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## **Apprenticeship and Progression in the Healthcare Sector: Can labour market theory illuminate barriers and opportunities in contrasting occupations?**

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### **Abstract**

There is growing research and policy interest in the extent to which government-supported Apprenticeship in England provides a platform for educational and career progression in different occupational sectors. This paper makes a contribution to this debate by presenting research on the healthcare sector undertaken in a regional health authority in England, and by suggesting that ideas associated with labour market theory can shed light on some of the key differences in Apprenticeship frameworks and the progression opportunities available in different kinds of healthcare occupations. The research included policy and documentary review as well as qualitative interviews with employers in NHS Trusts. More specifically, our analysis applies key characteristics of occupational and internal labour markets to show how Apprenticeship frameworks fit and reinforce variations in employment, training and career opportunities in two contrasting Advanced Apprenticeship frameworks, Clinical Healthcare Support, and Pharmacy Services. We conclude that the labour market lens is useful in focusing attention on the structures and key stakeholder relationships which determine the development of vocational training and the barriers or opportunities for educational or career progression in diverse sectoral contexts and occupations across the economy.

**Key Words:** Apprenticeships, Progression, Healthcare sector, Labour Market theory, Occupation, Career

### **Introduction**

The number of government supported Apprenticeships in England has increased in recent years. Over half a million (520,600) people started an Apprenticeship in 2011/12 up from nearly 280,000 in 2009/10. In a recent strategy document, the government reinforces its commitment to Apprenticeship and draws attention to the need for ‘clear ladders of progression’. (BIS 2010:18). Whilst the centrality of Apprenticeship to successive governments’ skills policies is clear (Leitch 2006, DIUS 2009), the extent to which the programme actually provides a platform for educational and career progression is a concern (Seddon 2005, FdF/UVAC 2008, Carter/UVAC 2009, Gittoes 2009, Fuller, Turbin and Wintrup 2010, Wolf 2011, Fuller and Unwin 2012).

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Fuller and Unwin (2012) explored the currency of qualifications in a range of Advanced Apprenticeships (Level 3) and found that most are unlikely to qualify candidates for entry to Higher Education (HE). This is despite the frameworks being positioned as Level 3 and therefore as equivalent to A-levels. A key barrier was that the vast majority of Level 3 qualifications included in Advanced Apprenticeship frameworks do not attract UCAS points. Whilst Smith and Joslin's (2011) tracking of Advanced Apprentices indicates a slight increase in progression rates from cohorts between 2005/06 to 2008/09, their figures indicate that only 6.8 per cent of the 2008/09 cohort progressed to HE. It is also important to investigate Apprenticeships at the level of the sector framework because of the variability between them. Some Level 3 Apprenticeships (e.g. Aerospace Engineering) are more likely than others (e.g. Business Administration) to include pathways requiring significant off-the-job learning leading to awards with higher exchange value for entry to HE (Fuller and Unwin 2008, Fuller, Turbin and Wintrup 2010, Fuller and Unwin 2012).

In recent research, Turbin, Wintrup and Fuller (2013) have focused specifically on examining Apprenticeship and progression in the healthcare sector in a project commissioned by the Hampshire and Isle of Wight Lifelong Learning Network (HI-LLN). The findings suggest that progression routes for those on Advanced Apprenticeship are not well-developed and could vary considerably across clinical areas and by employer. Whilst there are examples of Apprentices moving into higher level education or training, their transitions are rarely smooth or straightforward. In this paper, we draw on this research to examine whether ideas associated with labour market theory can help shed light on some of the key differences in Apprenticeship frameworks and the progression opportunities available to Apprentices in different occupational areas of the healthcare sector. Specifically, we explore whether the idea of different kinds of labour market can be used to locate Advanced Apprentices and their career pathways and ceilings within the context of broader workplace structures and processes as well as those associated with different healthcare occupations. The paper develops this argument through a consideration of workforce development strategies in the healthcare sector, and also with reference to case studies of two Advanced Apprenticeship frameworks in Clinical Healthcare Support, and Pharmacy Services.

Following the Introduction, the paper is organised in six sections. Firstly, we look briefly at the policy context which is shaping workforce development and the uptake of Apprenticeships in the healthcare sector in England. Secondly, we provide an overview of the characteristics of occupational and (firm) internal labour markets. Section Three outlines

the methodology used in the research project, and introduces the two cases which are then discussed in turn. The ‘Clinical Healthcare Support’ Advanced Apprenticeship framework for Clinical Support Workers or Healthcare Assistants (hereafter referred to as CSWs) provides an example which reflects an employer rather than occupational focus to the training of CSWs (Section Four). This suggests that the labour market within which CSWs are employed has some of the features of an internal labour market. In contrast, the Pharmacy Services Advanced Apprenticeship framework appears to have been grafted on to an existing and established training programme designed to prepare trainees for a specified and now registered occupation ‘Pharmacy Technician’ (PT). This suggests that the labour market within which PTs are employed has some of the features an occupational labour market (Section Five). In different ways, the two cases illustrate the role of professional bodies in regulating access to registered status in healthcare professions and the implications this has for those seeking to climb the career ladder. The examples also highlight the gap between the learning and attainment outcomes of the qualifications included in the Advanced Apprenticeship frameworks and the academic achievement required for entry to HE. The final section (Six) discusses the extent to which labour market theory may provide a useful lens through which to understand the particular features and possibilities of Apprenticeship in the healthcare sector. We conclude that it highlights some important factors that contribute to a more comprehensive analysis of Apprenticeship as a strong or weak platform for career and educational progression in different organisational and occupational contexts.

### **Workforce Development and Healthcare Apprenticeships in England<sup>i</sup>**

In the NHS, the training provided through the Apprenticeship Programme is one component in what are far reaching changes in career and training frameworks in the healthcare sector. The context for these changes can be traced back to the recommendations of the Wanless inquiry (2002). More recently, the report ‘High Quality Care for All’ (Darzi 2008) provides the rationale for changes in training and career frameworks for health-related occupations. These reports and the National Skills Strategy documents (BIS 2009, BIS 2010), provide the basis upon which current workforce development policy is being driven within the healthcare sector.

One important initiative has been the development of the generic NHS Career Framework. The Career Framework is organised into nine levels ranging from the bottom of the hierarchy at Level One (entry level) to the top at Level Nine (Director of Service). In the

area of healthcare (as opposed to other non-clinical parts of the sector), Levels One to Four are associated with clinical support (non-registered) roles, and Levels Five to Nine are associated with clinical (registered) and managerial roles. The Career Framework is defined by competences and linked to reward and responsibility through the NHS Agenda for Change (AfC) pay banding system<sup>ii</sup> (DH 2004). In general, Intermediate Apprentices (qualification Level 2) are located in NHS Career Framework Level 2/AfC Band 2 and Advanced Apprentices in NHS Career Framework Level 3/AfC Band 3, although there are variations both occupationally and at local level. The commitment to the development of Apprenticeships has been emphasised by the Department of Health National Apprenticeship Advisory Committee who recommended that progression routes for apprentices should be strengthened (DH 2010, recommendations 5 and 6).

The development of healthcare Apprenticeships has taken place alongside changes in the organisation of the healthcare workforce more generally (Fuller et al. 2013). Skills for Health (SfH), the Sector Skills Council for the healthcare sector, identified a number of priorities within the Career Framework (SfH 2009, 2011). In particular, it is supporting the development of new roles at Levels 3 and 4 that are intended to enable workers, who may have been working in Level/Band 2 and 3 roles, to take on a wider range of tasks so helping to free up registered and ‘professional’ staff at Bands 5 and above. Growing the intermediate level workforce at Level/Bands 3 and 4 reflects a strategic desire to change the ‘shape’ of the workforce by increasing the number of staff occupying roles just below Career Framework Level 5 associated with professional registration, usually following the attainment of an approved Bachelor degree (qualification Level 6). Overall, emphasis is being placed on the development of a more flexible workforce ‘using competences as a key vehicle’ (SfH 2011:17) and in this regard Apprenticeships are seen as an important instrument for workforce development congruent with the efficiency drive.

### **Labour Market Theories and Employment Mobility**

In this paper we explore how the concept of a segmented labour market (one where barriers make it difficult for groups of workers to move from one segment to another) can shed light on the (lack of) opportunities for career progression experienced by healthcare Apprentices. We do this by identifying the different conditions and career development pathways implied by two labour market types - occupational and internal labour markets - characterised by contrasting forms of labour mobility. The central characteristic of an

occupational labour market is the ability of workers in the same occupation to move between employers on the basis that they have acquired widely recognised and certified occupational skills. By contrast, the central characteristic of an internal labour market is the ability for employees to change jobs within the same firm on the basis of their in-house training (Eyraud, Marsden and Silvestre 1990). The approach to recruitment, skills and qualifications associated with each type is key:

While an OLM features skills that are transferable because they are needed in many firms, the skill developed by an ILM are much less easily transferable, either because there are no corresponding jobs in other firms or because access to such jobs from outside the firm is closed by institutional ground rules. (Eyraud, Marsden and Silvestre 1990, 502)

The concepts of occupational and internal labour markets have been subject to some change and scrutiny over the years, not least in terms of whether either occupational (Eyraud, Marsden and Silvestre 1990) or internal labour markets (Grimshaw et al. 2001) are being transformed or lost altogether. Workforce flexibility and the impact of the global economy on skill formation, organisation and wages have also been a key focus of attention (see for example, Piore et al. 2001, Brown et al. 2008 and Brown, Lauder and Ashton 2008). Whilst it is important to recognise the advent of new kinds of workers and organisational flexibility (e.g. the growth of the freelance, consultant or contract worker, or the development of outsourcing key functions), and the impact of globalisation on the differentiation of labour and skills at an international, rather than occupational or firm level, the idea of different types of labour markets still helps to expose issues affecting workforce development and work organisation as well as signalling where policies seem simultaneously to strengthen and weaken these markets. For this reason, our analysis draws on the early work of dual labour market theorists<sup>iii</sup> (see for example, Doeringer and Piore 1971; Bosanquet and Doeringer 1973) which identified a primary sector (typified by secure, permanent jobs with good terms and conditions) and a secondary sector (typified by low grade, low pay and insecure jobs) and later versions (segmented labour markets) which sub-divided the primary sector into professional/occupational and (firm) internal labour market structures (Rubery 1978, Piore 1979, Wilkinson 1981, Ashton, Maguire and Garland 1982, Osterman 1982, Rubery, Tarling and Wilkinson 1984).

Table One (below) summarises the key characteristics of segmented labour markets with respect to the primary sector split between occupational/professional and (firm) internal labour markets.

## TABLE ONE NEAR HERE

The contrasting features presented above have implications for factors such as recruitment strategies, the degree of internal promotion, existence and strength of professional or occupational groups to protect the status of the workers within the profession or occupation, and the relative importance ascribed to transferable and job specific training and skills within the two labour market types. In applying some of these insights to our analysis of Advanced Apprentices in the healthcare sector, we also draw on the ideas put forward by Rubery, Tarling and Wilkinson (1984), who identify three dimensions of a labour market analysis. These are, ‘capital labour conflict’, which takes into account power relations including the ability of different groups to protect and maintain their position in the labour market (e.g. professional bodies); ‘industrial organisation’, e.g. the use of segmentation or deskilling as a means of maintaining or creating efficiency and the type of product market or service delivered that may impact on this organisation; and ‘supply side’ factors such as the effects of education and employment systems which might include a consideration of both pre- and in-market segmentation. We now turn to our own research.

### **Methodology and Scope**

The research outlined in this paper was funded by the Hampshire and Isle of Wight Lifelong Learning Network (HI-LLN) and was carried out in the latter part of 2010 and the first six months of 2011. The project followed on from an earlier study which investigated the progression of Advanced Apprentices to Higher Education in the LLN area in seven curriculum areas (Fuller, Turbin and Wintrup 2010). Our more recent project focused specifically on Apprenticeships in clinical or related pathways in the Healthcare Sector, primarily those operating in the southern part of the NHS in the South Central region (Turbin, Wintrup and Fuller 2013).

The scope of the project was limited to the public sector, in particular the NHS, rather than the healthcare sector more generally. The geographical focus on the Hampshire and Isle of Wight (HIoW) area should also be noted given the importance of local variation and determination which extends to workforce development. In addition, whilst the healthcare sector employs personnel in a range of different roles and occupations, the research was only concerned with health and allied pathways. This excluded occupational areas in the NHS where Apprenticeships are better developed, for example Business Administration and Estates Management, and also those engaged in the broader area of ‘social care’.

The project was divided into three inter-linking phases involving both desk-based research and interviews with key informants as follows:

- Phase One: Involved a desk-based analysis of policy documents relevant to Advanced Apprenticeship and progression, with particular emphasis on the healthcare sector.
- Phase Two: consisted of desk-based research into the provision, within the HI-LLN area, of appropriate HE opportunities for Advanced Apprentices, including identification of course entry requirements. It also involved analysis of data and material relating to Advanced Apprenticeship frameworks relevant to clinical career pathways. This included Apprenticeship frameworks for clinical support workers across a broad range of specialities (e.g. general clinical, allied professional, and antenatal and midwifery support roles) as well as those associated with scientific and technical roles.
- Phase Three: involved Key Informant Interviews with employers, education and training providers (e.g. FE colleges and HEIs) and other stakeholders (e.g. Skills for Health (SfH), NHS South Central, the regional Strategic Health Authority; National Apprenticeship Service (Health representative); Employers within the NHS Trusts; as well as Advanced Apprentices) to explore issues raised in the initial two phases of the research. In total, we conducted 17 interviews.

The interviews explored a range of topics including: the way in which Advanced Apprenticeships in healthcare are being used in terms of workforce development and progression, and in relation to what kinds of job roles and target staff groups; how Advanced Apprenticeships are perceived by different stakeholders (e.g. employers, training providers, apprentices) and how they 'fit' with the training needs of particular job roles and occupations; whether Advanced Apprenticeships are able to contribute to the career progression pathways being developed in a range of healthcare areas, and what stakeholders perceive the barriers and opportunities for progression to be. The data collection methods used for this research were consistent with a case study approach, bringing together policy and secondary sources of information and data with primary data collection, mainly in the form of qualitative interviews. The data on which the two cases (below) are based is drawn from our analysis of the relevant Advanced Apprenticeship frameworks and the interview data.

The healthcare sector itself highly complex – with regional, local and intra-organisational variations but the development of Apprenticeships within occupations has also varied

considerably. So, for example, an Acute Trust in one area may have developed work teams for wards or specialist services in a different way to both an Acute Trust in the same region, and/or one in another region. Whilst subject to similar sets of conditions at a macro level, the way in which these are experienced, and then dealt with in terms of workforce strategies can vary. A challenge for this project has been to try to develop an approach to looking at these factors that might extend understanding beyond the description of specific examples. To address this (and as outlined above) we suggest that theories seeking to explain how employment mobility and career progression is influenced by the occupational or internal nature of the labour market in which employees in different kinds of jobs are located, can shed light on two contrasting examples in the healthcare sector: the Clinical Support Worker (CSW), and the Pharmacy Technician (PT).

The case study approach allows us to consider each role using the concepts of occupational and internal labour markets. Whilst utilising the framework indicated in Table One, the discussion of each example takes a more integrated approach– in practice it is difficult to separate out the four characteristics of training cost, career progression, qualifications and regulation. Each case looks at three main aspects: occupational role, in particular how well defined the occupation and occupational role/group is within healthcare; the content of the Advanced Apprenticeship framework that ‘fits’ this job role at Level/Band 3; and progression and career pathways for Advanced Apprentices. The analysis includes, in line with Rubery, Tarling and Wilkinson (1984) an understanding of the role of professional bodies, the pressures on employers to pursue strategies designed to maximise ‘efficiency’ in workforce deployment, and the role and impact of supply side factors, including HE admissions criteria.

### **Case 1: Clinical Support Workers**

CSWs work primarily in ‘front-line’ positions that involve patient contact and care, and make an important contribution to the healthcare team in all departments. Although many may be located in areas of clinical care (e.g. on hospital wards or clinically run residential facilities) CSWs will also work in more specialised areas alongside Allied Health Professions, as well as in the community.

#### ***Occupational Role and Implications for Training***



In focusing on CSWs we were essentially looking at staff occupying AfC Bands 2 and 3 posts (Levels 2 and 3 on the NHS Career Framework). There are minimum standards of training in place for CSWs at Band 2 in order to ensure patient safety, although this training is not extensive and concentrates on health and safety aspects of the work role rather than technical skills. However, some Trusts have created more skilled and specialised roles for CSWs at Bands 2 and 3. Increasing both the skill and responsibility levels of this group can be seen as aligning with the NHS 'efficiency' strategy of devolving work tasks downwards from registered to non-registered staff.

The variability of CSW roles was well understood at local and policy level. Key informants made the point that it would be difficult to define a Band 2 or Band 3 role in terms of levels of responsibility and skill and therefore what needs should be met by education and training.

There hasn't been any clear development pathways so if you were to take the HCAs [CSWs] ... they are rambling, there's no certain number of Band 2s or Band 3s, and no 'to be a Band 2 you need such and such and then to be a Band 3 you need such and such training'. It is, and was, very much mixed up. (Trust)

Historically the training of CSWs has been undertaken in-house, with the content determined by the local employer with some sectoral requirements (e.g. compulsory health and safety training). Typically then training has been at a fairly low level, with a high level of specificity and flexibility, with costs (in accordance with an internal labour market) carried by the employer. There is a strong culture of 'on-the-job' training, and where non-prescribed training takes place this has usually been a response to particular job roles or functions that necessitate a particular worker, or group of workers, to carry out specific tasks.

You could not define a career pathway [for CSWs] because it almost varies between ward to ward and location to location. That's why the vocational education fits in ... because you're allowed flex in your different pathways. (Trust)

The lack of clarity and agreement about what constitutes the CSW role means that it does not have the hallmarks of a distinct occupation: in practice, the job is highly employer specific and non-standardised. The role and where it is placed in the AfC banding structure varies across the sector because of local employer determination. This makes it difficult to develop shared occupational standards and agreements about the provision of broader-based transferable training. In this sense then the mobility of CSWs appears to align with the features of an internal labour market. By and large, CSW training is specified to the needs of the individual employer reducing the portability of staff skills to other organisations.

### ***Clinical Support Workers and Apprenticeship***

Prior to the introduction of Apprenticeships, NVQs were used as a standalone approach that resonated with the employer's need to certify CSWs workplace competence. In some Trusts this would include off-the-job training but for most this was either non-existent or minimal. The NVQ allowed employers to train without having to deal with 'backfill' issues caused by staff being out of the workplace for training purposes. Apprenticeship frameworks for CSWs were developed to align rather than challenge this tradition as they have been geared towards on-the-job and competence-based training. The Advanced Apprentices in our study were existing employees and the training they received was identify themselves as Apprentices. In addition, the use of Apprenticeships was pragmatically linked to current sources of government funding:

If they have no previous qualifications at all then we will look to put them on a Level 2 qualification which nowadays, because it attracts the money, is Apprenticeships. (Trust)

We analysed the key features (see Table Two) of the Advanced Apprenticeship framework in Clinical Healthcare Support used for CSWs.

TABLE TWO NEAR HERE

The Diploma in Clinical Healthcare Support represents the most substantial element of the framework accruing 65 Credits at qualification Level 3, 21 of which are 'knowledge-based'. This means that it easily surpasses the 37 Credits, 10 of which must be 'knowledge-based' required for acceptance as a Level 3 Apprenticeship framework (SASE 2011). However, the specification for off-the-job learning is highly limited and, importantly, the framework qualifications do not attract any UCAS points. It could be perceived that the existence of a sectoral Apprenticeship framework for CSWs superimposes some characteristics consistent with an occupational market (e.g. the idea that the skills of all those who have completed the same framework should be transferable across employers). However, the way the framework has been developed and implemented falls short of generating this outcome. Recruitment is to a job role rather than a training programme, and training and qualifications do not, necessarily, lead to a higher level post. In this case, completion of an Advanced Apprenticeships does not represent an entry route into a well-defined occupational labour market.

### ***Career Progression and Pathways***

Key informants were mixed in their views as to the career progression possibilities for CSWs in AfC Bands 2 and 3. One problem was the, as yet, limited availability of Band 3 and 4 posts to support those employees who wanted to progress. In this regard, we also encountered informants who were ambivalent about the ‘need’ to reshape the workforce to create these posts. Within the NHS Trusts participating in this research, the development of Band 3 and particularly Band 4 posts tended to be at an early stage and, in some cases, CSWs were concentrated in Band 2. Overall, the mobility for CSWs was more akin to a truncated internal labour market as although there were some local, employer-determined opportunities for internal promotion from Band 2 to 3, the opportunity to progress beyond this, including to registered clinical roles was highly limited. The provision in the Advanced Apprenticeship framework of specific formal guidance on the pathway to registered status provides an indication of why progression for ex-Apprentices might not be straightforward:

To become a qualified Practitioner (e.g. Nurse, Allied Health Practitioner, Healthcare Scientist) Apprentices would have to progress from their Apprenticeship to undertake a specific qualification, often a 3-year university Degree, which on completion, would enable them to register as a professional. To do this, individuals would have to meet the specific entry qualifications as outlined by their chosen Higher Education Provider. (Skills for Health Framework 605, May 2011; 33)

As can be seen from the final sentence in the guidance, entry to Bachelor degrees providing access to registered status is dependent on candidates possessing the required qualifications. As discussed above the currency (for entry to HE) of the Level 3 qualification included in the Clinical Healthcare Support Advanced Apprenticeship framework is weak. An analysis of entry criteria for nursing and allied health degrees (NHS South Central 2010) supports the view that the criteria for most full-time Bachelor degree programmes effectively rules out a transition from the Advanced Apprenticeship. A more viable route for CSWs who have completed the Advanced Apprenticeship, would be to progress onto a (two year full-time equivalent) Foundation degree (qualification Level 5) and from this to an appropriate Bachelor degree (e.g. Nursing, Physiotherapy, Occupational Therapy). In many cases this would entail starting at the beginning of the Bachelor degree, or possibly in Year 2, meaning that their pathway would take at least four if not five years.

Our interview evidence indicated that there were examples of staff with NVQ level 3 being admitted to undergraduate programmes. Some Trusts had used the Open University (OU) as a route to nursing for work-based learners, and queried why the entry requirements varied so considerably between different HE providers.

We've had some of our people who have done our NVQ3... they've now qualified as a registered nurse through the OU programme ... they haven't gone away and done any additional study to do that ... whereas if that same person had applied to go to (*institutional name omitted*) University they wouldn't have got on. (Trust)

In some cases there was a feeling that work-based routes to registered status prepared a different type of person and a different type of worker. This difference was seen to affect their relative potential in career terms with the 'academic' nurses being seen as those who would become Advanced Practitioners and the 'vocational' nurses those who would stay at Band 5.

Nurses from the university are turned out more able to question, more analytical... more agile... Our OU nurses are much more grounded in the organisation, in fundamentals of care, so probably are less agile ... you would get a different type of nurse in terms of their career trajectories. (Trust)

The current structure of the NHS Career Framework demonstrates a split between low to intermediate skill levels (i.e. Levels/Bands 1-4) and higher level professional registered occupations (Level/Bands 5 and above). This split is in part a reflection of the current priorities within the NHS – i.e. to develop senior support and assistant/associate practitioner roles at Bands 3 and 4 as part of the 'efficiency' measures to release registered practitioners at Band 5 and above from more routine tasks. It is also reinforced by professional bodies which regulate access to their professions. Alongside this is the view that emphasising the desirability of progression into registered posts actually devalues the role and skills of newly created Band 3 and 4 jobs. There is a particular narrative around the new Band 4 Associate Practitioner positions with key informants arguing that this should be seen as a role in itself, and not a stepping stone to registered practitioner status. It is interesting that these two outcomes should be perceived as somehow mutually exclusive.

That (progression) needs to be thought about and there needs to be a strategy for it, but not at the cost of recognising that these are valuable roles in themselves... sometimes we have a habit of always looking to the next role and seeing it as a stepping stone and actually we need Band 4 practitioners because we need Band 4 practitioners. (Trust)

The role of regulatory bodies such as the Nursing and Midwifery Council (NMC) is also of relevance as the requirements for registration are tightly linked to educational pathways. For the nursing profession there are still routes (e.g. Foundation degrees and OU) that allow work-based learners access to higher level programmes of study, but for other occupational areas in health this is not the case, particularly at a local level. A related factor which can be seen through many of the healthcare professions is the privileging of academic qualifications over competence-based training, qualifications and work-experience. This co-

exists with a competence-based approach to workforce development for those in the lower bands. It follows that the work-based learner inevitably falls short of meeting the knowledge-based, academic criteria applied to entry to higher level training for registered health care positions.

There is not a route at all from the university point of view for these people to access health care. We are not providing a route ... the only way they can get into healthcare now, through the universities is if they have the academic qualifications they need to do a professional course, in which case they need to remain in FE and keep doing A Levels, Access courses. (HEI).

Navigating the NHS Career Framework, then, from clinical healthcare support roles to professionally registered positions (e.g. nurses, physiotherapists, etc.) is not straightforward. It is apparent that the educational gateway to 'registered practitioner' roles set by the relevant professional body regulators and implemented by HE providers is not readily open to those CSWs coming from the Advanced Apprenticeship route. In this case, the 'institutional ground rules' (alluded to by Eyraud, Marsden and Silvestre 1990) surrounding access to the occupational labour markets associated with registered healthcare professions help explain the barrier aspiring CSWs are likely to encounter as they are, effectively, trying to move from an internal to an occupational labour market situation.

## **Case 2: Pharmacy Technicians**

The Pharmacy Technician (PT) is a healthcare occupation which exists in the public and private sectors, and whilst the majority of PTs work in the community (private) sector, e.g. in High Street Pharmacies, there is also a strong tradition of Pharmacy in NHS hospitals.

### ***Occupational Role and Implications for Training***

The General Pharmaceutical Council (GPhC) regulates Pharmacists, PTs and pharmacy premises, replacing the role of the Royal Pharmaceutical Society for Great Britain (RPSGB). Since July 2011, in order to practise in England, Scotland or Wales, Pharmacy Technicians must be registered with the GPhC with transitional arrangement made for those who trained and practised prior to this date and had undertaken training approved by the RPSGB. As a statutory registered occupation, PT is associated with a standardised role and prescribed responsibilities supported by a mandatory training and qualification route. This means that PTs are a clearly identifiable occupational group that is nationally defined, although in practice, there may be some differences in actual work roles, for example, between community and hospital Pharmacy. At local level there is also likely to be some

ability for employers to organise tasks and roles to suit local conditions, but this occurs within a distinct and bounded occupational role. All PTs have been through a recognised training programme and will have achieved qualifications approved by the regulator. Their work is supervised by qualified and registered Pharmacists but PTs are able to undertake a number of tasks independently which, though ‘checked off’, nevertheless gives them both responsibility and a level of autonomy.

In the Trusts participating in this research, trainee Pharmacy Technicians were recruited onto a training programme usually through open competition, rather than internal promotion. The recruitment process did not favour internal candidates over external applicants. Competition for traineeships was intense as the following quotation illustrates:

It’s not just Band 2’s ... It’s externally advertised. We put a week’s expiry on it but ... yesterday it was at 58 and we’re going to close it at 100 ... we’ve had people (*internally*) who’ve applied 3 or 4 years on the trot. We do encourage them (*but*) it is a competition.  
(Trust)

In contrast with the CSWs who were employees receiving training, trainee PTs had formal trainee status which was also reflected in their level of pay. As we saw in Table One (above), lower trainee pay (compared with the rate for qualified staff) acknowledges the portability of the qualifications and skills being acquired within an occupational labour market. It was reported by employers that generally speaking successful completion of the training would lead to a registered post, although there was some fluctuation in both supply and demand.

On entering the workforce, trainee PTs are placed on Level 4 of the NHS Career Framework (AfC Band 4) and can ultimately progress up to Level 7. As an occupational group they sit between the relatively low skilled ‘Pharmacy Assistant’, a non-registered role for which there is limited but mandatory training and the registered profession of Pharmacist which requires a Master’s degree and a period of in-service training and experience. Although it is possible to illustrate the Pharmacy occupational family according to the NHS Career Framework as a ladder of levels, in reality they are more accurately viewed as different occupational groups with barriers to movement into and between the two registered occupations. In the case of the PT (as for the Pharmacist), recruitment practices, standardised and externally approved education and training pathways to registration, as well as the facility the occupation affords for qualified staff to move between employers evokes the notion of an occupational labour market.

## *Pharmacy Technicians and Apprenticeship*

The requirements for training PTs are designed to fulfil the demands of the GPhC (and formerly the RPSGB) and pre-date the introduction of the Advanced Apprenticeship for Pharmacy Services. Regulatory requirements dictate that the framework includes qualification elements approved by the GPhC (i.e. the NVQ3 Diploma in Pharmacy Services Skills and the L3 Diploma in Pharmaceutical Science) as well as a minimum of two years work-experience under the supervision, direction or guidance of a Pharmacist (for at least 14 hours per week). Table Three shows the content of the framework, the qualifications and their value, and the requirements for on and off the job learning.

### TABLE THREE NEAR HERE

In comparison with the CSW Advanced Apprenticeship framework (Table Two), the Pharmacy Services Framework is much more substantial. It generates much higher credit, and requires significantly more off-the-job training to deliver the knowledge-based element. Typically the L3 Diploma in Pharmaceutical Services would be studied day-release over two years at college although. According to the UCAS website ([http://www.ucas.com/students/ucas\\_tariff/qualifications](http://www.ucas.com/students/ucas_tariff/qualifications) accessed 4th April 2013) this qualification is included in the tariff (in line with similar Edexcel and City and Guilds qualifications) and accrues the points listed in Table Three. However, somewhat confusingly the official framework document specifies that UCAS points are not applicable.

The concept of the PT Apprenticeship differs markedly from the CSW Apprenticeship in terms of its approach to recruitment, the pay and status of trainee PTs, and the way in which the training has been designed and standardised to lead to a distinct (registered) occupation recognised across employers in the sector. In this case the link between the occupational and educational pathways and levels is explicit and regulated by the GPhC. The Advanced Apprenticeship represented a formalised package of on and off the job training, qualifications and supervised work experience based on an approach to PT training and registration that existed prior to the development of the framework. For the employers in this study the use of Advanced Apprenticeship was primarily perceived as an administrative change and funding stream. The additional features now required to be incorporated in all government supported Apprenticeship frameworks, such as ERR and key skills (Maths and English), were not significant when set against the substantial qualification elements of the programme.

## *Career Progression and Pathways*

There are established pathways for PTs from the entry point through to a Level/Band 7 ceiling. Normally, PTs who have completed an Advanced Apprenticeship and gained registered status are expected to take up entry level posts at AfC Band 4, although in the Trusts included in this study the majority of PTs worked in Band 5 posts. The interesting point here is that despite ‘only’ needing to achieve (specified) Level 3 qualifications (in contrast with most registered healthcare occupations that require a Level 6 Bachelor degree), PTs can progress up the NHS Career Framework including into the Band 5 and above posts. Unlike the CSWs, their transition to Career Framework Level 5 is straightforward. However, whilst the career path for PTs is transparent and well-structured, our evidence suggests that individuals’ progression may still depend on the extent to which their employer facilitates their upward trajectory. ‘Extended Roles’ for PTs involve the use of additional training modules that allow for upward career progression. The PT qualification that leads to registered status is the entry point, and progression to higher levels will be dependent on fulfilling additional criteria (e.g. training and in-service experience). The occupational status of the PT also allows a high level of transferability between employers as although there is some local determination of roles, the need to fit within the GPhC framework ensures standardisation even where local employers choose to develop roles. However, overall career development is considered to be more favourable for PTs working in NHS Trusts than in the community healthcare sector.

If you go to community Pharmacy their technicians wouldn’t do half of what our technicians do ... Their qualified technicians are often doing what our Band 4 qualified technicians do. But our main group of technicians is actually at Band 5 with the extended role. (Trust)

Whilst PTs can progress within their own occupation, they can experience barriers to accessing higher level educational programmes. No matter how experienced they may be as PTs, if they wish to become a Pharmacist they can only do so by completing a Master’s degree programme approved by the GPhC. Accessing a place on a Master’s degree usually requires applicants to have at least one Science A-level (Chemistry) but preferably two. This means that the qualifications included in the Advanced Apprenticeship Pharmacy Services framework are highly unlikely to be sufficient even if they are combined with relevant experience:



They have to do a 4 year's Masters course with no accreditation of prior learning... and then they have to do a year's in-service training and they can't even get any accreditation against that. (Trust)

There are examples of PTs going onto Master's degree programmes in Pharmacy although, in our study, none did so without gaining additional academic qualifications. There are no work-based routes that allow senior PTs to become Pharmacists even though they can be employed in AfC Bands 6 or 7 (i.e. on a par with registered Pharmacists). Although there are Foundation degrees in Pharmacy services these are linked to extended or advanced technician roles and are not part of a pathway towards a Masters degree and registration as a Pharmacist. As they were developed to address the training needs of Pharmacy Technicians, they also sit alongside, and perhaps compete with, the Level 3 qualification route, rather than acting as a stepping stone to Pharmacy training. (Herrera, Brown and Portlock 2013).

## **Discussion and Conclusions**

The variation between Clinical Healthcare Support and Pharmacy Services Advanced Apprenticeship frameworks reflects key differences between the two occupations (CSW and PT) with which they are associated. The former framework seems to have developed as a consequence of employer-led requirements around the non-standardised design and status of a job role in particular workplaces, whilst the latter reflects the externally regulated and standardised nature of the PT occupation. Looking at the position and progression opportunities of Advanced Apprentices in these two contrasting occupational areas through the lens of labour market theory allows the position of Apprentices to be illuminated with reference to wider labour market dimensions, such as job regulation and qualifications, which shape and maintain barriers to entry. We have also considered the way Apprentices are utilised in the Trusts participating in this research and the extent to which wider workforce strategies are at play. Drawing on insights about occupational and internal labour markets helps explain the contested positioning, perception and value of Apprenticeships in the two occupations we have featured as well as in other areas of healthcare.

The labour market within the healthcare sector is clearly complex. At the lower levels, for example the CSWs in AfC Band 2, there remain aspects of an almost secondary market, with low status and limited training opportunities. There are examples of CSWs being trained and put on pathways that offer some development, albeit often finely tuned to specific job roles at Trust (rather than national or sectoral) level. Advanced Apprentices in this labour market have the potential to become more highly skilled but, as we have seen,

they are first and foremost employees who are being trained to perform a set of tasks and competences within a (locally) defined job description. They have some opportunity for internal career progression, particularly from Band 2 to 3 which can be supported by the relevant Apprenticeship framework. However, beyond this the Apprenticeship ‘journey’ available for CSWs does not challenge the wider institutional barriers underpinning the truncated internal labour market in which they are employed.

In contrast the case of the PTs shows how Apprenticeship can be used as a route into skilled work providing employment mobility and prospects for progression. Here the Advanced Apprenticeship framework has co-opted existing training and certification arrangements that qualify trainees for entry to a statutory registered occupation. The differences between the CSW and PT Apprenticeships, across a whole raft of criteria, are stark. The Pharmacy Services framework contains many of the components of a traditional-style Apprenticeship (including structured on and off the job training over at least two years). Whilst there are aspects of locally defined practice which affect career development opportunities, the occupation itself transcends these local contexts through its standardised training, and governance by the independent regulator.

The NHS Career Framework is based around development trajectories that stress both general (i.e. in the form of national standards) and specific (i.e. locally based tailoring to ‘needs’) aspects of workforce development and organisation. Whilst pegging job roles to particular levels, based around a rationale of linear competences, the Career Framework is not able to show the ‘breaks’ or ‘gaps’ in the ladder that exists for particular occupations. An important factor in facilitating or inhibiting upward transitions is the role of those registered professional groups who occupy posts at AfC Band 5 and above. Arguably, the position of registered occupations has been further strengthened through the move towards graduate-only entry criteria (nursing would be an example of where this has happened). However, the net effect of this is to create a barrier for those who have followed a work-based route and do not possess the academic qualifications at Level 3 required for entry to Bachelor degrees. This can be seen for both the cases discussed in this paper. Access onto professional courses in a whole range of specialities is not straightforward for the Advanced Apprentice. In the HIoW area this is compounded by a lack of appropriate provision at sub-degree level that can act as a stepping stone to the completion of a full Bachelor degree. Where work-based routes to registered nurse status are still available, our participants suggested that nurses qualifying via

this route would have more limited career trajectories than those who came from an ‘academic’ route.

A final way in which an analysis from a labour market perspective can help to illuminate factors shaping the career development of Advanced Apprentices is by looking more broadly at where they fit within workforce strategies and overall policies. The use and position of Apprentices in the healthcare sector has to be seen within the context of policies that impact on workforce development more generally. The emphasis placed on progression linked to a widening participation agenda has been weakened in favour of one that stresses ‘efficiency’. This ‘efficiency’ model is based around the need to reshape the NHS workforce by creating more posts at AfC Bands 3 and 4 for non-registered posts, and Band 7 for registered posts. These key priorities do not emphasise the progression of Apprentices from Band 3 and 4 posts into (professional) registered posts, but are based around the expansion of these pre-registered roles. Whilst at an individual level progression will remain an option, at a strategic level it is no longer a priority.

This paper has made some tentative steps towards introducing a segmented labour market perspective into debates about the role and positioning of Apprenticeship. The case of Advanced Apprenticeship in the healthcare sector has identified labour market features which we suggest help explain some of the limitations of the model to support career progression. The Advanced Apprenticeship in Clinical Healthcare Support was not able to overcome the tensions associated with the truncated internal labour market that exists for CSWs, and that characterise the lower bands of the NHS Career Framework. This weakness was highlighted through the contrasts that could be drawn with the Advanced Apprenticeship in PT, which worked well to support the characteristics of an established occupation operating in a well-organised, regulated but segmented occupational labour market.

Going beyond the healthcare sector, our analysis suggests that unless Apprenticeship is constructed as an integral education, training, and entry route to jobs located within strong occupational labour markets, it is less likely to provide a strong platform for educational and career progression. We conclude that labour market theory has the potential to provide a useful conceptual and analytical lens for understanding the variation in the ability of Apprenticeships to support educational and career progression across the economy.

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**Table One Characteristics of Occupational and Internal Labour Markets**

Labour Market Type	Burden of training costs	Career progression and movement	Qualifications	Job regulation
Occupational	Trainee - through low pay acknowledging transferability of skills between employers	Reduced number of levels of competence, greater movement between firms/organisations	Externally validated/sanctioned	Defence of skill and inter-firm labour market. Defence of job content to maintain transferability and limit substitution. Importance of transferability and job categories within which skills fit.
Firm-Internal	Firm – acknowledging specificity of training to firm and reduced transferability between firms	Upgrade of existing staff (through promotion/firm specific training), more movement within firm/organisation	Firm specific (or tailored)	Defending principle of seniority and job within the company. Importance of making links between jobs

Source: Amended from Eyraud, Marsden and Silvestre (1990) with additional material from Marsden (2007)

**Table Two Advanced Apprenticeship Framework in Clinical Healthcare Support**

Framework Elements	Qualification Level (Awarding Bodies)	Credit Value in QCF	Guided Learning Hours <sup>iv</sup>	UCAS Points
Combined Competence and Knowledge Based Qualification	L3 Diploma in Clinical Healthcare Support (City and Guilds; EDI; Edexcel; NCFE)	65 (a minimum of 21 are through knowledge based learning)	373-494 Minimum: 12 hours off-the job training 361 on-the-job	0 (not included in UCAS tariff)
Functional Skills	Level 2	10	90 (45 Maths, 45 English)	N/A
ERR	Choice of three qualifications which fulfil the ERR and PLTS components	7	53	N/A
Total		82	516 (min)	0

Source: Skills for Health, Framework FR00605, England, May 2011<sup>v</sup>

**Table Three Advanced Apprenticeship Framework in Pharmacy Services**

Framework Elements	Qualification Level (Awarding Bodies)	Credit Value in QCF	Guided Learning Hours (on and off the job)	UCAS Points
Competence Based Element	NVQ3 Diploma in Pharmacy Services Skills (City and Guilds or Edexcel)	75	344-352 (344 on the job)	0 (not included in UCAS tariff)
Knowledge Based	Level 3 Diploma in	120	720 (all off the job)	80 - 280 (depending



Element	Pharmaceutical Science (City and Guilds or Edexcel)			on grades achieved)
Functional Skills in English and Maths	Level 2	10	90 (all off the job)	N/A
Employee Rights and Responsibilities		N/A	N/A	N/A
Personal Learning and Thinking Skills		N/A	N/A	N/A
Totals		205	Min 1154 of which min 819 off the job	80-280

Source: Skills For Health Apprenticeship Framework in Pharmacy Services (Advanced), Framework Number FR00610.

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<sup>i</sup> The area of study for this research was within the NHS for England (Department of Health) jurisdiction. In addition, the Apprenticeship Frameworks considered as part of this research were those for England.

<sup>ii</sup> The NHS Career Framework uses the concept of ‘Levels’ which do not always accord with the same AfC Banding. However, for simplicity this paper uses the terminology of AfC – i.e. bands, rather than Levels unless directly referring to the NHS Career Framework. This is because it reflects actual practice within the Trusts who continue to use Bands to describe their workforce rather than Levels.

<sup>iii</sup> No attempt is made here to describe the development of dual labour market theory to segmentation theory, nor does it seek to identify the key factors that led to the development of this theory, such as the need to move away from human capital theory in the explanations of marginalisation and discrimination in the labour market. For an example of the use of Dual Labour Market Theory to explain discrimination in terms of the primary and secondary labour market see Rubery 1978 and Ginzberg 1979.

<sup>iv</sup> These figures are taken from the Framework for Clinical Support Worker AA (605). However, the different options within the pathway mean that the figures are not accurate for all Apprentices and can vary depending on options taken. As a minimum they will also vary according to the delivery arrangements made by different providers and may well exceed minimum levels for both on and off-the-job training.

<sup>v</sup> Data is taken from the frameworks that were current at the time of the research. Each of the frameworks have been reviewed a number of times, although the changes are not significant for the analysis contained in this paper. The current frameworks are FR01967 (Clinical Healthcare Support), and FR01952 (Pharmacy Services).