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Workforce Development for Assisted Living Technology: understanding roles, delivery and workforce needs – a national survey

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Glossary

ALIP	Assistive Living Innovation Platform
ALMO	Arms Length Management Organisation
ALS	Assisted Living Services
ALT	Assisted Living Technology
AT	Assistive Technology
CIRCLE	Centre for International Research on Care, Labour and Equalities
DALLAS	Delivering Assisted Living Lifestyles at Scale
DH	Department of Health
EIF	Employer Investment Fund
HMG	Her Majesty's Government
LET	Life Enhancing Technologies
PCT	Primary Care Trust
SfC	Skills for Care
SfCD	Skills for Care and Development
SfH	Skills for Health
WSD	Whole System Demonstrator

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Executive Summary

Introduction

Assisted Living Technology (ALT), including telecare and telehealth, digital participation services, and wellness services, is increasingly being offered to individuals in need of social care support as a way of assisting them to maintain independence and to promote quality of life at home. It is recognised that the delivery of Assisted Living Services (ALS) (the term used to refer to this collection of services) has implications for the workforce.

This report, commissioned by Skills for Care, sets out the findings of an on-line quantitative national survey of a range of organisations involved in delivering ALS, including: local authorities; voluntary, community and faith sector organisations; and private and commercial providers. The survey assessed the workforce development implications of ALT and explored the applicability of previous qualitative case study research (Wigfield *et al.*, 2012) within different types of organisations across England. The specific objectives of the research were to: contribute to a broader understanding of the range of ALS within England by examining the associated workforce roles and the skills and knowledge required and possessed by the workforce across the range of organisations involved in ALS.

Methods

Based on key themes identified in the previous case study research, the survey questions covered topics such as ALTs available / delivered; information about service users; ALT service delivery models; staff roles; training, knowledge and skills. The survey link was sent to a database of 310 national contacts which was compiled as part of this research and recipients were asked to forward the link to other relevant individuals. The survey was also publicised in relevant e-newsletters and websites. 254 completed questionnaires were received, the data from which was subsequently checked, cleaned, and analysed in SPSS (Statistical Package for the Social Sciences).

Organisations and ALT delivery models

Many of those surveyed worked for local authorities, but individuals working across all types of organisations involved in ALS responded to the survey. Most organisations were delivering first and second generation technologies but third generation technologies were being delivered by just under a quarter of organisations. There appeared to be some correlation between the type of organisation and kinds of ALT delivered, with private and commercial organisations and, to a lesser extent, local authorities more likely to be offering third generation technologies, whilst VCF sector organisations and Housing Associations were more likely to be offering first generation technologies. Most organisations were delivering ALS to over 2000 service users and there were many partnership arrangements in place between different types of organisations in order to deliver ALS, with primary care organisations and private care / commercial providers frequently involved.

Some progress towards mainstreaming ALT appears to have been made in many organisations but there is further progress to be made here, particularly in terms of disseminating knowledge, understanding and skills, and integrating ALT further into existing social care packages.

Staffing and job roles

Half of the survey respondents were in a management and commissioning role, but the sample also covered a range of job titles including specialist ALT roles and more generic health and social care roles. A range of tasks relating to ALT delivery were carried out by respondents, the most frequently cited being ALT awareness raising and promotion both amongst the workforce and amongst service users and families, followed by the provision of learning and support to the workforce. This reflects the fact that ALS delivery is a relatively new and growing area and, as a consequence, promotion of the service and support for staff working within it continues to be important.

Many of those surveyed had worked in an ALT role for over five years and those in specialist roles had a range of employment backgrounds including social care and health; technical; telecare and telehealth; and social and community work, reflecting the wide range of skills and knowledge that ALT service delivery can require. For many, ALT-related work formed part of another broader more generic role, rather than constituting a specialised ALT role, thus demonstrating a degree of mainstreaming of ALT within the organisations surveyed.

Skills, knowledge and qualifications

A range of different skills were seen as being important for the ALT workforce by those surveyed, including specialist ALT knowledge and generic health and social care skills. Respondents rated their own knowledge and skills relatively highly, although few indicated they were 'highly skilled' or 'very knowledgeable'. Individuals who were working in health and social care roles were more likely to give a low rating to their own skills and knowledge, whilst those in specialist roles were more likely to rate their own skills highly. Moreover, a lack of appropriate ALT knowledge and skills amongst the social care workforce was highlighted as a potential gap / limitation in terms of maximising the impact of ALT. Although those working in specialist ALT roles sometimes had an ALT qualification, most working in the delivery of ALT did not. ALT qualifications were seen as useful for a role in ALT but some closer links between the qualifications and the content of practitioners' job roles was seen as a useful future development.

Training

Different types of training are available in ALT related fields, although most training reported was voluntary rather than mandatory, and was provided mostly by suppliers and, to a lesser extent, by employers. Very little training provided by colleges or universities was taken up by those working in the field. Training is often undertaken in an on-the-job setting, and often involves equipment demonstrations and awareness-raising. Off-the-job training appears to be less widespread and tends to focus on topics such as working with vulnerable people, health and safety, and knowledge and understanding of health conditions. Although some respondents had attended ALT specific induction training, most had not suggesting that it is not commonly offered by organisations across the country.

Current training opportunities were rated as average to poor and preferred modes of training delivery included workshops, shadowing and short training courses, with on-line training viewed as the least useful. Respondents noted several barriers to training which included limitations on the amount of time that they had to spend on training, as well as a lack of knowledge of training opportunities. There was a view that training could be improved by providing knowledge which directly related to job roles and tasks and by providing a broader

range of competencies in a range of relevant areas, and some respondents wanted access to training which provided recognised qualifications.

Three recommendations were identified from the research:

Recommendation 1: Encourage and provide support for organisations to further mainstream ALS into their wider social and health care provision.

Recommendation 2: Continue to promote ALS amongst the social and health care workforce and amongst potential service users and their families through awareness raising, promotion activities and culture change initiatives.

Recommendation 3: Provide training opportunities which enable the ALT workforce to develop a range of competencies relevant to their work and which lead to ALT related qualifications where possible. Training opportunities and time to attend training should be available to all who work with ALT, even if this forms only a small proportion of their role.

1. Introduction

1.1 Background and policy context

Assisted Living Technology (ALT) is increasingly being offered to individuals in need of social care support as a way of assisting them to maintain independence and to promote quality of life at home. Assisted Living Technology, sometimes known as Assistive Technology (AT), is a broad term which encompasses a range of equipment, and the term is often interpreted differently by different people. For the purposes of this report, the definition of ALT is based upon the Skills for Care[1] (SfC) definition which is adapted from Lewin *et al.* (2010) and includes:

- Telecare and telehealth: delivery of cost effective social and health care using technology in the homes of those needing support to enable them to live longer at home and in their communities. This may include returning home after a period of illness.
- Digital participation services: to educate, entertain and stimulate social interaction to enrich the lives of people in need of social support living at home.
- Wellness services: to encourage people to adopt and maintain a healthy lifestyle, to help prevent or delay the need for support.

SfC refer to this collection of services as Assisted Living Services (ALS) but nevertheless acknowledge that practitioners and policy makers tend to use the terms of telecare and telehealth more frequently. This survey provides the opportunity to investigate the current thinking amongst practitioners in relation to the terminology around ALT provision.

The use of ALT has become more acceptable in recent times as technology has become an increasingly important part of everyday life. The Telecare Services Association estimates, for example, that 1.7 million people use telecare in the UK[2], including older people, people with physical disabilities and cognitive impairments (including dementia) and people supported by community mental health teams. Its growing use has also been a response to policy trends directed at supporting the ageing population, including self directed support and personalisation, self care, early intervention and preventative action and re-ablement.

The opportunities for technology to facilitate independence have been recognised for a number of years. The 1998 NHS report *An Information Strategy for the Modern NHS 1998-2005* noted:

> *Telecare technology will be used to provide a reliable but unobtrusive supervision of vulnerable people who want to sustain an independent life in their own home* (DH, 1998: 15).

Successive governments have supported the wider use of telecare in private households. Thus the Department of Health (DH) set 'ambitious targets for telecare to be available in all homes that need it by December 2010' (Audit Commission, 2004: 4), and the DH policy document *Building Telecare in England* set out guidelines to inform local authorities of the resources, systems and procedures necessary to implement telecare effectively (DH, 2005).

[1] Skills for Care is an employer-led organisation with a remit for developing the workforce in England to meet adult social care needs.
[2] http://www.telecare.org.uk/consumer-services/what-is-telecare.

The importance of telecare for carers, as well as service users, was highlighted in the national carers' strategies (HMG, 1999; 2008; 2010) and the significance of telecare was also acknowledged in the key policy documents *Putting People First* (HMG, 2007) and *Shaping the Future of Care Together* (HMG, 2009).

Several government-funded programmes have been introduced to encourage the use of telecare. The Preventative Technology Grant provided £80 million of funding between 2006-2008 and was designed to support local authorities to work in partnership with other agencies in the voluntary, health and housing sectors to develop telecare initiatives (DH, 2006). The Whole System Demonstrator (WSD) programme, designed primarily to strengthen the evidence base about telecare and telehealth, operated in three integrated social and health care sites (Newham, Kent, and Cornwall) between 2008 and 2010, aiming to benefit 6,000 service users, 660 carers, and to be *'largest randomised control trial of telehealth and telecare in the world'* (DH, 2008; 2011).

More recently the DALLAS programme (Delivering Assisted Living Lifestyles at Scale) reflects the current government's commitment to ALT. The programme represents £37 million investment (£25 million of which is government funding) to establish four consortia-led initiatives in the UK, including one in Scotland reflecting Scottish contributions to the investment. The initiatives include: i-Focus, a nationwide programme offering people a range of products and services to help them feel more comfortable in their own homes such as on-line and mobile technologies designed to enhance and organise informal care networks; Year Zero, an online application that is designed to empower individuals to actively manage their health information throughout their lives; The Feelgood Factory, which encourages people living in Liverpool to plan for their future in order to better manage their health and social care needs, supported by Life Enhancing Technologies (LET); Living it Up which focuses on developing innovative solutions that will enable people in communities across Scotland to live happy, health and safe lives, enabling choice and better control over their health and well-being[3]. The programme aims to recruit 10,000 people to each initiative and demonstrate how ALT and ALS can be used to 'promote well-being, and provide top quality health and care, enabling people to live independently – including a preventative approach' (Technology Strategy Board, 2011:1).

The government has also initiated '3millionlives'[4], a strategy to enhance the lives of three million people over the next five years by accelerating the roll-out of telehealth and telecare through the NHS and social care, by working with industry.

1.2 ALS and workforce development

Emerging evidence from the WSD programme indicates that equipping the workforce with the confidence and skills to engage with available technology is an important factor in the successful delivery of ALS (SfC, 2011). The Department of Health has also recognised the implications of ALT for the workforce in the health and social care sectors (DH, 2009), and the recent White Paper on social care reform emphasised that improving skills and training

[3] https://connect.innovateuk.org/web/assisted-living-innovation-platform-alip/articles/-/blogs/8113842

[4] See http://www.dh.gov.uk/health/2012/01/roll-out-of-telehealth-and-telecare-to-benefit-three-million-lives.

amongst the care and support workforce is 'an important part of raising standards overall' (HMG, 2012: 51).

SfC suggests that while the advancement of ALT is supported in policy, and there is recognition of the importance of a supported and skilled workforce, there has been less detail on how to develop and maintain practitioners' skills and knowledge in this area. They point to four key documents which set out: the indicative behaviours for a trained workforce; the role of the workforce in promoting understanding of technology; the role of management and the need for strong leadership to drive change; and the broader context of skills required to implement technology (SfC and SfH, 2008; DH, 2009; SfC, 2011; SfC and Development, 2011).

Several other funded initiatives are already in place to support workforce development in relation to ALT, for example: the Assistive Living Innovation Platform (ALIP); WSD (mentioned earlier); and the National Catalogue of Equipment for Independent Daily Living.

In addition, the Employer Investment Fund (EIF) has recently funded SfC and Development (SfCD) to develop a UK-wide workforce strategy and to develop knowledge and skills sets. This work complements ongoing developmental work undertaken by SfC to continue to support workforce development in England.

Understanding the learning and development needs of the workforce involved in the delivery of ALS is of paramount importance though it is not straightforward, partly because service delivery models vary throughout England, with the range of professionals and practitioners involved in assessing, installing and reviewing ALT differing between localities. SfC (2011) points out that:

> *there is a real and current need to address this situation as the number of people requiring social care and health support continues to increase and there are fewer people in the 'caring professions' to meet the demand* (SfC, 2011:5).

Responding to the need to enhance understanding of the workforce development needs involved in ALT/S delivery, SfC commissioned CIRCLE (Centre for International Research on Care, Labour and Equalities) at the University of Leeds in January 2012 to carry out research in three English local authorities currently delivering ALT (Sandwell Metropolitan Borough Council; Kent County Council; and the London Borough of Lambeth) (Wigfield *et al.*, 2012). The report concluded that ALT and ALS are growing areas of social and health care provision and can present many benefits to services users, their families, friends and carers. It also suggested that the approaches to delivery vary by local authority and so do, in turn, the implications for job roles, and tasks, and the associated skills and knowledge required. The report highlighted the implications of these issues for workforce development and learning and outlined seven recommendations in relation to this which included: the need for further research across a wider range of local authorities in England, as well as research on self-funders; strengthened partnership working between social care and health; ALT leads to champion and drive forward services; a generic framework outlining skills and knowledge needs amongst the social care and health professionals and an associated national framework of learning and development; awareness raising and marketing initiatives; and specific learning and development requirements which can be built into the proposed next stages of development for Skills for Care (Wigfield *et al.*, 2012).

1.3 Research objectives

In response to the first recommendation outlined by Wigfield *et al.*, (2012), SfC commissioned CIRCLE to carry out further research on the workforce development implications of ALT through a quantitative national on-line survey. In recognition that ALS are supplied by a range of types of organisations including local authorities, Voluntary, Community and Faith (VCF) organisations, and private providers, the research involved a study of the full range of organisations offering ALTs across England.

This report outlines the findings of the research which explored the applicability of the findings from the three case studies (Wigfield *et al.*, 2012) at a national level and the relevance of the findings within different types of organisations. The specific objectives of the research were to: contribute to a broader understanding of the range of ALT service delivery within England by examining the associated workforce roles and the skills and knowledge required and possessed by the workforce across the range of organisations involved in ALT delivery.

1.4 Methods

Developing the survey

The findings from the case study research (Wigfield *et al.*, 2012) were used to develop an on-line survey for distribution across the range of types of organisations involved in the delivery of ALTs. Key themes from the previous research were identified to develop the survey questions and these covered topics such as ALTs available / delivered; information about service users; ALT service delivery models; staff roles; training, knowledge and skills. A key challenge was to ensure that the survey captured a diversity of different roles and delivery models, and to establish appropriate terminology for use in the questions. The use of appropriate terminology was particularly important in the context of the variety of different terms and definitions used to refer to ALT. The research team attempted to ensure that the usage of the term ALT was understood by the respondents by presenting a clear definition within the text used to explain, publicise and introduce the survey.

Ethical approval was obtained through the University of Leeds and as the survey was directed at Adult Social Services staff in local authorities in England, amongst others, research governance approval was obtained from ADASS (the Association of Directors of Adult Social Services). The survey was developed in Survey Monkey[5], an on-line survey and questionnaire tool, and the link to the survey was distributed to a target sample (see below). No personal or demographic information was collected from participants for the purposes of the survey. An initial 'filtering' question was used to ensure that only participants from England completed the survey whilst those from other parts of the UK were directed to a 'companion survey'[6]. Another filtering question was used towards the end of the survey to target questions specifically to those in a commissioning or management role working at a strategic level.

Target sample

Potential respondents for the target sample were identified by contacting all local authorities in England and in each case obtaining details of at least one named contact who was acting

[5] http://www.surveymonkey.com/.

[6] The companion survey was administered by Skills for Care and Development and covered Wales, Scotland and Northern Ireland.

as a lead in ALT. In situations where ALT was fully or partially delivered by other organisations such as local VCF organisations or private companies, details of relevant staff in these external / partner organisations were also taken. The Telecare Services Association[7] website was also used to obtain contact details for other non-local authority organisations.

Details of all individuals (including name, job role, telephone number and email address) were then entered onto a database in Access. In total, 310 named contacts were entered on the database, and the link to the on-line survey was subsequently emailed to all of them. Recipients of the survey link were also asked to forward the link to relevant colleagues and / or distribute it amongst the workforce in their organisation. The survey was also publicised in relevant e-newsletters and websites, including the Telecare LIN[8] newsletter, and the Skills for Care and Skills for Health[9] websites. Email reminders were sent to the database of named contacts two weeks after initial contact was made, following which telephone calls were made to encourage further responses. In total 254 completed questionnaires were received. As it is not clear how many people will have seen the publicity for the survey or how many individuals the survey link was forwarded to, it is not possible to calculate this figure as a response rate.

Analysis

Analysis of the survey data was carried out by producing frequencies in the form of statistical tables and graphs for each question. Some cross tabulations were carried out where appropriate, although in many cases the sample size was too small to offer statistically significant correlations. By carrying out the analysis of the data presented here, and adding breadth to the depth provided by the previous case study research (Wigfield *et al.*, 2012), the research team were able to produce some recommendations in terms of roles, delivery and workforce needs in relation to ALS.

The remainder of the report comprises the findings of the survey drawing out some key similarities and differences between the survey responses and the findings of the previous case study research. A number of key topics are explored, each of which forms a separate section of the report: Section 2 examines the organisations and ALT delivery models; Section 3 looks at staffing and job roles; Section 4 examines skills, knowledge and qualifications; and Section 5 discusses issues around training. Finally, Section 6 brings together the insights provided to develop some recommendations and conclusions.

[7] The Telecare Services Association (TSA) is the industry body for telecare and telehealth. The website can be found at http://www.telecare.org.uk/about-us.

[8] The Telecare Learning and Improvement Network (LIN) is a national network which supports the incorporation of telecare and telehealth into local services. It produces a monthly newsletter providing information on relevant activities, conferences and workshops and other news from UK and Europe http://www.telecarelin.org.uk/.

[9] Skills for Health is the Sector Skills Council for Health http://www.skillsforhealth.org.uk/.

2. Organisations and ALT delivery models

2.1 Introduction

In order to find out more about the kinds of organisations that are delivering ALS and the way that the services are being delivered, data about the organisations that the respondents worked for, the kinds of ALT being used, and the delivery models and partnerships in place were explored.

2.2 Types of organisations

As already mentioned, unlike the previous research (Wigfield *et al.*, 2012), the survey aimed to engage with respondents from a range of types of organisations. Ultimately, however, a large majority of respondents to the survey (68%) were working for local authorities (Table 1). Moreover, the proportion working for local authorities was probably even higher than this as some who indicated they worked in an 'other' organisation also appeared to be working for a local authority. Other respondents falling in the 'other' category worked for manufacturers, reablement organisations, care services and educational establishments. Similar proportions of respondents worked for Primary Care Trusts (PCTs) / Health authorities (6%); VCF sector organisations (7%); commercial or private sector organisations (8%) and housing organisations (6%).

Table 1: Types of organisations delivering ALS

Type of organisation	**Number**	**%**
Local authority	141	68
PCT / Health authority	12	6
Other statutory sector agency	4	2
Housing organisation (e.g. ALMO, housing association)	12	6
VCF (including social enterprise)	14	7
Commercial or private sector organisation	17	8
Direct employer (i.e. working for an individual)	1	<1
Other	5	2
TOTAL	**206**	**100**

2.3 Types of ALT

Although a range of ALT was available in the three localities studied in the previous research (Wigfield *et al.*, 2012), first generation ALT (primarily pendant alarms) remained key to ALT strategies across the case study sites. All three authorities had nevertheless moved beyond this and were utilising a range of more sophisticated second generation technologies such as sensors monitoring the home environment, vital signs and physiological measures and all three authorities were also moving towards third generation technology too (equipment using broadband, wireless and audio-visual technology). This pattern is broadly reflected nationally as the responses to the survey show, with large proportions of the organisations in which the survey respondents work providing first and second generation technologies (51% and 52%

respectively) (Table 2) and fewer respondents (19%) working in organisations providing third generation ALT. A further 4% of survey respondents were not sure what kinds of ALT their organisation provided.

Table 2: Types of ALTs delivered by organisations within which respondents work

Type of ALT	Number	%*
First generation	130	51
Second generation	133	52
Third generation	47	19
Not sure	11	4
Base number of respondents	254	

*Respondents were able to tick more than one option and therefore percentages do not add up to 100.

There appeared to be some correlation between the types of organisations and the types of ALT that were being delivered. Private / commercial, housing, and VCF organisations were most likely to be providing first generation ALT, whereas local authorities were most likely to be providing second generation ALT, as were PCTs. Those working for commercial or private providers were most likely to report that their organisation provided third generation ALT (35%), followed by those working for local authorities (22%). None of the respondents working for housing organisations reported that their organisation provided third generation ALT.

It would therefore appear that newer technologies are being included in ALT provision across different types of organisations but that local authorities and private sector organisations are perhaps being more experimental and innovative in this respect. Housing associations and VCF organisations tend to be more associated with first generation pendant alarms and similar technologies, perhaps reflecting their core activities and also funding streams and availability.

These findings relating to the types of technologies prevalent in the organisations surveyed are confirmed further when looking at the types of ALT that the survey respondents have personally been in contact with as part of their job. As Table 3 shows, most of the respondents stated that they came into contact with both first and second generation ALT, whilst only 22% of respondents said they came in contact with third generation.

Table 3: Types of ALT respondents came into contact with

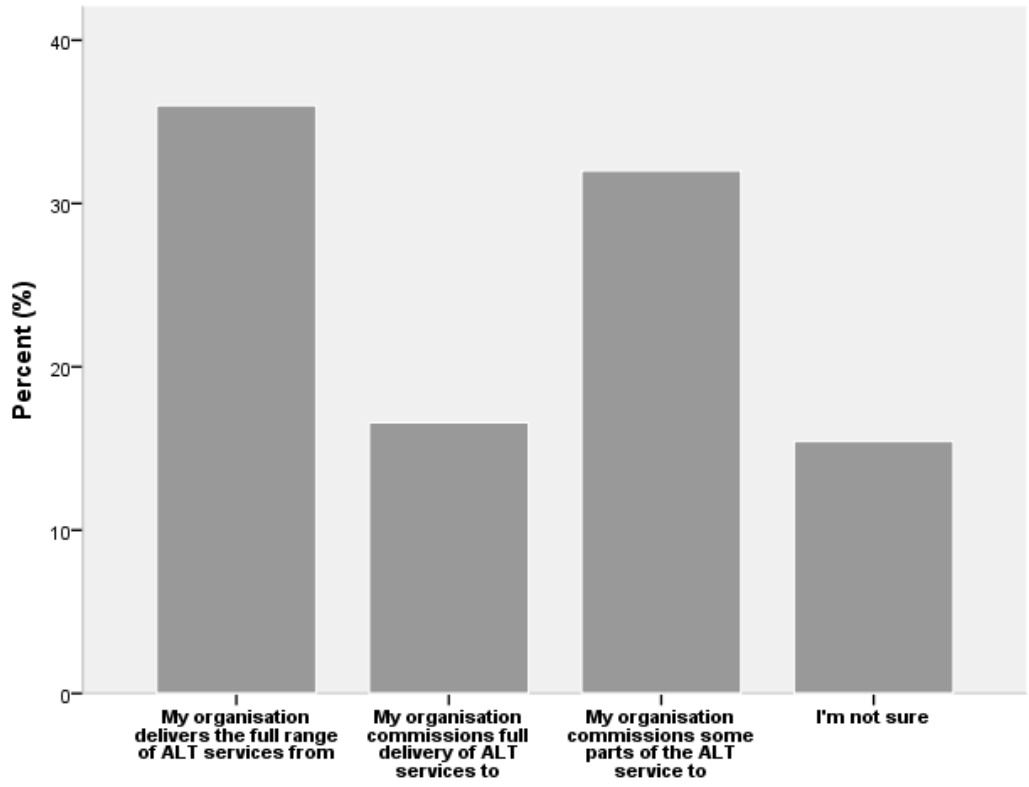
Types of ALT respondents came into contact with	Number	%*
First generation	134	53
Second generation	131	52
Third generation	56	22
Not sure	15	6
Base number of respondents	254	

*Respondents were able to tick more than one option and therefore percentages do not add up to 100.

2.4 ALT delivery models and partnerships

The case study local authorities involved in the previous research (Wigfield *et al.*, 2012) were chosen, in part, due to the different ways in which they delivered ALS. In order to establish which of these delivery models (or others) are most frequently in operation in England, respondents were asked in the survey how ALT is delivered in the organisations that they work for. 36% stated that they worked in organisations which are responsible for delivering the full range of ALS, while a slightly smaller proportion (32%) worked in organisations which commission some parts and deliver others. Respondents were least likely to state that they worked for an organisation which commissioned all its ALS (17%). This suggests that in most cases, at least some service delivery takes place in-house (Figure 1). A fairly high proportion of respondents (15%) were not sure how ALT was delivered in their organisation, perhaps suggesting that the delivery models can be complex and / or that not all individuals are aware of the service delivery structures. The range of delivery models in existence means that the particular tasks and job roles involved with ALT will inevitably vary in different organisations, presenting challenges in terms of workforce development and learning as found by Wigfield *et.al*, (2012).

Figure 1: ALT delivery models



Respondents working in a commissioning and management role (70 of the 254 respondents) were asked about the partnerships involved in ALT service delivery and it appears that organisations included in the survey are most likely to be working in partnership with primary care services (63%) and private care providers (49%), followed by voluntary sector care providers (46%), secondary care services (43%) and emergency services (31%) (Table 4). 'Other' organisations were mentioned as partners in ALT delivery by 11% of respondents, and these organisations included charities, housing associations, and local authorities. This

demonstrates the diverse types of organisations involved in ALT delivery, and the different kinds of partnerships which exist.

Table 4: Types of organisations worked in partnership with to deliver ALS

Partner organisations	Numbers	%*
Primary care services	44	63
Secondary care services	30	43
Emergency services	22	31
Private care providers	34	49
Voluntary sector care providers	32	46
Other	8	11
Base number of respondents**	70	

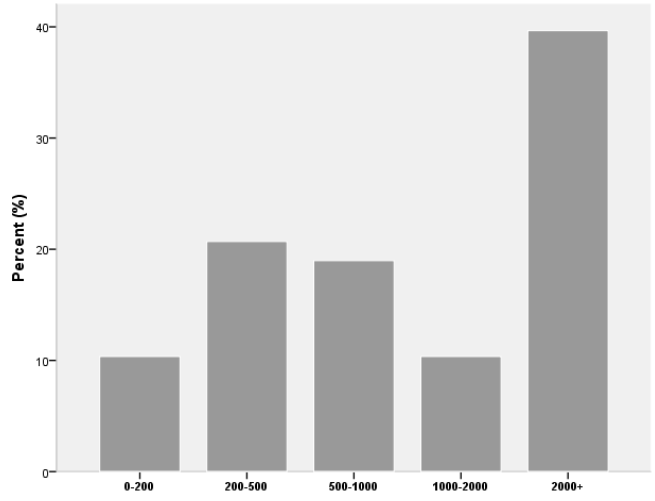
*Respondents were able to tick more than one option and therefore percentages do not add up to 100.

**This question was only asked of respondents working in a management / commissioning role

2.5 Capacity and reach of ALT service delivery

To gain an idea of the scale and capacity of ALT service delivery around the country, respondents working in a commissioning or management role were also asked how many ALT users their organisation delivered to. Two fifths indicated their organisation provided ALS to over 2000 users, with smaller proportions delivering their service to fewer users. Only 10% of respondents delivered ALS to less than 200 users (Figure 2). The number of service users would be expected to increase over time as knowledge and publicity of the service becomes more widespread.

Figure 2: Numbers of service users supported



Commissioners and managers were also asked some detail about the user groups to whom their organisation delivered ALS and responses here suggest that ALT is fairly commonly used to support of a range of different health conditions and impairments, although older people are the most likely group to be in receipt of ALS. The most commonly supported user group was older people at risk of falling or other household dangers (93%), with three

other groups of users also widely supported: individuals with mobility impairments (89%); people with learning difficulties or cognitive impairments (86%); and people with other long-term health conditions (85%). An additional three quarters (77%) said that they provided ALT to those receiving reablement care after returning home from hospital. There were few differences in the types of users that the different types of organisations supported. The organisations were generally less likely to support children and young people, with none of the voluntary sector organisations providing ALS to this group. PCTs were most likely to support people with mobility impairments.

2.6 Mainstreaming

To provide an insight into the degree to which ALT has been mainstreamed in the organisations within which the respondents work, commissioners and managers were asked about the extent to which they agreed with a series of seven statements relating to: the workforce's understanding of ALT-related tasks; the extent to which core funding is in place; the extent to which ALT provision is taken into account in strategic workforce development planning; and levels of skills and knowledge amongst staff. The exact statements provided to commissioners and managers and the results of these questions are represented in Figures 3 – 9.

As Figure 3 shows, the majority of respondents felt that ALT was important within their organisation with approximately two thirds saying that ALT was seen as very or quite important within existing social care packages within their organisation, and a further 30% that it was seen as somewhat important. The majority of respondents (81%) also said that there was a clear understanding amongst the workforce of the various tasks associated with ALS, (25% answering 'yes', 56% answering 'to some extent') (Figure 4). A similarly high proportion (82%) said that ongoing core funding for ALT was in place, with 49% answering 'yes' and 33% answering 'to some extent' (Figure 5). Opinion was slightly more divided when respondents were asked if ALT provision was taken into account in strategic planning for workforce development, and although the majority (65%) stated that they thought it was (35% answering yes and 30% saying 'to some extent'), 28% answered this question negatively (Figure 6). Respondents were less positive about the statements relating to knowledge and skills levels of the ALT workforce. 36% of managers and commissioners said that staff did not have enough ALT related learning and support (Figure 7), or adequate knowledge to deliver ALS to achieve maximum benefits for the organisation (Figure 8), and 34% said that they did not have adequate skills to achieve maximum benefits for the organisation (Figure 9).

It therefore appears that some progress has been made to mainstream ALT in many of the organisations within which the commissioners and managers work, but that further progress could take place in this direction, particularly in relation to facilitating the dissemination of knowledge, understanding and skills within the workforce. This point is further confirmed further by the survey results. Indeed, when all respondents were asked about potential limitations or gaps in maximising the impact of existing ALT provision almost one third

(32%), representing the second most popular answer to this question, stated that a lack of integration of ALT within social care packages was a gap / limitation.

Figure 3: Level of importance respondents felt is placed on ALT within existing social care packages in their organisation

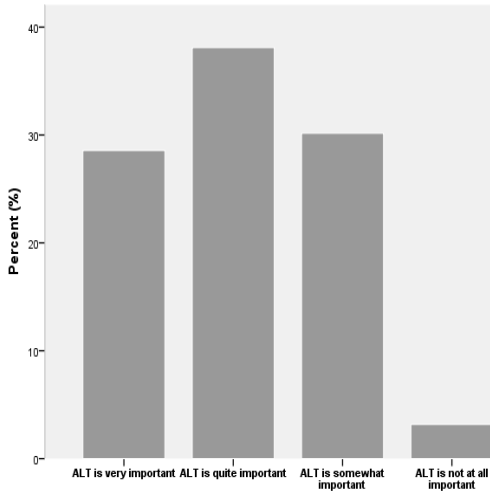


Figure 4: There is a clear understanding amongst the workforce of the different tasks associated with the delivery of ALS

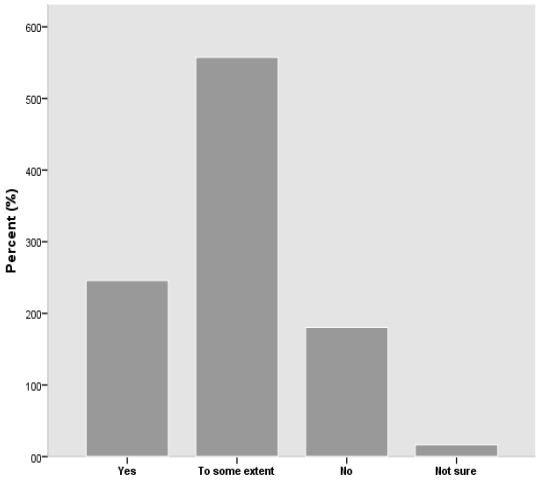


Figure 5: Ongoing core funding for ALT is in place

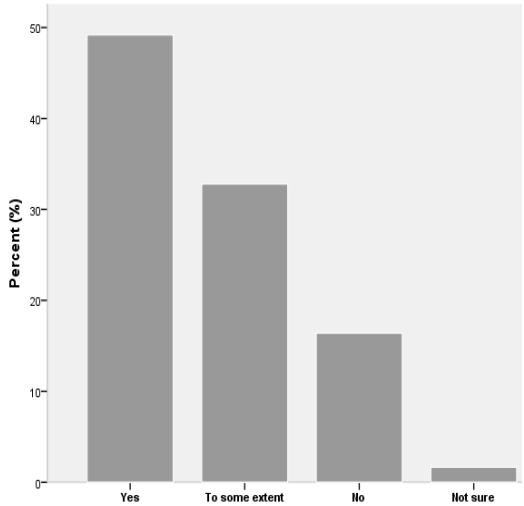


Figure 6: ALT provision is taken into account in strategic planning for workforce development

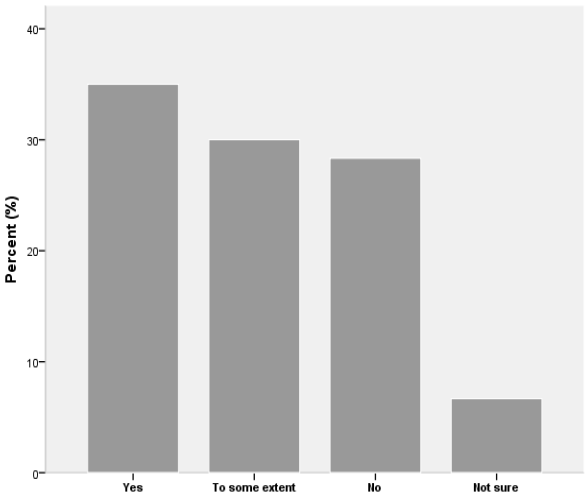


Figure 7: Staff have enough ALT related learning and support

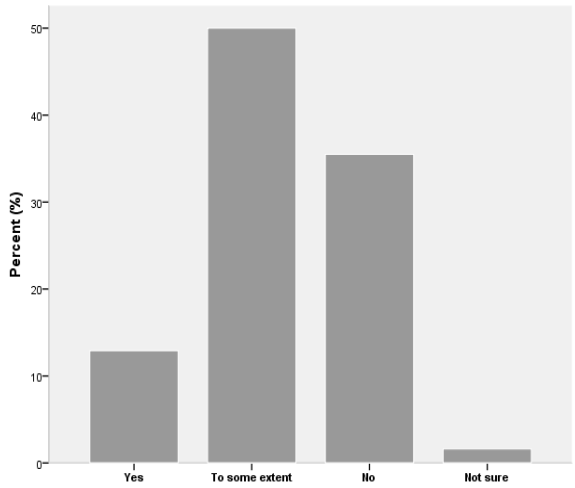


Figure 8: Staff have adequate skills to deliver ALS to achieve maximum benefit for the organisation

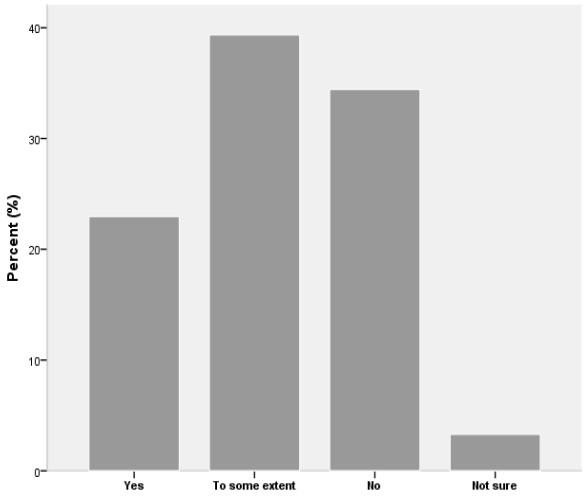
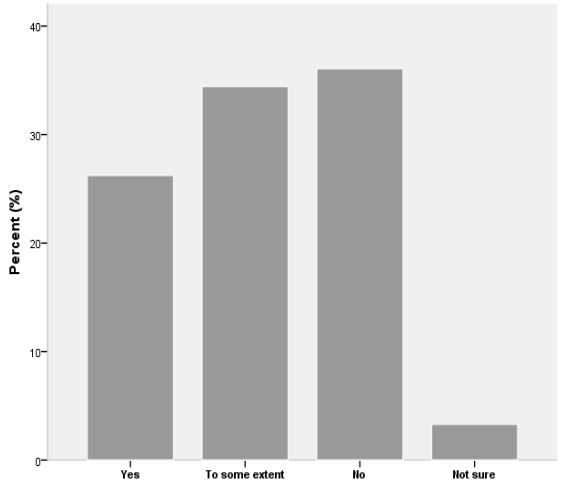


Figure 9: Staff have adequate knowledge to deliver ALS to achieve maximum benefit for the organisation



2.7 Summary

- The majority of the survey respondents worked for local authorities, but those working across all types of organisations involved in ALT service delivery responded to the survey.
- First and second generation technologies are most frequently available, but third generation technologies are being delivered by just under a quarter of organisations.
- There appears to be some correlation between the type of organisation and kinds of ALT delivered with private and commercial organisations and, to a lesser extent, local authorities more likely to be offering third generation technologies, whilst VCF

sector organisations and Housing Associations are more likely to be offering first generation technologies.

- There are many partnership arrangements between different types of organisations involved in the delivery of ALS, with primary care organisations and private care / commercial providers frequently involved.
- Most organisations deliver ALS to over 2000 service users.
- Progress towards mainstreaming ALT has been made in many organisations but there is further progress to be made here, particularly in terms of disseminating knowledge, understanding and skills, and integrating ALT further into existing social care packages.

3. Staffing and job roles

3.1 Introduction

In order to examine the staff involved in ALT service delivery, the types of roles they perform, and the tasks they carry out, all respondents were asked a series of questions about their current job titles and roles, their employment backgrounds, and the length of time they had worked in an ALT-related field.

3.2 Job titles

Survey respondents were working in a range of jobs, although half said that they worked in either a management or commissioning role (Table 5). The concentration of managers and commissioners responding to the survey probably reflects the contacts to whom the survey was initially sent, who (as mentioned in Section 1) tended to be those responsible for a lead role in telecare. Significant proportions of respondents worked as social workers (10%); telecare or telehealth assessors (6%); support / care workers (5%); and occupational therapists (5%). Some of the respondents worked as equipment installers (3%), and a small proportion were also nursing staff (2%). Only one call handler and one call responder completed the survey. Those who specified another unlisted role (12%) included several speech and language therapists; people with a background in clinical science / technology; people working in social care and residential care, including care / support workers and managers; those from a range of ALT and telecare / telehealth roles including sales, development, consultancy, reviewing and assessment work, programme and project managers. All of the respondents were involved in supporting adults, and some (18%) additionally supported children.

Table 5: Job titles of survey respondents

Job title	Number	%
Commissioner of ALS (inc. telecare and telehealth)	27	13
Telecare or telehealth service manager	41	19
Operational manager or service manager in a general service	35	16
Learning and development manager	4	2
Workforce development manager / officer	8	4
Occupational therapist	10	5
Social worker	21	10
Support worker / care assistant / personal assistant	10	5
Telecare or telehealth assessor	14	6
Equipment installer	7	3
Call handler	1	<1
Call responder	1	<1
Nursing staff	5	2
Training officer	6	3
Other	26	12
TOTAL	**216**	**100**

The responses in Table 5 show a mix of the newer specialist ALT roles (e.g. telecare / telehealth assessors; equipment installers) as well as more traditional social care and health professional roles which now entail working with ALT. This demonstrates that the range of different job roles which currently involve working with ALT is very broad and perhaps broader than was reflected in the previous case study research (Wigfield *et al.*, 2012).

3.3 ALT related tasks

As outlined in Table 6, the most common tasks performed by survey respondents relating to ALT service delivery involved promotion and awareness-raising of ALT amongst the workforce (46%) and amongst service users, families and carers (44%). These tasks were identified in the previous research (Wigfield *et al.*, 2012) as a key element of ALT service delivery within local authorities, in both newer specialised roles and in more generic job roles too. The fact that awareness-raising is the most commonly performed task would seem to indicate a recognition amongst many organisations that further progress is to be made in terms of culture change and broadening the reach of ALS. Just over a third (34%) of the survey respondents reported providing learning and support to the workforce which formed a key part of tasks undertaken in the case study authorities in the previous research.

Just over a quarter of respondents (28%) reported carrying out assessment for ALT (Table 6), and given that only 7% of *all* the respondents reported performing a specialist assessment role (Table 5) this would seem to suggest that in many organisations assessment is part of broader job roles and responsibilities rather than being carried out by a specialist assessor. This perhaps demonstrates a certain level of integration of ALT tasks into health and social care services, thus supporting the evidence provided in Section 2 that some progress towards mainstreaming has taken place within the organisations.

Around a quarter of respondents carried out tasks associated with: supporting service users, families and carers to use ALT (27%); referral to ALS (25%); and installation of ALT (23%), whilst just under a fifth were involved in both maintaining and commissioning ALT/ALS (Table 6). The lowest proportions of survey respondents (12%) were involved in monitoring and call handling and responding to emergency situations linked to ALT (14%), which probably reflects the small numbers of respondents working in roles with the respective job titles (Table 5). 'Other' tasks mentioned by respondents included: consultancy; developing service referral pathways; manufacturing; research; budgetary responsibility; and service feedback.

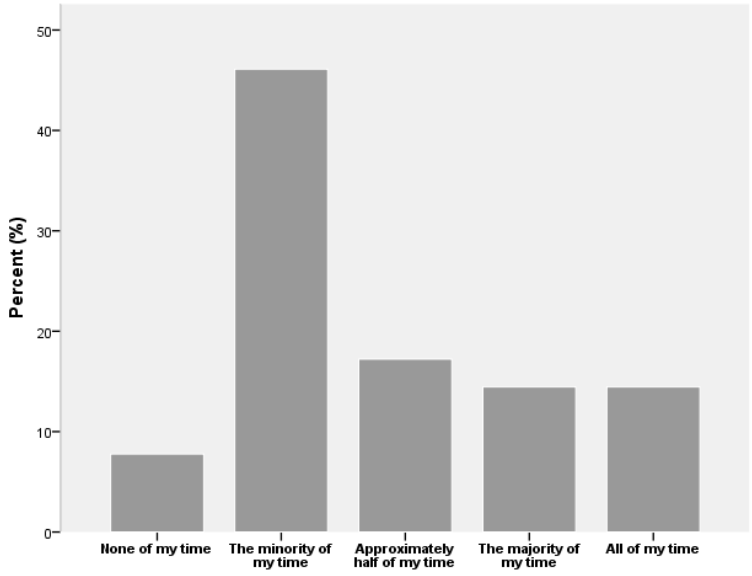
Table 6: Tasks undertaken by respondents as part of their role

Tasks carried out	Number	%*
Promotion and awareness raising amongst the workforce	116	46
Promotion and awareness raising amongst service users and their families	112	44
Providing learning and support to the workforce	86	34
Assessment for ALT	71	28
Support for service users, families and carers to use ALT	68	27
Referral to ALS	63	25
Installation of ALT	58	23
Maintenance of ALT	48	19
Commissioning of ALS	48	19
Responding to emergency situations linked to ALT	35	14
Monitoring and call handling	30	12
Other	20	8
BASE NUMBER OF RESPONDENTS	254	

*Respondents were able to tick more than one box and therefore column does not add up to 100%.

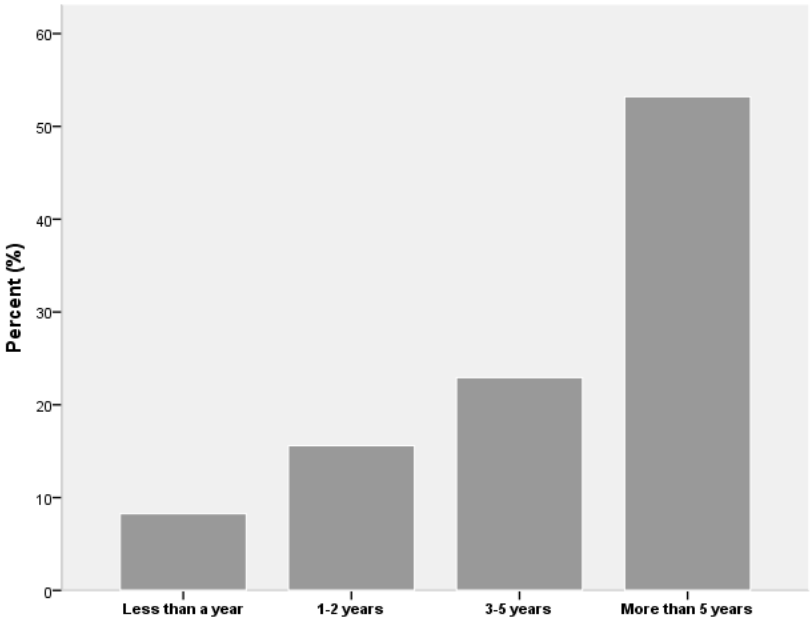
Almost half (46%) of the respondents said that they spent a minority of their working time on the delivery of ALT (Figure 10) but 31% said that they spent approximately half or the majority of their time on ALT delivery. A small proportion (8%) said they spent none of their time in the delivery of ALT. This indicates that many respondents do not work in a specialised ALT role, rather that ALT-related work forms part of another broader more generic role, and therefore again indicates that there is some degree of integration of ALT into existing health and social care systems.

Figure 10: Amount of time spent on delivery of ALS by respondents



All those in ALT specific roles[10] were asked how long they had been working in an ALT related role, and over half had done so for over five years, 23% had worked in an ALT role for three to five years, and only 8% had worked in ALT for less than a year (Figure 11), suggesting that the majority of those working in an ALT specific role had done so for some time.

Figure 11: Length of time respondents working in an ALT specific role had worked with ALT



Respondents working in a specialised ALT role were also asked about their previous employment and the roles they filled prior to taking up their current employment position and the results show that staff had come from a range of different employment backgrounds. Some were previously Occupational Therapist technicians, technical consultants, and medical engineers, perhaps reflecting the technical expertise required in certain ALT roles. Several respondents came from social care and / or health backgrounds, for example care assistants, homecare and social care managers, speech and language / occupational therapists and therapy, clinical scientists, demonstrating the strong link between ALT and existing health and social care systems and roles. Others came from a specific ALT-related background, such as in community alarms, telecare project management or commissioning, and these inevitably brought specialist experience and knowledge from their previous role with them. There were also several respondents from social and community work backgrounds, for example voluntary sector workers, social workers and housing workers. Finally, a small number of respondents indicated they had come from apparently unrelated employment backgrounds, albeit with relevant transferable skills, such as fork lift truck engineer, public house licensee, marketing director and several from finance and IT backgrounds.

[10] ALT specific roles included those working in the following roles: commissioner of ALT services; telecare / telehealth service manager; telecare or telehealth assessor; equipment installer; call handler; call responder.

3.4 Summary

- Half of the respondents were in a management and commissioning role, but the sample also covered a range of job titles including specialist ALT roles and more generic health and social care roles.
- 44% of respondents worked in a specialist ALT role.
- A range of tasks relating to ALT delivery were carried out by respondents, the most frequently cited being ALT awareness raising and promotion amongst both the workforce and service users and families, followed by the provision of learning and support to the workforce. This reflects the fact that ALT service delivery is still a growing area and as a consequence promotion of the service and support for staff working within it continues to be important.
- Respondents working in ALT specific roles were most likely to have worked with ALT for over five years.
- Many respondents do not work in a specialised ALT role, with ALT-related work forming part of another broader more generic role, thus demonstrating a degree of mainstreaming of ALT within the organisations.
- Respondents' previous roles covered work in a range of sectors, including social care and health; technical; telecare and telehealth; and social and community work, reflecting the wide range of skills and knowledge that ALT service delivery can require.

4. Skills, knowledge and qualifications

4.1 Introduction

A key element of the survey was to explore the skills, knowledge and qualifications required by, and present within, the existing ALT workforce. This section examines the findings of the survey in relation to these issues.

4.2 Skills and knowledge

Wigfield *et al.*, (2012) suggested that it was useful for the ALT workforce to have a 'global awareness' of a range of different skills, meaning that it was important to have more than simply technical expertise and that a range of other skills were also important for practitioners, such as observational, communication and listening skills and sensitivity to clients' needs and their living environment:

> *the main thing is to be able to link a person's needs with what the technology could do, which doesn't necessarily mean knowing how the equipment works, it's just about knowing what it does, and what it can do* (Wigfield *et al.*, 2012: 25).

Similar findings were reflected in the survey results for this research, which revealed that the most important skills were seen to be:

- The ability to listen and communicate effectively with service users (85% rated this as very important) (Figure 12).
- Knowledge of the range of ALT available (83% said this was very important) (Figure 13).
- Skills in matching equipment to users' needs and home environment (75% rated this as very important) (Figure 14).
- Knowledge and skills to promote independence (70% said this was very important) (Figure 15).

These responses show that respondents felt that a range of different kinds of skills were important, both those specific to ALT, and other – more generic – health and social care skills. The lowest rated skills were those relating to technical ability, and IT. 'Other' responses listed included knowledge of funding.

Figure 12: Ability to listen to and communicate effectively with service users

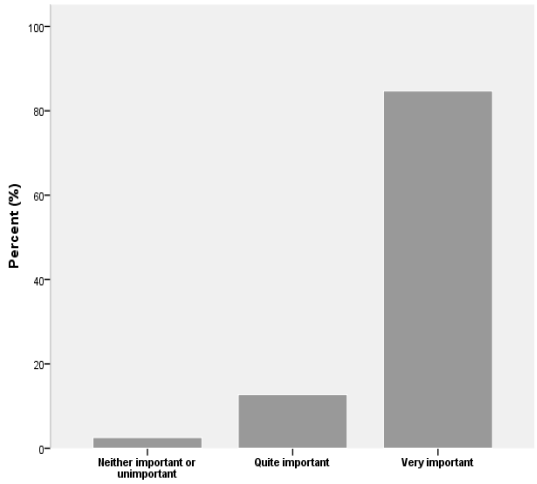


Figure 13: Knowledge of the range of ALT available

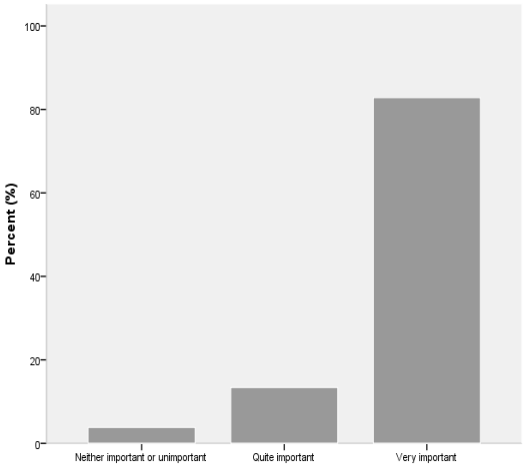


Figure 14: Skills in matching equipment to users' needs and home environment

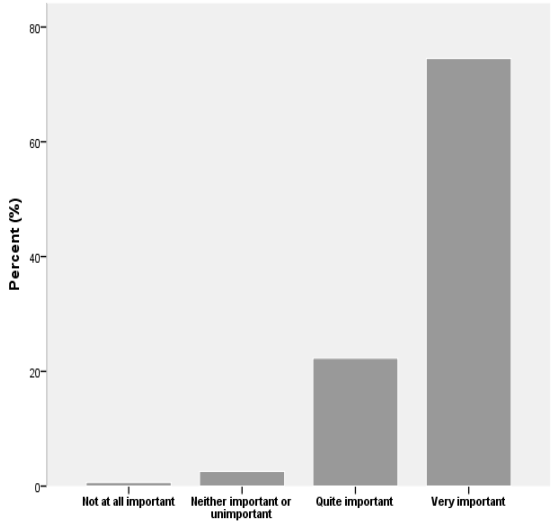
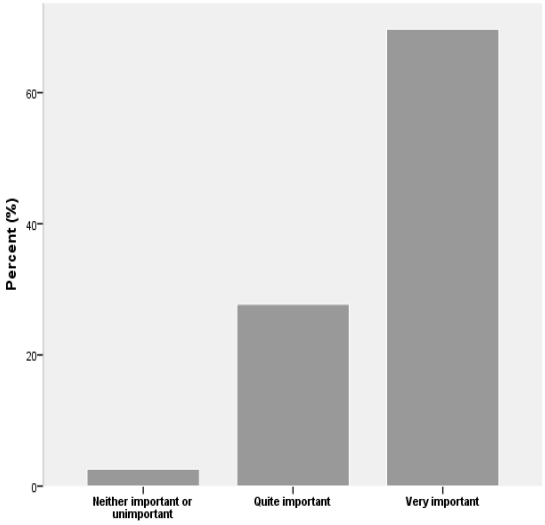


Figure 15: Knowledge and skills to promote independence



Having asked respondents to outline the skills and knowledge that they felt were important for the ALT workforce to posses, they were then asked how they rate their own skills and knowledge. Most respondents rated themselves as knowledgeable about ALT with almost 80% stating that they are quite (50%) or very (29%) knowledgeable (Table 7). Just over a fifth (21%) said that they thought they had little knowledge. Furthermore, the majority (60%) rated themselves as adequately skilled for their roles in ALT, with a further 29% rating themselves as highly skilled (Table 8). However, a significant minority (11%) felt they had

few or no relevant ALT skills. This suggests that most of the respondents felt fairly confident about their knowledge and skills of ALT, although further support in this area for some sections of the ALT workforce would be beneficial.

Table 7: Respondents' ratings of their own knowledge of ALT

Level of knowledge	Numbers	%
I am very knowledgeable	46	29
I am quite knowledgeable	79	50
I have a little knowledge	34	21
TOTAL	**159**	**100**

Table 8: Respondents' rating of own ALT skills

Level of skills	Numbers	%
I am highly skilled	45	29
I am adequately skilled	95	60
I have few or no relevant skills	17	11
TOTAL	**157**	**100**

Those working in more general health and social care roles (e.g. social workers and occupational therapists) were more likely to give a low rating to both their skills and knowledge of ALT, whilst those in more specialised ALT roles (e.g. telecare and telehealth service managers, telecare and telehealth assessors and equipment installers) were more likely to rate their own knowledge of ALT highly. This can be explained by the fact that individuals working in these more specialised ALT roles were more likely to have formal ALT qualifications (see later). Furthermore, knowledge of ALT is also more likely to be a prerequisite of specialist ALT roles in comparison to general health and social care roles. This potential lack of skills and knowledge of ALT within the existing social care workforce was one which many respondents recognised as an important barrier to maximising the impact of ALT in the future. Indeed, almost half respondents (47%) said that a lack of knowledge of ALT within the social care workforce was a potential gap / limitation, and 31% said a lack of appropriate skills amongst the social care workforce was a potential limitation / gap.

Knowledge of ALT was largely perceived as beneficial to practitioners, indeed when asked about the usefulness of their ALT knowledge in their current job, the majority (60%) felt their knowledge of ALT was very useful in enabling them to carry out their job, with a further third suggesting that they felt it was quite useful (Table 9). Only 5% felt that their knowledge of ALT was not that useful, with just one respondent stating that it was not at all useful. Most of those who rated their knowledge as "not that useful" were those who stated they spent a minority of their time on ALT related tasks. The importance of appropriate knowledge and skills amongst the workforce is further reinforced when looking at the factors which the survey respondents listed as potential limitations or gaps in maximising the impact of ALT. Issues around knowledge and skills of the social care workforce were mentioned here, with almost half (47%) stating that a lack of appropriate knowledge amongst the social care

workforce and 31% stating that a lack of skills amongst the social care workforce were potential barriers in maximising the impact of ALT.

Table 9: Usefulness of knowledge of ALT in carrying out job

Usefulness of knowledge of ALT in carrying out job	Numbers	%
Very useful	96	60
Quite useful	53	33
Not that useful	8	5
Not at all useful	1	1
Not sure	1	1
TOTAL	**159**	**100**

4.3 Qualifications

A large majority (89%) of the respondents did not have any qualifications relating to ALT (Table 10), with only 15 (9%) stating that they have ALT related qualifications and an additional two (1%) stating that they were currently completing a qualification. This apparent absence of formal qualifications amongst the ALT workforce supports findings from the previous research (Wigfield *et al.*, 2012) which indicated that in the three case study local authorities most of the training that was provided was not accredited and / or did not lead to formal qualifications. This lack of accredited training, or training leading to qualifications, was a point which Wigfield *et al.*, (2012) identified as an area where improvements could be made, although they also noted that providing accredited training and / or training which led to qualifications could be challenging when offering it across organisations with different services and different models of delivery.

Table 10: Qualifications relating to ALT

Qualifications	Numbers	%
Yes I have a qualification	15	9
I am currently completing a qualification	2	1
No I have no qualifications	143	89
TOTAL	**160**	**99**

There were some noticeable differences in terms of the types of respondents who were most likely to have qualifications. As mentioned previously, the highest proportions of respondents with formal qualifications were those in telecare and telehealth assessor roles and equipment installers. None of those in a specific commissioning role reported having any ALT related qualifications. It would therefore seem that qualifications are most likely to be held by those in specialised roles which involve directly working with ALT, although this conclusion is drawn from a very limited number of responses.

Of those who had completed a formal qualification, most had completed on-line modules relating to ALT, telecare or telehealth, or had completed postgraduate modules or courses in AT. Only one respondent had completed an undergraduate module or course (Table 11). Of those respondents who had a qualification, most had completed it after starting to work in

ALT, although some had done so prior to taking up such a role. It would therefore seem that most of the respondents had been motivated to achieve qualifications by working in ALT rather than studying in order to gain employment in ALT-related employment. Their studies may also have been facilitated / funded by their employer, or required as part of their role.

Of the small numbers who had qualifications, over half (nine respondents) felt their ALT-related qualifications were somewhat appropriate for the work they carried out, and five respondents felt they were very appropriate. Just two respondents felt they were not at all appropriate. This suggests that ALT related qualifications are useful for the ALT workforce but that closer links could perhaps be made between ALT-related qualifications and the requirements of ALT roles in the workplace.

Table 11: Types of qualifications and whether obtained before or after starting work in ALT

	When qualification was acquired	
Qualification	**Before starting work in ALT (No.)**	**After starting work in ALT (No.)**
Postgraduate modules or course in Assistive Technology	0	5
Undergraduate modules or course in Assistive Technology	0	1
BTEC in Healthcare and Assistive Technology	0	0
City and Guilds Certificate in Supporting Users of Assistive Technology	1	1
Certificate in Telecare Services	1	2
Individual QCF module relating to ALT, telecare or telehealth	2	2
On-line modules relating to ALT, telecare or telehealth	2	6

4.4 Summary

- Respondents identified a range of different skills which are important for the workforce involved in the delivery of ALS, including specialist ALT knowledge and generic health and social care skills.
- Respondents rated their own knowledge and skills relatively highly, although few indicated they were ‘highly skilled’ or ‘very knowledgeable’.
- Those working in health and social care roles were more likely to give a low rating to their skills and knowledge, whilst those in specialist roles were more likely to rate their skills and knowledge highly. Moreover, a lack of appropriate ALT knowledge and skills amongst the social care workforce was highlighted as a potential gap / limitation in terms of maximising the impact of ALT.
- Most respondents do not have a formal qualification in ALT, but those in specialist ALT roles were more likely to have ALT qualifications.
- Whilst ALT qualifications are seen as useful for working with ALT, some closer links between qualifications and the content of practitioners’ job roles would be a positive step forward.

5. Training

5.1 Introduction

This section of the report outlines the survey responses to a series of questions about training provision for the ALT workforce, including: the kinds and frequency of training opportunities, how and by whom training is delivered, staff perceptions of training opportunities, its usefulness in relation to job roles, and ways in which training might be improved.

5.2 ALT Induction

Wigfield *et al.*, (2012) found that both Lambeth and Sandwell local authorities provided ALT induction courses for new staff, although Kent County Council did not. In contrast, only a small proportion of the survey respondents (19%) had attended an ALT specific induction course (Table 12). This suggests that the experiences of Lambeth and Sandwell are the exception and not necessarily the norm. Nevertheless, there was some variation here between the different types of organisations, with respondents working for commercial or private organisations marginally more likely to report that they had attended ALT-specific induction training, compared to respondents working for local authorities. Respondents working for housing organisations were even less likely to receive this kind of training and none of the respondents working for VCF organisations received ALT-specific induction.

Table 12: Respondents attending ALT-specific induction

Respondents attending induction	Number	%
Yes	30	19
No	123	78
Don't know	4	3
TOTAL	157	100

5.3 Training providers

Employer-led in-house training was provided in all three case study authorities discussed by Wigfield *et al.*, (2012). Supplier-led training was also used but in varying quantities across the three local authorities. However, when examining the types of training provision taken up by the workforce in different organisations around the country through the on-line survey, slightly different patterns of training provision emerged. Supplier training was most frequently mentioned by the respondents (69%), followed by employer-led training (55%) (Table 13). This is an interesting finding given the indications in Wigfield *et al.* (2012) that supplier-led training can be rather limited, *'too market oriented',* often focused on specific pieces of equipment, and *'should not be the sole mechanism for learning and development'* (p.30).

The survey respondents were least likely to have attended training provided by a college or university, with only 19 respondents (18%) reporting that they had done so. These small numbers perhaps support evidence provided by Wigfield *et al.* (2012) which suggest that college / university based training tends to be too lengthy and require too great a commitment of time.

Table 13: Providers of training undertaken by respondents

Types of training providers	Yes, training attended (%)	No, training not attended (%)	Don't know (%)
Supplier	69	29	2
Employer-led	55	43	3
College or university	18	81	2
External training provider	30	67	3

Again, some differences were noticeable between different types of organisations. Higher proportions of those working for PCTs than for any other organisation reported attending supplier-led training, whilst those working in commercial / private sector organisations were the least likely to have attended employer-led training.

5.4 On-the-job versus off-the-job training

Wigfield *et al.* (2012) found that combining on and off-the-job training was an effective way of training the ALT workforce. Of the survey respondents who had attended training, most were likely to have attended on-the-job training, with respondents much less likely to have undertaken off-the-job training across a whole range of areas (Table 14).

Table 14: Content of training and type of delivery

	On the job training (%)	Off the job training (%)	No training (%)
Equipment demonstrations	69	24	14
Awareness raising of range of AT equipment	68	21	21
Working with vulnerable people	60	33	20
Basic technical awareness	57	22	31
Awareness and understanding of health conditions and underlying factors	55	40	22
Understanding of how AT can be used to support people with particular health conditions and underlying factors	53	24	31
Training in specific equipment	51	18	37
Health and safety training	50	32	29
Ethics and consent processes	49	27	35
Customer care training	45	19	42
Training in assessments	45	20	45
Installation and maintenance training	36	8	62
Training in monitoring	29	6	70

Training in response	25	9	71
Advanced technical training	20	12	74

On-the-job training was most likely to have involved equipment demonstrations; awareness raising of the range of ALT available; working with vulnerable people and basic technical awareness. *Off-the-job* training tended to consist of awareness and understanding of health conditions; health and safety; and working with vulnerable people. Respondents were least likely to have attended advanced technical training; training in response; and training in monitoring and response, either on or off-the-job. This probably reflects the low numbers of respondents reporting that they worked in monitoring or response, and the lack of technicians completing the survey.

5.5 Mandatory versus voluntary training

There were elements of mandatory training provided within the case study authorities as outlined in the previous research (Wigfield *et al.*, 2012), although much of the training offered was voluntary in nature. The survey responses suggest that this tendency towards voluntary training programmes is reflected across organisations in England, with 59% of respondents reporting that the training they had attended was voluntary, whilst only 12% had attended mandatory training (Table 15). A further 29% said they had attended both voluntary and mandatory training.

Table 15: Mandatory / voluntary training

Type of training	**Number**	**%**
Mandatory	17	12
Voluntary	82	59
Both	40	29
TOTAL	**139**	**100**

The kinds of mandatory training undertaken by the respondents included: health and safety (which was the most frequently mentioned); issues around safeguarding; working with vulnerable adults; telecare awareness; and training relating to specific conditions, e.g. dementia. There are some overlaps here with the content of Lambeth Borough Council's mandatory training programme, which covered awareness training and using equipment to meet particular needs. Health and safety and safeguarding training tends to be a legal requirement and generic training in these areas is often provided throughout the workforce, which perhaps explains the prevalence of this form of training.

5.6 Usefulness, barriers and improvements to training

Workshop sessions were most likely to be rated as a very useful form of training (also highly rated by participants in the three case study authorities (Wigfield *et al.*, 2012), followed by shadowing, and short training courses (Table 16). Mentoring was rated highly amongst survey respondents when the very useful and quite useful scores are combined. On-line training resources were most likely to be rated as 'not at all useful'. The lack of direct engagement and 'hands on' experience involved in on-line training may explain its low rating. Indeed, one respondent suggested *'hands on works best'*, and others highlighted

equipment demonstrations as particularly useful. This supports evidence provided by Wigfield *et al.* (2012) who found that interactive, hands on training was perceived to be particularly useful, especially in supporting the development of the required technical knowledge for a range of tasks, such as recommending equipment; or matching equipment to individuals and / or their accommodation.

Table 16: Usefulness of different types of training

Type of training	Very useful (%)	Quite useful (%)	Somewhat useful (%)	Not at all useful (%)	Not applicable (%)
Workshop sessions	41	27	11	2	20
Shadowing	27	18	6	1	48
Short training courses	24	33	10	2	32
Mentoring	21	18	9	0	52
Blended learning	21	18	7	2	53
On-line training resources	11	23	20	6	40

Most respondents reported accessing training occasionally (49%), with an additional 18% stating that they access it frequently. Just over a quarter (26%) said that they access training rarely and 6% reported never accessing training.

Survey respondents were asked about any potential barriers that they face in relation to accessing training and, of the listed issues, the most frequently selected answer (30%) was that respondents had only a limited amount of time to attend training but a further 25% also reported being unaware of any appropriate training opportunities (Table 17). Of the 'other' issues listed, a lack of funding available for training was mentioned most frequently.

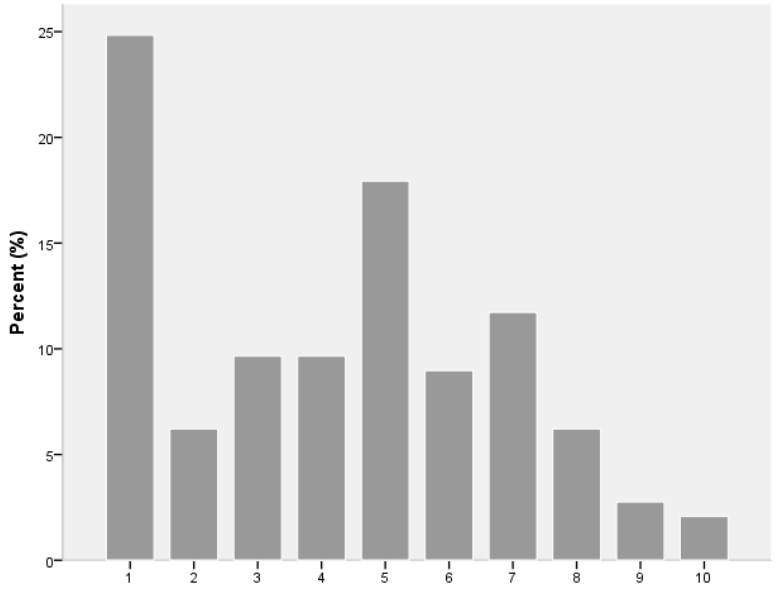
Table 17: Barriers to training

Barrier	Numbers	%
I only have a limited amount of time to attend training	41	30
I am not aware of any appropriate training opportunities	34	25
The responsibilities of my job prevent me from being able to attend training	14	10
I have booked training but then been unable to attend due to other work responsibilities	10	7
None of these	60	44
Other	11	8
BASE NUMBER OF RESPONDENTS	136	

Nearly a quarter (24%) of respondents rated current training opportunities as poor, whilst only 2% rated them as excellent (Figure 16). 18% gave training opportunities a score of 5/10, indicating that they felt they were average/satisfactory. These responses would suggest that a great deal of improvement could be made in terms of training opportunities provided to the ALT workforce. When asked about potential improvements to training, the

answer most frequently provided (by 24% of the respondents) was that training needs to provide knowledge which directly relates to respondents' jobs. Almost a fifth (19%) felt that training needed to be broader and provide competencies in a range of relevant areas; a further 18% wanted to have greater access to training that led to recognised qualifications; and 15% wanted more specialist technical training. The least frequently mentioned answer was providing training in interpersonal skills.

Figure 16: Respondents' rating of training opportunities (where 1=poor and 10=excellent)



5.7 Summary

- Most respondents had not attended ALT specific induction training, suggesting that it is not commonly offered by organisations across the country.
- Supplier-led training was most frequently undertaken, followed by employer-led training. Training provided by colleges or universities appeared to be less popular.
- Most training undertaken was provided in an on-the-job setting, with fewer examples of off-the-job training mentioned.
- The most common on-the-job training involved equipment demonstrations and awareness raising, whilst off-the-job training tended to involve working with vulnerable people, health and safety; and knowledge and understanding of health conditions.
- Most training was voluntary, rather than mandatory.
- Preferred modes of training delivery included workshops, shadowing and short training courses with on-line training viewed as the least useful.
- Barriers to training included limitations on the amount of time respondents had to spend on training, as well as a lack of knowledge of opportunities.
- Current training opportunities were rated as average to poor.

- There was a view that training could be improved by providing knowledge which directly related to job roles and tasks, and by providing a broader range of competencies in a range of relevant areas. Some respondents wanted access to training which provided recognised qualifications.

6. Conclusions and Recommendations

The findings presented here provide an insight into the range of ALS delivered within England across a range of types of organisations, and give some idea of the extent to which ALT has been mainstreamed and integrated into existing health and social care provision. The research has also provided an overview of the different job roles involved in the delivery of ALS; the tasks carried out by the workforce; and their skills, knowledge and training.

Organisations and ALT delivery models

Most organisations delivering ALS are providing first and second generation ALT with some also providing third generation technologies. There appear to be some differences between types of organisations and the kinds of ALT that they provide, with private and commercial organisations and, to a lesser extent, local authorities more likely to be offering third generation technologies, whilst VCF sector organisations and Housing Associations are more likely to be offering first generation technologies. Organisations most commonly deliver the full range of ALS themselves, although a large proportion commission out part of their ALS to one or more other organisations, with very few commissioning out all of their ALS. There are many partnership arrangements between different types of organisations involved in the delivery of ALS, with primary care organisations and private care / commercial providers frequently being involved. A range of user groups are supported through ALS, including those with a number of different physical and mental impairments, and health conditions, although older people are the largest ALS user group. Some progress towards mainstreaming ALT has been made in many organisations but there is further progress to be made here, particularly in terms of disseminating knowledge, understanding and skills, and integrating ALT further into existing social care packages.

Recommendation 1: Encourage and provide support for organisations to further mainstream ALS into their wider social and health care provision.

Staffing and job roles

Many staff working in ALS do not work in specialised ALT roles, rather ALT-related work forms part of broader more generic roles. The most common tasks carried out by the staff involve awareness raising and promotion amongst the workforce and amongst service users and their families, which suggests that ALT service delivery is still a growing area and as a consequence promotion of the service and support for staff working within it continues to be important.

Recommendation 2: Continue to promote ALS amongst the social and health care workforce and amongst potential service users and their families through awareness raising, promotion activities and culture change initiatives.

Skills, knowledge and training

The findings of the research indicate that there are some gaps in the skills and knowledge of the ALT workforce which potentially limit the impact of ALT services. Differences exist between those in specialist roles and those working in more generic health and social care roles, with the former appearing to be more likely to have undergone training and to feel they have appropriate skills and knowledge than the latter. Many generic roles, however, now involve working with ALT and require some level of ALT-specific knowledge and skills.

Making time for ALT specific training is difficult for those whose work entails spending only a minority of their time on ALT-related tasks, and in any case the training opportunities that are currently available are not necessarily directly relevant or delivered in the most appropriate way. Training could be more directly relevant if it included knowledge of the range of ALT available; the ability to listen and communicate effectively with service users; skills in matching equipment to users' needs and home environment; and knowledge and skills to promote independence. More training that leads to qualifications in ALT would be seen as a positive step, as long as it was linked closely to the job roles of practitioners. This supports the findings of the previous research (Wigfield *et al.*, 2012), which suggested that the workforce need to have a range of different skills encompassing some technical knowledge and awareness / understanding of ALT equipment, as well as an ability to understand how these relate to the specific requirements of service users.

Recommendation 3: Provide training opportunities which enable the ALT workforce to develop a range of competencies relevant to their work and which lead to ALT related qualifications, where possible. Training opportunities and time to attend training should be available to all who work with ALT, even if this forms only a small proportion of their role.

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