Healthcare Science **Equivalence**

NHS Education for Scotland

What are the pros and cons of equivalence?

What needs to happen to overcome the cons?

PROS	CONS
Avoids duplication [*where pre-existing qualification in cognate subject*]. Tailored to suit individual [*gap fill*]. Widens access [*dip into unutilised graduate pool*] Assist recruitment / workforce supply problems AHCS oversight Flexibility for trainees and centres Lack of national training places means the pathway is vital to maintain workforce. Standards of professionalism [*can be included in plan*] Freedom to adjust plan depending on Board Common sense approach [*with a plan, mindful of protection/safety*] Cost saving. Agility.	If professional "degree" absent, may limit future opportunities. Lack of university experience Lack of understanding [*of process*] / suspicion of process Lack of structure [*ready*] / training plan Less interaction with trainee peers Pressure to deliver service may hamper training opportunities Inability of a department(s) to provide all content / learning Trainees could be seen as clinical [*trained*] staff when supernumerary Communication / cultural differences [*with existing staff*] Staff time to train Training of staff to support [*variation of approach threatens consistency*] Process can be lengthy May threaten existing role definitions Definition of what an equivalence training programme is and how it differs from the standard model may be confusing Heterogeneity can be a challenge: mix of specialised and generic learning Practical costs

Mitigating the cons
Education [*about the process*] Use national training plan to ensure all competencies [*mapped and*] covered Participating in workshops, events and training [*to help clarify*] Standardisation of assessment [*can be a challenge*]

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How should we "govern" training by equivalence?
Who decides? Who is responsible?
Think how this compares with the "standard" training route

If a discipline allows a [*standard*] pathway e.g. STP, then this should be the gold standard.

Consortium of departments in the professional groups should have oversight… e.g. medical physics & clinical engineering have such an approach.

Possibility of uploading evidence to an online portfolio e.g. at NES.

Consistency during training and at end assessment – standardised competency assessment

Standard training plan. Responsibilities of all participants. NES QA oversight.

How: map against existing programmes / affiliation to professional body outcomes and benchmarks, and codes of conduct

Who: unbiased lay / registered practitioners / regional assessor. (AHCS > HCPC)

Registered trainers [*recognition*] / more specialism training for assessors

"Deanery" with common aim of training quality oversight

Each discipline should have an identifiable lead. Training centres responsible for meeting objectives in training plan.

NES funding / system setup

What minimum (threshold) assurance standards should be in place DURING training using an equivalence route?

…for trainees and for trainers?

Not discussed owing to time. Probably covered in preceding responses

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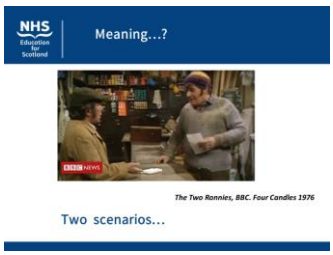


Scenario 1 “The individual with a cognate degree”

Department X has recruited a graduate whose degree, whilst being in the general scientific area, has had little direct clinical application. They know some of the “theory” but there are significant gaps in understanding in the clinical setting. Knowledge of the wider healthcare team is limited and, as it stands, they are not able to join the profession’s register.

Nevertheless, the department is confident that they can “home school” the individual to a point where they are safe to practise and can deliver the required tasks.

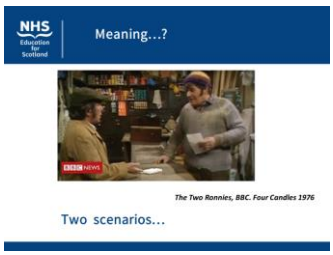
What would you, the service lead, do as next steps if you had taken this decision to employ this member of staff?

Training needs analysis
Training plan (include MDTs, clinical experience visits
Consult / identify how to deliver staff / involved trainers
Source other resources, arrange blocks / rotations in other departments
Link with networks – e.g. other trainees
Formal review of progression
Mentoring for trainees and supervisors

Learning styles of trainee
Competency sign-off
Shadowing opportunities.

Independent scrutiny
Progression monitoring
Consideration of financial implications - ensure funding to fulfil training needs [*able to complete*]
Gaps in department knowledge [*ability to deliver training*]

Map against generic route [*standard route*]
Liaise with other centres
Proof that training [*as it progresses*] has been completed and met



Scenario 2 “The collective alternative”

Departments X, Y and Z have had some experience of developing individuals within their respective departments who are recruited with a science background but no formal clinical grounding. With three departments “home schooling”, there is a debate about whether this is efficient; for each they have written a separate plan. Indeed, sometimes departments have shared bits of training experience unavailable in the host department. It all depends on the individual they employ.

Department X has suggested adopting a more formal approach to this type of trainee. What would you as service leads do as next steps in crystallising this more formal approach?

Need a co-ordinator
Need an external perspective
Need to collate existing plans
Liaise by transferring elements of different plans across departments to create specific [*shared*] “training objectives”
National standardisation across disciplines.

Meet with other departments; discuss next steps.
Look for affiliations to set training framework too
Speak to “higher ups” about appropriate approach for governance

Identify strengths and weakness of each site. Share resources.
Formal approach with cross-centre flexibility. Pre-planning
Standardisation relative to [*agreed*] benchmark to ensure X Y & Z meet the standard
Assessment process / QA for all three
Ensure access to a clinical grounding – involve a new centre
Core training plan concept [*distilled from the work of the 3 centres*]
Generic minimum content that departments can tailor - i.e. play to strengths
Trainees rotate across 3 centres where strength / timings are.