# NHS England East of England –

# Advanced practice notification of change form

## Purpose

This form should be used to notify NHS England (NHSE) East of England (EoE) Faculty for Advancing Practice of the following advanced practice trainee changes:

* Transfer to a new employing organisation
* Transfer to a new work address (site of work)[[1]](#footnote-2)
* Transfer to a new education provider
* Temporary withdrawals or leave of absences (including maternity leave) from training programme
* Complete withdrawal from training programme

This form should be completed as soon as possible, before any changes take place.

## Who should complete this form?

It is the responsibility of the trainee undertaking the advanced practice training programme to notify NSHE EOE Faculty for Advancing Practice of changes to circumstances.

## Where should this form be returned to?

Once the form is fully completed (including required signatures in the [Confirmation of understanding](#_Confirmation_of_understanding) section) it should be emailed to the NSHE EoE Faculty for Advancing Practice via [england.eoeapfaculty@nhs.net](mailto:england.eoeapfaculty@nhs.net)

## How NHSE EoE will be storing and processing the data you provide

Your information will be securely stored by NHSE EoE as the data controller. Personal data that we gather as part of this process will only be accessed, seen and used by NHSE EoE staff who need access to the personal data to fulfil their role. We will not share your personal data with any third-party organisations that are not involved in your training.

## Definitions

|  |  |
| --- | --- |
| **Term used** | **Definition** |
| Trainee | The person undertaking advanced practice training |
| Supervisor | The coordinating educational supervisor of the trainee |
| Advanced practice lead | Named person at employing organisation who leads on the development and governance of the advance practice workforce |

## Part one: notification of change form

**This form should be completed following a discussion with your supervisor, as soon as possible before any changes are to be introduced**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1. Trainee details** | | | | | | | |
| **Name of trainee:** |  | | | | | | |
| **Name of education provider:** | | | | | | **Cohort start date:** | |
|  | | | | | | MM/YYYY | |
| **Details of modules already completed and those still outstanding, with dates (to be completed by trainee and current employer/education provider representative or module/programme lead)** | | | | | | | |
| **Modules Completed:** | | **Date of completion:** | | | **Modules still outstanding (with estimated completion dates if known):** | | |
|  | | DD/MM/YYYY | | |  | | |
| **Section 2. Reasons for this change** | | | | | | | |
| **2. a) Temporary withdrawal or leave of absence** | | | | | | | |
| **Date of change:** | | | | **Date to meet to plan return to programme:** | | | |
| DD/MM/YYYY | | | | DD/MM/YYYY | | | |
| **Please write brief details about the circumstances of the leave of absence in box below:** | | | | | | | |
|  | | | | | | | |
| **2. b) Complete withdrawal** | | | | | | | |
| **Date of change:** | | | | | | | |
| DD/MM/YYYY | | | | | | | |
| **Please write brief details about the circumstances of the withdrawal:** | | | | | | | |
|  | | | | | | | |
| **2. c) Change of employer** | | | | | | | |
| **Date of change:** | | | | | | | |
| DD/MM/YYYY | | | | | | | |
| **Please write brief details about the circumstances of the change of employer:** | | | | | | | |
|  | | | | | | | |
| **Will your contact email address change at your new employer?** | | | | | | | |
| YES/NO | | | | | | | |
| **If you answered YES to the above question, please enter new contact email below. If you don’t yet know the new contact email, please email** [**england.eoeapfaculty@nhs.net**](mailto:england.eoeapfaculty@nhs.net) **once this information is confirmed** | | | | | | | |
|  | | | | | | | |
| **Do you know the name of your new co-ordinating educational supervisor?** | | | | | | | |
| YES/NO | | | | | | | |
| **If you answered YES to the above question, please enter the name of the supervisor below. If you don’t yet know the name of the supervisor, please email** [**england.eoeapfaculty@nhs.net**](mailto:england.eoeapfaculty@nhs.net) **once this information is confirmed** | | | | | | | |
|  | | | | | | | |
| **Existing employer name, address, and line manager contact details:** | | | **New employer name, address, and line manager contact details:** | | | | **Start date:** |
|  | | |  | | | | DD/MM/YYYY |
| **2. d) Change of work address (site of work)**  *Complete this when employing organisation is the same, but you have transferred to a new site of work within the same organisation. If you have transferred to a new employing organisation and completed section 2. c) above you do not need to complete section 2. d)* | | | | | | | |
| **Date of change:** | | | | | | | |
| DD/MM/YYYY | | | | | | | |
| **Please write brief details about the circumstances of the change of work address:** | | | | | | | |
|  | | | | | | | |
| **Existing work address, and line manager contact details:** | | | **Existing work address, and line manager contact details:** | | | | **End date:** |
|  | | |  | | | |  |
| **Will your co-ordinating educational supervisor change at your new work address?** | | | | | | | |
| YES/NO | | | | | | | |
| **If you answered YES to the above question, please enter the name of the supervisor below. If you don’t yet know the name of the supervisor, please email** [**england.eoeapfaculty@nhs.net**](mailto:england.eoeapfaculty@nhs.net) **once this information is confirmed** | | | | | | | |
|  | | | | | | | |
| **2. e) Change of education provider** | | | | | | | |
| **Please write brief details about the circumstances of the change of education provider:** | | | | | | | |
|  | | | | | | | |
| **Has your new education provider agreed to recognise the module credits you have completed at your existing/former education provider?** | | | | | | | |
| YES/NO | | | | | | | |
| **Are you formally registered on an advanced practice MSc pathway at your new education provider?** | | | | | | | |
| YES/NO | | | | | | | |
| **Existing/former education provider institution name:** | | | **Existing/former education provider course name:** | | | | **End date:** |
|  | | |  | | | | DD/MM/YYYY |
| **New education provider institution name:** | | | **New education provider course name:** | | | | **Date of transfer:** |
|  | | |  | | | | DD/MM/YYYY |

## 

## Part two: confirmation of understanding (please complete as appropriate)

**By completing this form, I understand that the NHSE EoE Faculty for Advancing Practice, education provider and advanced practice lead(s) will use my information in line with GDPR guidance**

|  |  |  |
| --- | --- | --- |
| 1. **Trainee confirmation**   I confirm that (please sign and date appropriate section(s) | | |
| 1. **Temporary withdrawal or Leave of Absence (LoA):** | | |
| * I have discussed and understand the implications of temporarily withdrawing/agreeing a leave of absence with the education provider and have discussed this with my line manager and supervisor | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| **b)** **Complete withdrawal** | | |
| * I have discussed my withdrawal with the education provider and my line manager and supervisor and understand that NHSE EoE funding for advanced practice training ceases after my withdrawal date | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| **c) Change of employer** | | |
| * My new employer is an NHS commissioned healthcare provider * I have advised my new employer that continuance of NHSE EoE funding for advanced practice training is subject to NHSE EoE approval and any funding currently supporting me may not transfer to my new employer * My new role is an advanced practice role * I plan to commence my new role, with my new employer on the date stated above | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| **d) Change of work address** | | |
| * I remain in advanced practice role at my new work address * I remain working in NHS commissioned service at my new work address * I plan to commence work at the new address on the date stated above | | |
| **Signed:** | | **Date:** |
|  | | DD/MM/YYYY |
| **e) Change of education provider** | | |
| * I have discussed the change of education provider with my line manager and supervisor * My new education provider has accepted my transfer request * I am transferring to an advanced practice MSc course at the new education provider | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Advanced practice lead at current employer (including employing GP Practice)**   I confirm that (please sign and date appropriate section(s) | | |
| 1. **Temporary withdrawal or leave of absence:** | | |
| * I have discussed and understand the implications of temporarily withdrawing/agreeing a leave of absence with the education provider and have discussed this with my employer | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Complete withdrawal** | | |
| * I have discussed the withdrawal with the education provider and my employer and understand that NHS EoE funding for advanced practice training ceases after withdrawal | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Change of employer** | | |
| * Any right to claim NHSE EoE advanced practice funding for the trainee will cease on their last day of employment with us * Any new/replacement advanced practice trainees will be subject to further NHSE EoE approval * We have discussed the reasons for leaving with the trainee and notified the NHSE EoE Faculty for Advancing Practice and Primary Care Workforce and Training Hub (through completion of this form) * We have agreed that the trainee will be leaving our employment as detailed in the Notification of change form above | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Change of work address** | | |
| * The trainee is employed to work in an NHS commissioned healthcare service * The trainee is employed as an advanced practice trainee and will be offered an advanced practice role on completion of their training | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Change of education provider** | | |
| * If the trainee is required to complete additional modules to complete their advanced practice MSc because of a transfer to a new education provider, NHSE EoE funding will not be extended to cover this and will remain at the rate and length of payment previously agreed | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |
| 1. **Advanced practice lead at new employer (including employing GP Practice)**   I confirm that (please sign and date appropriate section(s) | | |
| 1. **Change of employer** | | |
| * We are fully aware of the commitment and support required to employ an advanced practice trainee * The trainee is employed substantively to work in an NHS commissioned healthcare service * The trainee is employed as an advanced practice trainee and will be offered an advanced practice role on completion of their training * The trainee will be provided with appropriate clinical support and supervision during their training * The trainee will be provided with a named co-ordinating education supervisor and a supervision plan * We acknowledge NHSE EoE advanced practice funding may not automatically transfer from the trainee’s previous employer and is subject to NHSE EoE approval * The trainee is expected to start with us on the start date detailed in the Notification of change form above | | |
| **Signed:** | **Date:** | |
|  | DD/MM/YYYY | |

Please return this form to [england.eoeapfaculty@nhs.net](mailto:england.eoeapfaculty@nhs.net)

## FOR INTERNAL NHS ENGLAND USE ONLY

|  |  |
| --- | --- |
| **Action** | **Completion date** |
| Completed form filed |  |
| Changes applied to NHSE EOE trainee database |  |

1. Where employing organisation is the same, but trainee has transferred to a new site of work within the organisation. [↑](#footnote-ref-2)