development focuses on very individual objectives e.g. around extension of clinical capability or contribution to service improvement.

It is essential that after, or sometimes alongside the acquisition of foundation competencies, that the newly appointed AP begins to focus on speech and language therapy specific clinical competencies.

Initially the plan was for a range of general clinical competency profiles based on the specific clinical areas e.g. neuro-rehab, ALD, children's service. However the individuality of services and complexity of the 'field of practice' makes this beyond the scope of this project. In the future there could be examples on the website of competency profiles within speech and language therapy specialist clinical areas, which could be referred to as examples of best practice by similar services.

"Professional practice is rich and complex in nature. In order to capture some of this complexity, the speech and language therapy competencies frameworks need to be set within a concept of practice that goes beyond a functional analysis of job role". (RCSLT, 2002)

The RCSLT clinical competencies are generic and can be adapted for different specialities giving a structured framework for practice development. Competency coaches and APs can draw on this APPF when planning development. It should

enable structured conversations around an individual's practice then joint identification of gaps and learning objectives.

Selected competencies can be recorded and tracked on the individual clinical competency profile in the Toolkit.

This profile is provided for recording clinical competencies. However, a service could use something 'in house', but it is necessary that for safe practice there should be a documented competency-based learning plan. Any competency plan needs to be updated on an agreed timescale, e.g. monthly, quarterly or annually.

Once an AP is experienced and established in post, in terms of the framework they have reached a 'safe platform', then focus changes to an individualised set of specialist competencies. The important thing is to 'think clinical' when discussing objectives.

A service/team could use the clinical competencies to identify the competencies required for a particular role, or it can be used as a focus to structure individual conversations about strengths and gaps for learning objectives.

For some specialist roles there may be an appropriate competency framework which is outside of speech and language therapy. For example, there is a framework for developing knowledge and skills in supporting children and young people with autism and another for learning disabilities — the content is very relevant to APs. Another example is the AAC Competency Framework (Scotland).

2.6. Practice development: training and development

"Professional practice draws on and consists of fluid and changing ideas, knowledge, understandings, theories and frameworks, skills, values and attitudes that interrelate with each other and are integrated in a personal and unique way by each therapist." (RCSLT 2002)

Professional learning is complex. We learn from experience in day-to-day practice. We attend training, we take time to study and read and integrate that knowledge with our experience. We go out once again into our day-to-day practice and we perhaps see things a little differently based on our insights from our learning, it's a reflective cycle.

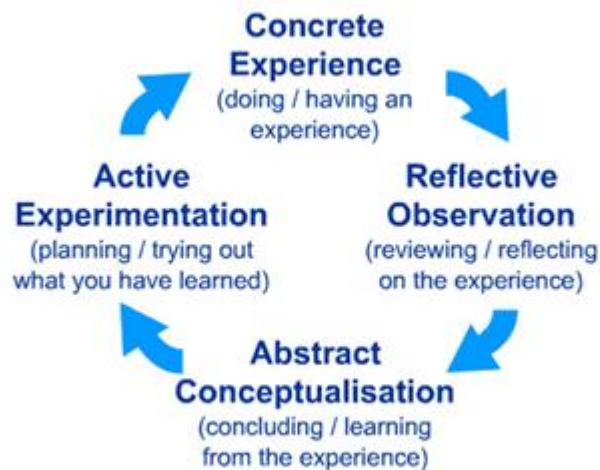
The RCSLT APPF is built upon a foundation of core professional competencies (HEE) and clinical competencies (RCSLT) with development through work based learning supported by reflective conversations and logged learning points.

Types of learning opportunities include:

- Work based learning

- Short courses
- Formal training programmes
- Modules
- Other e.g. networks/coaching/mentoring

Diagram: Reflective Learning Cycle (Kolb, D.A. 1984).



The approach in the RCSLT APPF to ongoing professional development is based on this cyclical approach with APs as engaged, reflective learners. The Toolkit contains examples of reflective learning models and RCSLT reflective writing self-study guide.

Practice development is a term which is more widely used in nursing or other AHP professions. However it should be better known and is very relevant in speech and language therapy. This is the concept of a clinical practitioner extending and developing their competencies/skills in a structured/individual framework, a reflective learning approach to practice development.

It is about how we learn and develop as professional practitioners.

In the early stages of a career we are more focused on acquisition of basic core competencies. For qualified SLTs the [RCSLT NQP Competencies Framework](#) is a 'rite of passage' in professional development. Competencies are acquired, evidence is provided and evaluated and 'ticked off' as achieved. For newly appointed APs the intention is that the AHP Framework of competencies will fulfil the same function.

Adult learners have different styles and strengths. With competency-based learning evidence can be gathered and presented and practitioners can blend learning with practical experience, online material, short courses and networking.

2.7. Education, experience and practice development (CPD)

There is national recognition that there is limited access to high quality training for ongoing development.

The competency driven approach to ongoing professional development continues after initial training. It is essential that APs keep extending their clinical and wider professional competencies over time. Learning can be planned, tracked and practice skills assured.

The RCSLT APPF is based on competency development, through work based learning with guided reflection on practice with the support of an experienced colleague – a competencies coach.

The key features include:

- Continue with a competency-based approach utilising work-based learning plus formal training opportunities
- The 'Grow your Own' approach of the HEE Framework is especially relevant in speech and language therapy. There are wide ranging roles under the associate practitioner umbrella
- There is a need for quality training in all services for this crucial, but unregulated clinical role
- It is essential that services ensure APs access continuing development.

The AHP guidance highlights the need for practitioners to 'develop within teams and progress their competencies'. However, this variability in professional training and development can make career progression very problematic for APs.

2.8. Safe and effective delegation

The involvement of APs in care pathways is an efficient use of resources by allowing the person delegating the work to concentrate on more complex parts of the job and improve the service. When delegating there needs to be confidence that the person is competent to undertake the work safely and effectively.

"When delegating a task, you will need to be confident that the person to whom you are delegating to is suitably trained, experienced, well supported, supervised and competent to undertake the task safely and effectively. You must not delegate a task that is outside their competencies." (2020, Royal College of Occupational Therapists Briefing)

The qualified SLT holds the ethical and legal 'duty of care' for the patient/client and consequently for the standard of duties delegated to an AP. An SLT must therefore always be responsible for the work undertaken by them.

There is concern in the 2021 AHP Framework about the variability in delegation and how assistant practitioners need to be able to grow in their roles. Within it, there is scope for decision making and adaptation of intervention. We know from the RCSLT survey (2020) and project group feedback that some qualified SLTs can be reluctant to delegate work or work which is at the top end of the scope of practice of the assistant.

What is important is that there is consideration of the APs' agreed competence level and reference to local procedure and protocol. There needs to be recognition that the AP will implement and monitor intervention and adapt as required.

"Within scope of role and working to operating procedure, protocols and procedures plans, implements and monitors own treatment and care plan interventions, including adapting to circumstances" (HEE, 2021)

This is an evolving landscape and as roles extend there needs to be careful risk assessment and identified support to ensure safe practice. Increasingly speech and language therapy services are designing care packages which are coordinated and delivered by APs. This is positive in that the service sets up this clinical system, with risk assessed, clear therapy guidelines with triggers for accessing qualified support. Initial training and ongoing support and supervision is integrated into the service provision. This becomes a service level mitigated risk with assured safe practice. Delegation by therapists is easier because it is within a care pathway in a framework which includes support for APs and ensures a responsive, quality service for clients.

The ladder of support and supervision was devised to support decision making in delegation. The RCSLT APPF gives guidance about how the style and level of support can change as the AP gains experience. There is an expectation that a trained, experienced AP will not require narrow parameters and guidance. It is possible for more collaborative discussion, with the AP able to make adaptations to the therapy programme if the client's reaction suggests this is needed. If the therapist is confident in the AP and their training then they are confident that decisions can be made with support available when required.

"Choosing tasks or roles to be undertaken by support staff is a complex professional activity; it depends on the SLTs professional opinion. For any particular task, there are no general rules. Additionally it is important to consider the competence of the support worker in relation to the activity to be delegated." (RCSLT Support workers policy statement on education and training (2009)).

In this context delegation is the process by which an SLT can allocate work to a support worker who is deemed competent to undertake that task. The support worker then carries the responsibility for the performance of that task.

The recommendation is that the role of APs is integrated into a services care pathways which allows positive delegation to experienced practitioners who have clear, discussed triggers to access qualified support as required.

The ladder of support and supervision in the visual model shows how the type/level of support changes over time. The scope of practice for each AP needs to be clearly identified and more experienced practitioners will have more flexibility and wider parameters in delegated duties. The [RCSLT Delegation Guidelines \(2017\)](#) considers that delegation within the context of a pathway or protocol can allow delegated discretion and autonomy for some elements of practice. These guidelines have been highlighted in the introduction to the clinical competencies section of the RCSLT Framework.

2.9. Spotlight on supervision

Professional (or clinical, or practice) supervision is an essential component of support for APs. All services involved in this project had supervisory systems in place. The [RCSLT Supervision Guidance](#) outlines standards and guidance for all practitioners. This has been extended specifically in relation to practically supporting APs in the Toolkit.

Practice supervision needs to be wider in scope than the individual case supervision which is given to APs working in clinical roles. This case related supervision is essential but there is also a need for supervision to cover wider aspects of practice. In essence there is no difference in the approach and content of supervision for an AP.

Procter's model is widely used and gives three functions of supervision: formative, normative and restorative. Supervision for an early career AP might focus on learning and development needs, whereas for an experienced practitioner the conversation might cover difficult relationships which are a barrier to implementing care plans or the ongoing need to prioritise workload and maintain wellbeing at work.

There was a concern from the survey feedback that the restorative and wider supportive supervision was less available for some APs in comparison to their SLT colleagues.

There will be further guidance for professional/clinical supervision in the toolkit.

3. Career pathway

3.1. What's in a name?

There is a national move across all AHPs around facilitating clinical assistant practitioner roles into a structured career, allowing progression within the role. It seems timely to consider job titles and whether these might influence colleague and client's perception of the role.

There are a wide variety of titles used for this role. The feedback is that often, in reality, practitioners are called 'assistants' whatever their job title or grading.

However, in a profession where we work with semantics and the impact of language on perception, it seemed appropriate to look at titles and gather views. Do APs feel their titles reflect their job roles effectively? Would a different title influence perception of the role?

What is noticeable is the developing awareness of the skillset of the AP and how it differs from that of a qualified SLT. It is essential within the profession that therapists begin to think in terms of 'assistants' as clinical practitioners who have skills and expertise in their scope of practice. There is a strong feeling that 'just being called an assistant causes frustration. It is a shift in mindset to think differently about what is a long-established, evolving, complementary role to the SLT. There is definitely a need for recognition and career progression.

Increasingly some practitioners are working in specific areas of support, with enhanced skills which are different to the core skill set of the SLT. An example is in universal/health promotion services where the practitioners can work in a service set up and supported by SLTs but they are not assisting in a therapy process.

Discussion within the project group clarified that there is unlikely to ever be consensus on job role titles. This is partly because the role is so diverse ranging from practitioners who provide part of a service within narrow parameters, to those who have a different, defined and professional role within a framework who require limited support.

After considering the various job titles the term Associate/Assistant Practitioner has been used in the project documentation along with an indication of experience and grading in this project. Assistant/Associate are used interchangeably:

- Speech and language therapy assistant/associate practitioner
- Senior speech and language therapy assistant/associate practitioner

- Specialist speech and language therapy assistant/associate practitioner
- Advanced/highly specialist assistant/associate practitioner (Band 5)

Link to a wide range of job titles (on RCSLT website) which reflect a diversity of roles under the umbrella title of assistant/associate practitioner.

Supporting information – spectrum of roles and job titles. (In progress)

3.2. The NHS bandings

As noted by HEE (2021) there are wide discrepancies in job roles and a confusing picture of grading across the UK. There is limited connection between any descriptive career progression, titles and bandings. This is out of scope of this project and the remit of RCSLT but needs noting as the discrepancies have caused complications when devising the RCSLT APPF for the future. This variability certainly impacts career progression.

3.3. Career progression

There is consensus about a lack of progression and consistency across areas/ regions/ countries through the Agenda for Change bandings.

Whatever the reason, it is still difficult for a practitioner to enter the role at Band 3 and progress through the grading to Band 4. This can be due to lack of local opportunities and most APs are recruited from the local community. Some organisations have a highly specialist role at Band 5, but this is rare and there are no Band 5 roles in NHS Scotland. There are fewer Band 2 practitioners in speech and language therapy in comparison to other AHP professions. It is possible to enter the role at Band 3 level.

References: Section 2 (in progress)

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