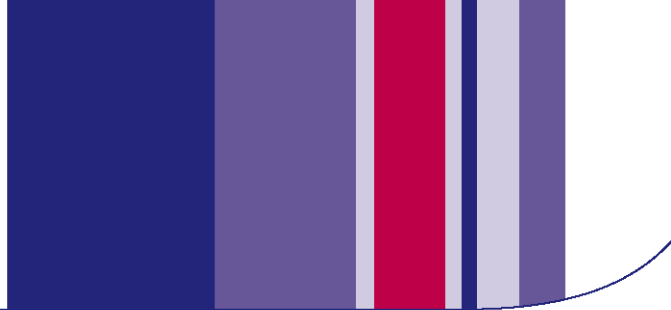


# Assistant Practitioners in the NHS in England

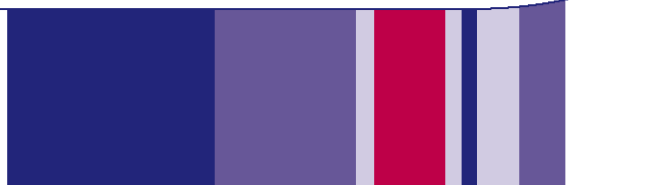
Linda Miller, Joy Williams, Rosa Marvell and Arianna  
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# Executive Summary

Skills for Health (SfH) commissioned research to examine the use of Assistant Practitioners in the NHS in England and explore the benefits of their use, the barriers to their further implementation and identify ways in which SfH can support their further introduction. The research consisted of: a literature review looking at existing evidence around development of the Assistant Practitioner role; interviews with regional representatives of the Health Education England Local Education and Training boards, employers, higher and further education institutions, professional bodies and a Clinical Commissioning Group; and focus groups and interviews with trainee Assistant Practitioners and Assistant Practitioners.

## **Roles and benefits**

There is growing recognition of the value of these posts. Stakeholders can clearly articulate the benefits of introducing the Assistant Practitioner role, which include improvements in quality, productivity and efficiency. Assistant Practitioners are working in a range of clinical, community and laboratory situations; they are increasingly seen in roles that cross health and social care and professional boundaries. However, a lack of consensus remains regarding the clinical areas in which they are able to practice, with variations from Trust to Trust and between departments within Trusts.

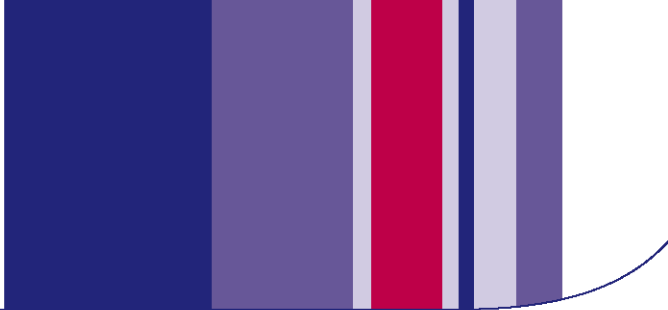
While developments to date largely have been in acute settings the changes planned for future delivery of healthcare mean there is likely to be an increasing focus on the use of Assistant Practitioner posts in primary and community care.

## **Implementation – facilitators and barriers**

Increasing service capacity remains a key driver in appointing Assistant Practitioners. Assistant Practitioner posts succeed where their introduction within a team meets a clearly identified need and where the roles and responsibilities of the Assistant Practitioner and the wider team are clear and understood. Assistant Practitioner posts are more likely to be successfully introduced where their development is part of workforce planning. Ensuring staff engagement with the process and that all staff benefit from the changes are central to success.

The introduction of Assistant Practitioner posts often appears to be prompted by the availability of funding rather than planning. Many people are unaware of the existence of standards for these roles, and those who are aware of these descriptions often find them too vague to be of help.

Concerns remain around delegation and supervision and the lack of registration and regulation. Arguments put forward in support of regulation and registration included: parity of esteem; credibility; accountability and



protection for the organisation and public; management of risk; and enabling control to be exerted over content of training. Some organisations have started to make steps to address these issues, with some success; these potentially provide a model for future developments.

## **Education and training**

A wide range of education and training routes is available; foundation degrees appear to be the qualification of choice at the moment. Other options include apprenticeships, HE Certificates and Diplomas and NVQs. The Francis and Cavendish reviews have led employers to be wary of providing training that might be challenged as being of insufficient quality or rigour.

At present, most employers are able to choose an education route that is right for their service. However, employers' decisions about the optimal education or training route are often informed by funding availability. There was some concern that education funding bodies do not fully understand the Assistant Practitioner role or the development route that would be best for individual organisations. Several LETBs have concerns regarding the value of foundation degrees; some have ended funding for this route.

Concerns appear to be emerging that courses are neither sufficiently general for all the students being sent on them nor sufficiently specialist for the specific occupational areas in which Assistant Practitioners work. Some specialist foundation degrees have been closed by HEIs and replaced by programmes with common cores and specialist modules; however, fluctuations in trainee numbers, changes in commissioning policies and reductions in funding have led to fears about future sustainability.

While in some areas the numbers of trainee Assistant Practitioners undergoing training has increased, elsewhere numbers are declining, particularly in those areas in which large numbers were originally trained and so have reached 'steady state'. While the stability of the Assistant Practitioner workforce is one of their particularly attractive features from the employer point of view, lack of churn can lead to a decline in demand for education and training with implications for sustainability.

## **Progression**

Many trainees reported that they were unlikely to obtain a band 4 post after completing their foundation degree. Some LETBs funded training when there was no guarantee of appropriate posts becoming available.

Employers understandably wanted programme content to be appropriate for the job the individual was undertaking. However, where programmes had a relatively narrow focus this could constrain the qualification's ability to support academic progression into pre-registration programmes. It could also constrain the ability of qualified Assistant Practitioners to move between employers.

Some employers recognised that a programme of study such as a foundation degree would not make a learner job-ready and it was the role of employers to provide job-specific training. Several examples of good practice were identified.

The research confirmed that many learners on healthcare-related foundation degrees had difficulty gaining credit when entering a pre-registration honours programme. Some LETBs and employers believe that oversight at national level or professional validation of foundation degree programmes would aid the design of foundation degrees that would enable easier progression into pre-registration programmes.

### **Recommendations**

The following is a summary of the main recommendations arising from the research. Skills for Health should:

- work with HEE to facilitate discussion between employers and HEIs about the nature of the Assistant Practitioner role, education options and the portability of qualifications.
- facilitate discussions amongst employers to encourage the sharing of information and practice in work-based learning.
- identify existing employer toolkits and examples of practice in developing and implementing Assistant Practitioner roles and facilitate the sharing of those toolkits and examples of practice through its website.
- provide exemplar templates for the design of training agreements to ensure employers reap the full benefits of the training and staff they have invested in.
- consider making facilities available for occasional face-to-face meetings for employers to network and discuss issues around the employment and training of Assistant Practitioners
- frequently publicise the support that SfH is able to give to employers in this area

Other recommendations are that:

- It may be possible to address regulation and registration issues through clear governance structures and policy but employers may need guidance and support in doing so. There is a role for the Royal Colleges and Professional Bodies to play in this discussion.
- The sector should review the core standards for the Assistant Practitioner role to ensure they are clearly understood and suitable for use in agreeing training needs between service provider organisations and higher education.

# 1. Introduction and method

Research was conducted between August and December 2014 to examine the use of Assistant Practitioners in the NHS in England, explore the benefits of their use, examine the barriers to their further implementation and identify ways in which Skills for Health can support their further introduction.

The work followed on from several previous pieces of research commissioned by Skills for Health that had identified developments of these roles as central to the future health sector landscape. A scenario-planning exercise undertaken in 2010 (Miller, Fairhurst and Hurley, 2010) and revised in 2012 to help Skills for Health plan for future skills requirements had identified jobs at this level (level 4 in the Career Development Framework) as being most likely to increase in future. More recently, research undertaken in Wales during 2013 (Miller, Williams and Edwards, 2014) had identified a range of barriers to the wider use of Assistant Practitioners. The recommendations arising from that work had resulted in discussions at national level and policy decisions to support the wider use of these roles in Wales.

Several reviews were conducted either in parallel with or shortly after conclusion of the work in Wales: the Francis Report, the Cavendish Review and the National Institute for Health and Care Excellence's (NICE) review of safe staffing levels and these served to focus attention on the role of registered practitioners in supporting quality of care whilst raising questions about the training and supervision of support staff.

There was therefore strategic interest within Skills for Health in re-engaging the health sector in debate about how these support roles can make a contribution to the future skill needs in the health and social care sectors in England. For Skills for Health a key concern was to determine how it might support the sector in taking forward developments in these roles.

In August 2014 Skills for Health commissioned the Institute for Employment Studies to undertake this research. The specified research requirements were as follows:

1. A literature review to establish the background to the work, drivers for development throughout England and the political and geographical context.
2. Review the usage and transferability of Assistant Practitioner roles across employers throughout England.
3. Explore how Assistant Practitioners are recruited to the roles and career progression routes for those in these roles.
4. Review the perception, expectations, recognition and actions of HEIs in relation to portability of foundation degrees.

5. Explore the current use of 'other' qualifications and training provision to assist in the effective development and deployment of these roles in England.
6. Where possible draw some comparisons with the development of Assistant/Associate Practitioner roles in Scotland and Wales.
7. Build on our understanding of opportunities and barriers in order to develop recommendations to take forward the development of Assistant/Associate Practitioner roles in England, taking into account broad trends in the development of this role.

## 1.1 Method

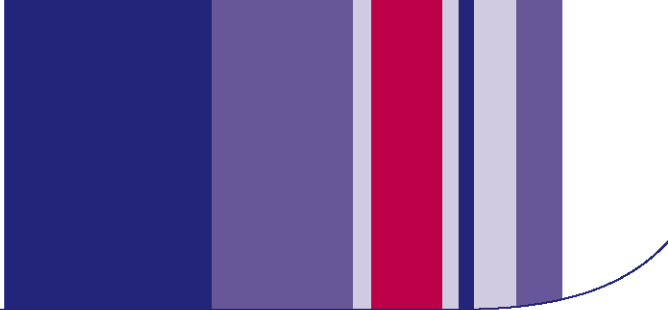
The work was undertaken between August and December 2014 and consisted of the following components:

- A literature review using online databases.
- Interviews (the majority conducted by telephone, a minority face to face) with:
  - regional representatives of the Health Education England Local Education and Training Boards (15 people interviewed in 12 interviews at 10 LETBs)
  - employers (22 interviews across 19 sites, plus email contributions from four individuals from other sites who were unavailable for interview)
  - higher education institutions and institutes (18)
  - professional bodies (3)
  - CCG (1)
- Focus groups with 47 trainee Assistant Practitioners and interviews with three Assistant Practitioners and three Trainee Assistant Practitioners.

In addition to focus groups and interviews with Trainee/Assistant Practitioners a short online survey was also circulated in order to capture the views of people who could not be available for the focus groups or for interview. This generated responses from a further six trainees and 19 Assistant Practitioners.

Separate sets of questions were designed for Trainee Assistant Practitioners and those who were already in post. Nineteen responses were received from current Assistant/Associate Practitioners (13 from Assistant Practitioners, four Associate Practitioners, one Senior Assistant Practitioner and one Senior Technical Instructor). The respondents came from all regions in England, with the majority from the North West and South East. Five responses were received from Trainee Assistant Practitioners, the majority in the North West and in NHS trusts with one response from a Trainee Assistant Practitioner in a Hospice setting. They were employed in Bands 2-





4 and all expected to be employed as Assistant Practitioners by the end of their course.

## **1.2 Structure of the report**

The remainder of this report starts with a review of literature. In Chapter 3 we consider the ways in which Assistant Practitioners are used in England, the benefits of their use and the factors that have served to drive developments.

In Chapter 4 we consider the factors that have affected implementation. Chapter 5 considers the ways in which Assistant Practitioners are educated and trained for their posts. Chapter 6 considers their options in terms of academic and career progression. In Chapter 7 we summarise the findings and make recommendations for actions that would help support further growth in these posts.

Rather than report the views of the different groups of interviewee the report adopts a themed approach. Therefore, the views of all groups are used to inform the various sections.

## **1.3 A note about terminology used in this report**

This report focusses on the introduction of roles at level 4 in the Skills for Health Career Progression Framework. Currently the most common term for these roles is 'Assistant Practitioner'. However, they are also referred to by a range of other names, including Associate Practitioners, Senior Healthcare Assistants and Senior Support Workers. Other titles include (in occupational therapy) technical instructors and (in community services) re-ablement officers. Many more titles exist based on the particular units and patient pathways in which Assistant Practitioners work.

Throughout this report we refer to the posts as 'Assistant Practitioners'. This term should be taken to include and refer to all the other job titles within this group, such as Senior Healthcare Support Worker, Associate Practitioner and Technical Instructor.

Secondly, and as we have already noted, it is the custom of Skills for Health to refer to these posts as 'level 4' posts, based on their position in the Career Development Framework. However, as we found previously in the work in Wales, and found again in the current work, the very great majority of participants (and especially the Assistant Practitioners and trainees themselves) refer to these jobs as 'band 4' roles (and, where they aspired to these, they would typically tell us they were currently in band 2 or band 3 posts at the moment). Employers too would contrast the roles of 'band 5 nurses' with 'band 4 Assistant Practitioners'. The custom in Health Education

England and LETB policy and strategy documents is also to refer to the support workforce as 'bands 1-4'<sup>1</sup>.

We recognise that this terminology is based on the position of a role within the Agenda for Change hierarchy which sets out pay grades, which, strictly speaking, is not the same as the Career Development Framework. In the NHS, though, the Agenda for Change bandings have become synonymous with career status and advancement as well as pay.

Not only has the 'Band 4' term achieved greater currency in the healthcare sector but a further difficulty has recently arisen in use of the term 'Level 4' to refer to these posts. This is because, with the rise of the foundation degree, it is common for people occupying or aspiring to Band 4 posts to have qualifications (most often a foundation degree at present) which sit at Level 5 of the QCF (Qualification and Credit Framework<sup>2</sup>).

Therefore to avoid any confusion, where we refer to **qualifications** in this document, we refer to '**levels**'; in common with practice in the sector, when we talk about **jobs and roles**, we refer to '**bands**'.

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<sup>1</sup> For example the current HEE Business Plan 2014-15 reports that 'Supporting health care assistants and bands 1-4' is one of HEE's business priorities (Source: HEE Business Plan draft 13 page 21).

<sup>2</sup> <http://www.accreditedqualifications.org.uk/qualifications-and-credit-framework-qcf.html>

## 2. Literature review

- Many of the Assistant Practitioner roles are emerging from the creation of new services and patient pathways; the expansion of new roles is being further driven by the focus on community-based provision and the drive towards integrated health and social care
- Automation has facilitated task devolution and the development of these roles in some technical areas
- The literature indicates that many of the barriers to progress previously identified still remain: the perceived absence or presence of guidance on defining and developing Assistant Practitioner posts; concern and lack of confidence regarding supervision requirements; fears about delegating tasks from registered to unregistered personnel; and difficulties in identifying appropriate education and training and mentoring
- The literature points to variation between and within institutions as to what the role entails, there are accounts of some staff continuing to feel threatened by these posts, and there remain issues around accountability

In this chapter we summarise and update what has been reported in the literature about the development of Assistant Practitioner roles. We consider the drivers of developments, what facilitators and barriers have been identified and whether any change is evident in attitudes towards, development for and deployment of these posts.

### 2.1 Search process

A literature search was conducted in July 2014 using the British Education Index, Cinahl, Psycinfo, IngentaConnect and Sage databases. The Advanced Search function was used to search for papers which had either 'Assistant Practitioner' or 'Associate Practitioner' in the title or abstract. Searches were constrained to articles published between January 2012 and July 2014 and for which full text was available in subscribed content.

A total of 48 papers were downloaded. After review, just 16 were found to be related to the research questions. Of these, seven reported material of an empirical nature relevant to the review and were included (the remainder consisting of news items and commentary). In addition, a report commissioned by Skills for Health but not in the public domain was also provided for inclusion in the review. The HEE document '*Talent for Care: A national strategic framework to develop the healthcare support workforce*' and the resulting consultation report were also included.

## **2.2 Factors affecting growth in Assistant Practitioner posts**

The literature review points to three main issues that are of interest to us in the development of Assistant Practitioner roles – first, the rationale or drivers for change; second, the factors that impede progress; and third the factors that facilitate change. While the literature review has been organised under these three broad headings, it should be noted that there are very large overlaps between the issues identified and in some cases attempting to categorise a factor as a facilitator (rather than its absence as a barrier), or as a facilitator rather than a driver, is an artificial discrimination.

### **2.2.1 Rationale or drivers for introducing Assistant Practitioner posts**

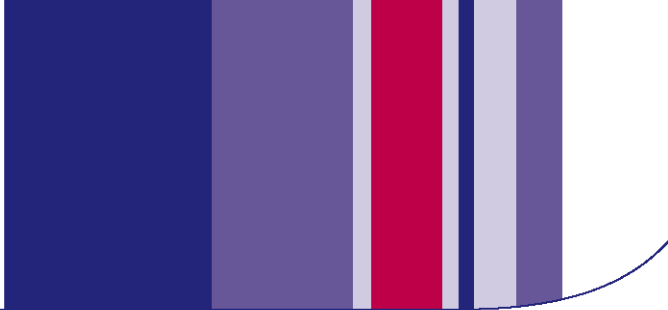
#### **Staff shortages**

The shortfall of registered staff at higher levels is cited by many (eg Chang, 1995, Bowman et al, 2003; Warr, 2002, Miller et al 2011) as a factor driving the task delegation and/or role substitution process which often underpins development of Assistant Practitioner roles. In part related to this, economics and cost-efficiency often play a large part in decisions about staffing levels and skill mix required in a department (although such discussions are now likely to be tempered by the debate regarding safe staffing levels – see sections that follow).

Note though that such drivers for the introduction of Assistant Practitioner posts can vary between departments within a single location. Therefore, while the (then) Derbyshire Strategic Health Authority reported that difficulties in recruiting professional staff had underpinned decisions to introduce Assistant Practitioner posts in specialisms such as Learning Difficulties and Dentistry, in others (such as the Surgical Directorate), the introduction of these posts was driven by the need for new skills or for workers in new areas of activity (see Box 2, Miller 2013). Therefore, while staff shortages can be one driver, it is unlikely to be the single determinant across an organisation.

#### **Increasing capacity and cost-efficiency**

Having simpler tasks undertaken (under supervision) by Assistant Practitioners is one way in which the throughput of patients can be increased (or similarly the length of wait can be reduced). Therefore Assistant Practitioner posts have been introduced as a cost-effective way of increasing capacity or meeting targets for waiting times. Radiography is a prime example. The increasing range of imaging technologies has led to significantly increased demand, because typically the newer imaging modalities are not substituted for conventional X-rays but rather lead to supplementary requests for these images in addition to X-rays. Because of this, radiographers have taken on many of the activities previously the preserve of radiologists, with Assistant Practitioners taking on many of the



activities previously undertaken by radiographers (Miller, Price and Vosper, 2011; Miller, Price, Hicks and Higgs, 2011).

Similar issues of capacity and flexibility have underpinned arguments about staffing levels and demand for services in areas other than radiography. For example, Chouliaria, Fisher, Kerr and Walker (2014) examined the challenges and facilitators to the implementation of two units providing stroke Early Supported Discharge services in Nottingham. They reported that the use of rehabilitation assistants (either Assistant Practitioners or support workers) was viewed as integral to success of the scheme but Assistant Practitioners were employed at only one of the sites; the authors note that these were '*more autonomous than support workers, being able to progress rehabilitation goals or take over the care of less complex patients*' (Chouliaria et al, *ibid*, p. 373). Chouliaria et al noted that assigning rehabilitation assistants to deliver the repetitive everyday exercises freed up the more highly skilled staff to focus on the more specialist elements of rehabilitation. Allen et al (2012) report that some organisations have found Assistant Practitioners to be a more cost effective and preferable option than use of agency nurses.

This downward delegation to support workers of some tasks that have more traditionally been undertaken by registered staff allows for more effective use of the skills of the whole workforce and is often referred to as 'role substitution' (Nancarrow and Borthwick, 2005). However, in some cases Assistant Practitioner posts have been introduced in addition to the existing staffing establishment, leading to an increase in staff numbers. For example, some hospitals funded these posts as part of an explicit attempt to reduce waiting lists and meet the targets set under the No Delays initiative, while on other occasions their introduction was prompted by the availability of development funding (Miller, Price, Hicks and Higgs, 2011). It should be noted that where Assistant Practitioners are additional to the previous staff establishment then this will tend to drive overall staff costs up rather than down (Miller, 2011). However, the increased service capacity can then lead to greater overall cost-efficiency (Miller, Price, Hicks and Higgs, 2011; see also Laurant et al, 2004) and it may only be through considering performance issues such as departmental capacity or patient throughput alongside staff costs that cost-efficiencies can be seen, and our work has shown that it is a minority of departments that undertake such analyses (Miller, Cox and Williams, 2009; Miller, Price, Hicks and Higgs, 2011). Where funding is tight or reduced this may lead managers to consider Assistant Practitioners to be a cost (that can be cut) rather than an aid to improved throughput.

Health sector policy aimed at encouraging more flexible working and to facilitate progression has helped drive this re-allocation of activities between roles at different skill levels. However, the recent NICE review of safe staffing levels for adult in-patient wards in acute hospitals focused attention on the numbers of registered staff on duty in wards during a shift (NICE, 2014) rather than overall skillmix. The general rule of thumb suggested by the review was that one registered nurse was required for every eight

patients, although the review did say that this remained subject to local decisions based on the nature of the patient group. The review was silent on the contribution made by support staff to safe staffing levels in wards.

## Technology

Technology has served to drive developments too. There is recognition that automation has changed the nature of the skills required and the Modernising Scientific Careers initiative is changing the ways in which work in the more technical areas is organised. Many of the jobs that previously required very highly qualified individuals can now be undertaken by those in band 4 posts, hence saving public money:

'In these two [science] sectors work has become very automated. Previously it was highly skilled practical work as well as requiring high levels of knowledge. We needed a jolt to get us away from thinking that just because it's been like this for years this is how it ought to be done. We need to ask "Is it appropriate?", look at the workflow. It's public money and we need to get as efficient as we can and look at the skillsets, the different skillsets that are needed now.'

Interviewee quoted in Miller, Williams and Edwards, (2014)

Miller, Williams and Edwards (ibid) reported that several interviewees in Welsh hospitals gave accounts of how the introduction of staff at band 4 had brought benefits to their departments, in particular through improving work flow and increasing capacity. Technology and in particular automation had led to greater use of Assistant Practitioners in several of the scientific areas (for example Haematology, Pathology, Biomedical Sciences) and in imaging services. Managers in those departments outlined the positive impact that the introduction of these roles had had, and this had encouraged them to consider to use – or to introduce more of – these roles (whilst noting some issues concerning supervisory arrangements). Others pointed to the fact that technology could help overcome the challenges of remote supervision, increasing the potential for band 4 staff to work unaccompanied but not unsupervised.

As well as being a driver of change per se, technology can also enable the working arrangements and supervision of Assistant Practitioners. For example the rehabilitation engineering department in Cardiff and Vale provides a national service across Wales. They envisage using Assistant Practitioners in the community, using video conferencing facilities when they need to seek advice from registered practitioners. Similarly, Radiographic Assistants working in mobile screening units with Breast Test Wales have their images signed off remotely by radiographers working elsewhere.

## The changing shape of health service provision

Two changes to the way in which healthcare is provided have led to increased demand for Assistant Practitioner roles. First, in many cases design of a new service – or redesign of an existing service - had led to recognition that new roles were required. For example, in work for Skills for Health Miller, Williams, Butler, Wilson, Rickard and Robinson (2013) reported on the development of re-ablement services:

'The need has arisen from the development of the re-ablement service and we needed to think about what the care plan would look like upon discharge from hospital.'

Head of Education, Learning and Development at an NHS Trust

The role that was designed in that instance was a Community Navigator to help with re-ablement following discharge. The re-ablement project offered patients three to six weeks of intensive support, during which time they were helped to become more independent in their own home. The Community Navigator's role was to point clients to the resources and opportunities available in the community.

That example provides an introduction to the second major change affecting service provision, which is the shift of care provision from secondary services into primary and community/home-based care. This change has led to the need for new roles to support individuals in their homes. In work assisting Skills for Health to gauge the extent of involvement of health sector staff in new role development one of the interviewees reported on the extensive range of issues that needed to be covered by new Assistant Practitioner roles:

'One [Assistant Practitioner] would assess patients in hospital (including A&E and admission units) so they can be discharged earlier and managed in the community. They would liaise with other organisations to get patients home sooner, liaise with wards to get discharge plans and pharmacy to make sure medicines are in place. The other role would be based in the community to help prevent the patient from going into hospital, crisis management – if they need something at home they can arrange it and collect medication for example.'

Clinical Education Lead

This shift of provision to community-based services has been further prompted in the past few years by Department of Health policy aimed at maintaining people in their own homes wherever possible and avoiding repeated admissions to hospital (the so-called 'frequent flyer' issue: see Miller, Robinson, Butler, Chubb and Oakley, 2011). This refocusing of provision is not restricted just to the NHS. An interviewee from a hospice (ie in the charitable sector) said:

'There is going to be an expansion in community services provision so as part of that we are going to be expanding our 'hospice at home' service. So the development of Healthcare Assistants is in part to address those things.'

Head of staff development, Hospice

The Clinical Education Lead also pointed to the fact that these new roles had been identified through the Commissioners of healthcare services working with Social Services. Integration of health and social care is the third major policy shift to have affected demand for posts at Assistant Practitioner level and we consider this next.

### **Integrating health and social care services**

In recent years there has been a policy focus on integrating health and social care services, spurring further interest in the development of new roles. While there have been discussions of the benefits of integrating health and social care for at least the last 20 years, developments were prompted first, by funding of the Integrated Care Pilots in 2009 and, more recently, by the £3.8bn Better Care Fund (formerly the Integration Transformation Fund) announced by Government in June 2013.

The Better Care Fund is focussed on delivering more integrated health and social care services for older and disabled people, with further funding anticipated during 2014/15. These changes have led to emergence of the need for many new, often community-based, roles at Assistant Practitioner level, in many cases very unlike the types of roles previously seen in the NHS. Work undertaken for the Local Government Association in 2014 revealed that Assistant Practitioner roles (or roles equivalent to these in Local Authorities) are being introduced as part of efforts to provide more integrated health and social care services<sup>3</sup>.

In work examining the use of Assistant Practitioner roles in Wales, Miller, Williams and Edwards (2014) reported that as more care is moved out from secondary services into primary and community/home-based care there may be more demand for Assistant Practitioners. There were reports of integrated roles combining health and social care components being in development at the time the research was conducted.

### **2.2.2 Factors that facilitate or impede progress**

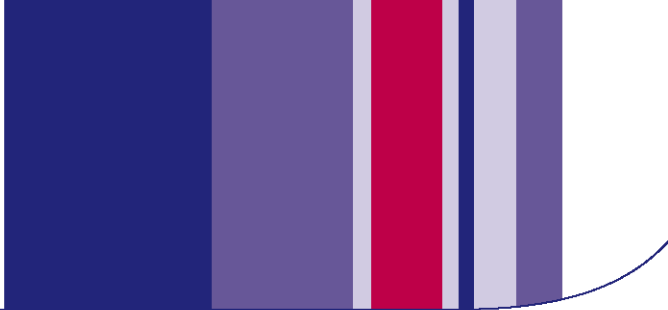
#### **Guidance and role definition**

Clear definition of the boundaries of any role is of high importance when introducing any new role within an organisation. The literature review points

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<sup>3</sup> The LGA case studies of integrated care can be viewed at <http://www.local.gov.uk/documents/10180/11689/Service+integration+and+the+workforce+-+four+case+studies.pdf/c91702b4-522f-425d-a8ee-1c77c59dca69>





to evidence that a lack of guidance and role definition can impede the progress and success of Assistant Practitioner roles.

Many organisations have tackled this issue by developing local guidance and toolkits to assist the organisation in designing, defining and implementing Assistant Practitioner roles.

However, while some Trusts have produced guidance and toolkits to guide developments, a significant proportion of Trusts have introduced these posts in the absence of any code of practice, training standard or guidance on delegation of roles.

Allen, McAleavy and Wright (2012) report on a service evaluation of the introduction of a cohort of Assistant Practitioners into the Critical Care units of a large NHS teaching hospital. The first group of trainee Assistant Practitioners were all experienced support workers from across the Trust. Some 28 trainees had been recruited and at the point of writing there were 16 fully trained Assistant Practitioners in post.

Allen et al reported some confusion and uncertainty around what an Assistant Practitioner can do, and noted that the role differed across clinical areas. They commented on the limitations of use of Assistant Practitioners in critical care, with the issue of drug administration, clinical location (see later section on Supervision) and concerns over accountability (see later section on Registration and Regulation) of the Assistant Practitioners being major considerations potentially placing restrictions on use of this role. The authors concluded that as the role becomes established and accepted across the UK there may be more national guidance which will help locally.

Thurgate, MacGregor and O'Keefe (2013) also identified a series of issues relating to this point: managers of Assistant Practitioners in an Acute Trust found the 'scope of practice' for Assistant Practitioners was not clear and believed that there was a need for a *'trust wide competency framework with guidelines on transferability between practice areas'*; registered nurses in some specialist teams did not initially understand the Assistant Practitioner role and (consequently) a local training opportunity for Assistant Practitioners in cannulation had been blocked for non-nurses (ie for Assistant Practitioners). Thurgate et al also go on to report that *'some Assistant Practitioners had given themselves licence to practice in relation to their own interpretation of their function'* which, the authors suggest, *'demands better clarification of role through a competency framework and job descriptions'* (Thurgate et al, *ibid.*, p. 248). It might also be suggested that this points to the need for better supervision, with this in turn being dependent upon the supervisors having a clearer understanding of both the role and their own supervisory responsibilities.

The Thurgate et al (2013) article builds on points made in a discussion piece by Thurgate and MacGregor (2012a). In this earlier article the authors consider the position of Assistant Practitioners in paediatrics and suggest that it should be considered a discrete area of care and that if or when Assistant Practitioners are introduced this should be with roles clearly

defined for this setting. They emphasise the need for clearly-specified competencies and technical skills.

### **Roles, job descriptions and competency frameworks**

The managers interviewed by Thurgate et al (2013) recommended that experiences in developing Assistant Practitioners should be shared across the Trust, using a trust-wide competency framework with guidelines on transferability between practice areas.

They also reported that managers believed it was important that they were involved in developing the Trust's job descriptions and competencies required for the role as *'the difference in competence is important between Band 4/Band 5'*. It is perhaps worth noting a particular point in respect of the managers' perspective here: this group wanted to be involved in defining the differences in expectations; much other work has pointed to the difficulties that managers have in understanding the differences between roles at these bands or levels. For example, several managers interviewed as part of research into the use of Assistant Practitioners in Wales commented on the difficulty in differentiating between bands 2, 3 and 4 (Miller, Williams and Edwards, 2014)<sup>4</sup>:

*'I am frustrated at the lack of a definition of band 2, band 3 and band 4 – what's the difference supposed to be between these roles? We need to understand what the difference is between these roles and how we should be using people in these bands differently.'*

The research by Miller et al (2013) into people's experiences in introducing new roles had also indicated that they need to be based on a clear rationale and workforce plan with the roles being identified within a clear vision and plan for service delivery.

### **Supervision**

Unregistered staff are required to work under the proximal supervision of a registered practitioner (ie, level/band 5 and above). This can present difficulties in departments where staff are distributed across several sites (Miller et al, 2011), in departments with only small numbers of staff (Miller et al 2011, 2014) and where staff work on their own in the community (Miller et al 2014). There are also fears about where responsibility for error lies, that is, whether it is the unregistered member of staff or the registered staff supervising the activity (Miller et al 2014). The CQC was understood to be producing guidance on supervision of support staff at the time the research

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<sup>4</sup> We understand that the Workforce, Education and Development Services for Wales (<http://www.weds.wales.nhs.uk/home>) is expected to publish definitions in the near future.

was conducted but had not been published in time for inclusion in this review.<sup>5</sup>

### **Inter-professional boundaries and inter-group attitudes**

There has been a considerable amount of writing on the issue of professional roles and boundaries, and conflicts arising from this (see for example Bach, Kessler and Heron, 2005; Nancarrow and Borthwick, 2005). While introduction of lower level roles in principle gives these professional groups the opportunity to delegate more basic tasks, thereby allowing them more time to work on more complex activities or indeed to develop further skills, in practice some have been reluctant to lose these activities. More recently, the economic climate (and in particular the freezing of vacant posts) has meant that registered staff may see no benefit from such changes in terms of further development opportunities (Miller et al, 2011).

Introducing new roles as part of a new service may be easier than introducing them into existing departments and staffing structures. There are reports of some staff groups being unwilling to accept these new roles in the past. While many managers have viewed Assistant Practitioners as being able to take on some of the tasks from registered staff and thereby bring cost-efficiencies for departments, existing staff have sometimes resented such changes.

In work undertaken for Skills for Health looking at organisations' experiences in developing new roles, a range of challenges were reported (Miller et al 2013). One interviewee pointed to the concerns of registered staff regarding why this role is needed, what Assistant Practitioners would do that was different and questioning the need for the role. There were problems with the clarity of the role, concerns about scope of practice and how it will impact existing staffs' roles, and consequently resistance from staff who felt that their role was being degraded. Norrie et al (2012) reported some tension between Assistant Practitioners and Registered Nurses and resentment that Assistant Practitioners had replaced Registered Nurses mostly due to cost savings considerations. Similarly, Thurgate et al (2013) reported that nurses expressed fears that their job and/or professionalism was threatened. These reflected some of the views reported by Miller, Price, Hicks and Higgs (2011) concerning the introduction of Assistant Practitioners in imaging departments in Scotland.

### **Registration and regulation**

SfH does not have a policy position on registration or regulation<sup>6</sup> and the UK government rejected the call by the Francis Review for the regulation of healthcare staff below Band 5 in England<sup>7</sup>.

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<sup>5</sup> Guidance on supervision is now available as part of the Care Certificate guidance available at <http://www.skillsforhealth.org.uk/projects/item/24-care-certificate>

It is worth noting that Assistant Practitioners are responsible to their employers when they undertake activities that are identified in local protocols (in other words, the Assistant Practitioner is responsible for their actions, rather than their supervisor). Nonetheless continuing concern regarding the non-registration of Assistant Practitioners is known to have impeded progress in some areas. Research in Wales by Miller, Williams and Edwards (2014) revealed concerns amongst interviewees regarding posts below Band 5 remaining non-registered and unregulated, with many interviewees believing that registration and regulation was a necessary step towards overcoming barriers to wider use of Assistant Practitioners in time. Therefore, while there is no Government intention in England to introduce statutory regulation for staff below Band 5, non-regulation remains a concern for some managers. While those concerns remain this is likely to impede progress. A Unison survey of Healthcare Assistants and Assistant Practitioners conducted in 2013 indicated that over 80 per cent of respondents believed Healthcare Assistants should be regulated as are other healthcare staff. Although the nuanced differences between regulation and registration are perhaps not always fully understood (given that terms are commonly used interchangeably), the findings from this survey do indicate broad support from the workforce itself. The Royal College of Nursing also supports regulation of all Healthcare Assistants and Assistant Practitioners, and their independent commission recommended that education be mandatory (Griffiths, 2013).

A particular source of anxiety reported by employers in Wales when considering devolving tasks to Assistant Practitioners is that a subset of activities is being taken from a registered and regulated professional and passed to a worker who is not registered/regulated. The concern for these employers was therefore the question of how, in the absence of registration or regulation, they could ensure that they delegated only those tasks that are

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<sup>6</sup> Registration and regulation mean different things but are often used interchangeably within the health sector. 'Registration' means that a health care professional has been assessed as having reached a standard of knowledge or competence such that they can be registered to appear on the list of individuals qualified to practise that specialism; the Health Care Professions Council (HCPC) maintains a register of health and care professionals who meet the specified standards. Registered practitioners are regulated through the body that oversees the standards for the relevant profession (the Regulatory Body): so, for example, in Nursing, the Nursing and Midwifery Council sets the standards and is the regulator; in Radiography this role would be undertaken by the Society and College of Radiographers. The Regulatory Body has two main responsibilities: assuring fitness to practice through specifying the standard to be achieved prior to registration; and investigating allegations of impaired fitness to practise (and taking disciplinary action where this is proven). Where impaired fitness to practise is proven, an individual can be struck off the register.

<sup>7</sup> The report of the Francis review into the Mid Staffordshire NHS Foundation Trust Public Inquiry can be downloaded here: <http://www.midstaffpublicinquiry.com/report>

clinically appropriate in a way that maintains clinical quality and safety (Miller et al, 2014)<sup>8</sup>.

### **Education, training and qualifications**

Miller (2013) noted that the majority of Assistant Practitioner posts appear to be filled by recruitment from amongst (and training and promotion of) individuals already occupying posts as Healthcare Assistants or other lower band posts. Indeed one of the reasons often cited by organisations for introducing Assistant Practitioner posts is to provide a progression route for people employed within Healthcare Assistant posts (Miller, Williams, Butler, Wilson, Rickard and Robinson, 2013). One issue that has emerged as a constraint on developments most recently is that of availability and accessibility of education and training.

There are no national specified types of qualification for Assistant Practitioners as there is for registered staff, although the SfH (2009) Core Standards for Assistant Practitioners document indicated that the education or training provided should sit at Level 5 in the Qualifications and Credit Framework and the apprenticeship for assistant practitioners is Level 5. However, employers are able to decide on the nature of the education and training provided. Data gathered by Skills for Health indicated that the main types of qualification typically required by these roles are an NVQ Level 3; a BTEC Higher National Diploma or Higher Education Diploma; or a foundation degree. Of the 68 descriptions of the training being offered or considered in England for these new roles in 2011, 60 were foundation degrees. Four referred to NVQs or a qualification 'based on competences', two were using BTEC awards and one a Higher Education Diploma (Miller, Williams, Butler, Wilson, Rickard and Robinson, 2013). In Scotland, the great majority of Assistant Practitioners in imaging services are being trained towards Higher National Diplomas (Colthart, McBride and Murray, 2010). However, when Greater Glasgow and Clyde piloted Healthcare Assistants and Assistant Practitioners within clinical units and departments, recruits were 'profiled' to determine their individual learning needs rather than an agreed training programme (or programmes) being arranged (material supplied by GGC NHS as part of the impact evaluation specification, 2010).

There are several issues regarding qualifications that can constitute barriers to the introduction of Assistant Practitioners. It can be difficult for managers to locate appropriate programmes, and there are accounts of appropriate programmes being closed due to small numbers (Miller, Williams and Edwards, 2014). Some believe that the types of programme offered are insufficiently focussed on the types of jobs that are undertaken by Assistant

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<sup>8</sup> Note there are exceptions. The Society and College of Radiographers has offered a voluntary accreditation scheme for Assistant Practitioners for some years (and see later in this report for a recent change to this policy), while Pharmacy has had a compulsory registration scheme for Pharmacy Technicians qualified at Level 3 since 2011.

Practitioners. Several of the programmes appear to comprise mainly of generic skills training with some competences focussed on the specifics or technical components of the job. For example, Smith and Brown (2012) describe the course at Bolton University which is based on the assumption that there are general skills which all health and social care workers should possess (communication and its barriers, positive and inclusive practice including law and ethics, evidence-based practice, working within both a uni- and multi-disciplinary team and planning care delivery). Thurgate, McGregor and O’Keefe (2013) examined clinical managers’ perceptions of an Assistant Practitioner training programme. Their manager interviewees recommended that:

‘... the assessment of competency needs to form an integral component of a training programme to ensure the Assistant Practitioner is competent in the skill with appropriate knowledge base. This involves the manager working closely with the HEI to ensure that the programme prepares APs who are fit for purpose.’

Thurgate, McGregor and O’Keefe (2013) p.248

The work by Miller, Williams and Edwards (2014) revealed that managers in Wales faced a particular difficulty given their (mostly) smaller and more widely dispersed populations and, consequently, struggled to generate the size of student cohort that could sustain college and university courses on an annual basis. Because of this, some who were closer to the border or located near to the better transport hubs were sending their staff to England for training. While this suggests that provision may be less of an issue in England, in fact there has already been loss of courses in England due to low numbers, suggesting sustainability may nonetheless remain an issue for some healthcare specialisms.

It should be noted that the use of foundation degrees in England has led to a wider range of provision in England, and a range that is potentially better placed to mesh with full degree provision. However, the lack of *part-time* progression options from levels 4 and 5 remains a barrier to career progression in some cases (Miller, 2011, 2013). A Hefce report published in 2010 indicated that fewer part-time foundation degree students progressed into an honours degree. The report also indicates that, of those who did progress, around four-fifths received full credit for their qualification when entering the honours degree programme.

8. For students who were registered at an HEI for their foundation degree, and who qualified with a foundation degree award in 2007-08, we found:

a. More than half of students who studied full-time for their foundation degree (59 per cent) went on to study an honours degree in 2008-09. Among part-time qualifiers this proportion was 42 per cent. Most students who continued their studies did so registered at the same HEI at which they were registered for their foundation degree.

b. Around 80 per cent of qualifiers were credited with the equivalent of full-time study for two years on an honours degree programme, regardless of whether or not they had changed institution for their honours degree study.

Hefce (2010) Foundation degrees: Key statistics 2001-02 to 2007-08

In addition, Healthcare Assistants studying to move into an Assistant Practitioner role often have no guarantee that their conditions of service will be protected while they study. Knight (2013) reports the case of one Healthcare Assistant who had to take a pay cut and work an extra day while she studied on a foundation degree in health and social science. In contrast, departments in Scotland with trainee Assistant Practitioners in diagnostic radiography were given funding to 'backfill' the posts while the trainees were at college; the costs of the courses were funded by NHS Education for Scotland and the trainees were seconded to the training on full pay (Miller, Price, Hicks and Higgs 2011).

### **Mentoring**

Many of the education and training programmes require trainee Assistant Practitioners to be given support by mentors in their employing department while they are learning. Several papers have pointed to shortcomings in the preparation to help staff mentor Assistant Practitioners during their training. Hicks (2011) examined the role of radiographers in mentoring trainee Assistant Practitioners in imaging services. The trainees had been recruited from existing Healthcare Assistants and consequently many were older and had not participated in education or training for some time. Hicks found that for many, the immersion in a relatively academic programme meant that a large part of the mentoring role in the first instance comprised of support to help trainees overcome their anxieties arising from this experience. Conversely, younger trainees were found to have more need for support in developing the skills and confidence to work in a team. Mentors also needed to be able to ensure that Assistant Practitioners were not taking on tasks that were outside their scope of competence during the training, too.

Griggs (2012) found that nurse mentors are often poorly prepared for supporting Assistant Practitioners. Nurse mentors can qualify through Nursing and Midwifery Council-approved mentoring courses, but these may not prepare individuals adequately to support trainee Assistant Practitioners. The candidate mentors are primarily selected based on their experience with nurse students and may not possess knowledge either of the Assistant Practitioner position or the foundation degree on which they would be studying. Consequently, mentors reported a lack of preparation for this responsibility.

In addition, and as is found in much of the research on mentoring, there are also issues identified regarding choice of individuals for the mentor role (while more senior staff have a more strategic perspective, they also have more demands on their time), concerns regarding insufficient clarity over role, accountability and competition between the time spent with student nurses and trainee Assistant Practitioners (with trainees more often being

seen as a 'lower priority' (Griggs, *ibid*, p, 330). Similarly, managers interviewed by Thurgate et al (2013) also recognised that the Assistant Practitioners required a mentor who understood the new role and levels of competency required but that nurses did not always fully understand the role.

## 2.3 More recent developments

The Francis and Cavendish<sup>9</sup> reviews had focussed public attention on the activities of healthcare staff, particularly in the context of ensuring safe standards within the health sector. The NICE review of safe staffing levels in Acute wards<sup>10</sup> had also been published shortly before the work commenced, only serving to further emphasise the importance of having 'appropriate' levels of registered staff present to ensure that care is safe. It was therefore of interest to explore the impact of these reviews on attitudes to the development of support roles in this work.

However, for bands 1-4 the most significant recent development is likely to be development of the Talent for Care strategic framework drafted by Health Education England (HEE) to support the development of the healthcare support workforce. This had gone out to national consultation in September 2014<sup>11</sup> and in November 2014 HEE approved the final version of the Framework<sup>12</sup>.

The document noted that:

The challenge is inconsistency. There is variation in access, with some support staff having no more than basic mandatory training while others are supported through apprenticeships or other vocational qualifications and training schemes. In the absence of a national framework, even those who have good access to training and education may find their qualifications or past training does not transfer from one organisation to another or enable progression into higher education.

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<sup>9</sup> The report of the '*The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings*' can be downloaded from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/236212/Cavendish\\_Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf).

<sup>10</sup> NICE (2014), *Safe staffing for nursing in adult inpatient wards in acute hospitals*, <http://www.nice.org.uk/guidance/sg1/resources/guidance-safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals-pdf>

<sup>11</sup> <http://eoe.hee.nhs.uk/files/2014/09/Talent-for-Care-Draft-Strategy-V9.pdf>

<sup>12</sup> <https://eoe.hee.nhs.uk/our-work/1to4/>



Overall, we gained a sense of disempowerment among support staff and an acknowledgement of this from leaders and organisations. This sets a challenge to devise a national strategy that not only addresses education and training, but also provides a catalyst to a national change in culture and recognition of people in a support role.

Employers, along with the local arms of Health Education England, the Local Education and Training Boards (LETBs) and HEIs, Skills for Health, Skills for Care and Local Authorities will now be considering how best to help challenge this situation. It is to be hoped that the research and recommendations reported here will help with implementation of this key strategy and support the central theme of the Framework: to help support workers to *'get in, get on, go further'*.

## 2.4 Summary

This literature review confirmed that the number of roles at Band 4 has continued to increase, driven by cost-efficiencies, shifts in policy and changes to service delivery arrangements. Technology has facilitated task devolution and the development of these roles in some cases, while a lack of guidance on role development (and differentiation between levels) and difficulties in accessing education and training can impede progress. The literature points to variation between and within institutions as to what the role entails (perhaps not surprising, given the range of roles involved), accounts of some staff continuing to feel threatened by these posts, and there remain issues around accountability.

Regarding accountability, the most recent work, on Assistant Practitioners in Wales, unpacked managers' concerns on this point, which included questions regarding what constitutes a suitable level of supervision, what tasks can be delegated and the legal situation should a problem arise with a delegated task. There are still accounts of unsatisfactory role recognition, which, while mostly reported through the perspective of Assistant Practitioners themselves, also indicates a failure of departments or organisations to communicate these roles adequately. Where there is a lack of clarity concerning these roles, it is unlikely that organisations will achieve the full benefits of these roles or that managers and staff will press for their greater use.

Economics and cost-efficiency concerns often play a part in decisions about the staffing levels and skill mix required in a department. However, such considerations now needed to be balanced against the guidance that had recently emerged from the NICE review of safe staffing levels. There was a view at the time the research was commissioned that this guidance was being interpreted as meaning that the employment of higher numbers of doctors and nurses was a safer option than innovating with unfamiliar roles, and serving to dampen enthusiasm regarding the development of support roles.

It was too early for these issues to have been considered in the literature by time of the review, and the current work therefore provided a timely opportunity to explore this matter. Such decisions, if found to be widespread, would serve to reinforce traditional ways of working and limit the potential for innovation.

There is little in the research literature concerning the factors that serve to tip organisations in the direction of these posts becoming fully established. Neither is there much in the literature exploring employer views on the appropriateness of the various programmes available for preparing people for Assistant Practitioner roles. This is perhaps understandable given that many of the reports are written by educationalists reporting the development of individual programmes to meet specific employer needs. However, as the numbers both of Assistant Practitioner roles and of foundation degrees increase it is timely to consider the extent to which these are delivering the types of development required by the various employers.

The issues identified in this literature review were used to inform development of the discussion guides for use with LETBs, professional bodies, employers, HEIs, Assistant Practitioners and trainees. These are shown in the appendices.

## 3. The use of Assistant Practitioners

### 3.1 Key points

- Stakeholders across the sector can clearly articulate the potential benefits of introducing the Assistant Practitioner role; this includes benefits to the individual teams, employers and the health sector as a whole
- Interviewees reported a range of clinical, community and laboratory situations in which Assistant Practitioners had helped with service delivery
- New roles that cross health and social care and professional boundaries are increasingly being developed. Examples identified include roles in the older adult care home liaison team and in the Re-Ablement, Community Falls, Smoking Cessation and Integrated Nutrition and Communication services
- In many settings Assistant Practitioners are acting autonomously; examples include organising ward admissions and clinics, running education sessions and training and assessing other support staff
- Increasing service capacity remains a key driver in appointing Assistant Practitioners while automation has helped facilitate these roles in scientific areas
- Assistant Practitioners are a stable workforce; retention levels amongst this staff group are high. They have helped employers who have experienced high levels of turnover amongst their registered staff provide a more stable, flexible service to patients

### 3.2 The benefits of introducing Assistant Practitioners

Employers reported a range of reasons for utilising Assistant Practitioner roles and the benefits arising from their use. One of the factors driving their use that was mentioned by many of the employers and LETB representatives was the shortage of nurses nationwide. The difficulties that they had encountered in trying to recruit nurses and other registered practitioners had caused employers to consider how they could use Assistant Practitioners to improve patient experience, ensure they had the skills required and in some cases to ensure the service could remain viable:

'We looked at what we could do to provide good quality care for patients. Looked at these roles and what we could do with them.'

'Managers are starting to seriously appreciate the role "If you've got a gap recruit an AP".'

'Managers are missing a trick in not considering APs, commissioners will soon start asking questions about them.'

[Developments have been driven by a] shortage of nurses, shortage of medical staff, people are keen to see some of the functions of medical staff undertaken by advanced practitioners who are grown from nursing stock so that exacerbates the nursing shortage. And the 50 per cent growth in health visitors has also impacted this. The negative side of this is that it's crucified our nurse workforce. It just puts additional pressures into the system...we now have an army of people who will not make it onto a nursing [degree] programme, they would have made good jobbing nurses and they are [instead] making their way into Assistant Practitioner roles. Clever directors of nursing are saying "I could get these close to a nurse, what used to be an enrolled nurse". They can do a foundation degree. We are seeing the development of a band 3 and 4 workforce with the foundation degree as a positive by-product of the decision to go for an all degree nursing workforce.

LETBs

One employer listed the following range of services into which they had introduced these posts and the activities in which these staff are involved:

- **Smoking cessation service** in schools and education sessions as well as the therapeutic role
- **Learning disability service** – programmes to support health and well-being of disabled people such as how to undertake self-checking for testicular cancer. They next plan to do something around prostate cancer.
- **Intermediate care service** – actively signpost patients to other services when doing home visits such as dial-a-ride, social services care package, dealing with social isolation issues.
- **Paediatric** –initial assessments, collaboratively putting plans together.

One Trust had introduced Assistant Practitioners into a Sexual Health unit and had found these posts to be very helpful and beneficial; regarding their Healthcare Assistants who were currently going through the foundation degree the staff reported many benefits in their wards arising from their increased clinical competence and knowledge.

Employers reported a range of benefits. They described the different types of skills developed and the ways in which this allowed the Trust to use these staff. Often supervisors had allowed Assistant Practitioners to take on responsibility for a specific area of work or a clinic.

'There is some excellent practice. In emergency admission units they [Assistant Practitioners] do initial assessments and then feed [that information] up to registered staff. In Stroke rehab and acute they can develop OT and PT competences.'

'We have Band 4 in inpatient areas but the intention is that we will have them in outpatients and be able to have ambulatory responsibilities in the medical assessment unit. We would like more TAPs and APs – in the past we had TAPs successfully in orthopaedic inpatients. As an organisation we want growth in specialist clinics.'

'They would be in charge of low level clinics of all different sorts or might run coffee mornings with carers and patients with dementia.'

'We have used Band 4s very well with children with complex needs who are at home on ventilators, mainly being cared for by their parents with support from a Band 3. We introduced the Band 4 role as someone to train the Band 3s, and appointed an AP after she had taken the foundation degree. The only bit [of the training] she couldn't do – because they were delegating nurse competences - was sign off on the competences, a nurse had to do that. But the Assistant Practitioner would provide the first training, then she role models the tasks and then the nurse signs off. It's been very successful'

Employers

In focus groups Assistant Practitioners themselves identified some of the benefits that are arising from the introduction of these roles. In one area the use of Band 4 in falls prevention both in the wards and in the community was seen as a really valuable, '*commercially viable*' position for trusts. Elsewhere in the same region, the role was seen to be well suited to supporting elderly patients moving in to residential care, where Assistant Practitioners can act as '*a bit more of a friend to them*'.

In one of the focus groups a Trainee Assistant Practitioner reported that there have been Band 4 staff for several years in haematology for this trust and, while initially there had been some hostility to the role, now that the role is established, registered staff are not just supportive of the role but see its real value:

'They almost refuse to do anything if they haven't got an AP on their shift – they'll really complain... 'cause they realise exactly what we do, and that we really are there to help them.'

Trainee Assistant Practitioner

Generally it was felt that trainees brought a number of years of experience from a wide range of settings: acute surgical wards, physiotherapy assistants, occupational therapy, wheelchair assistance or accident and emergency. One course leader described how mentors in the practice settings had become aware of how the practice of trainees had developed, to the extent that this was now cascading to other people around them.

Another HEI interviewee noted that Assistant Practitioners are working relatively autonomously and across professional boundaries:

'There are some very good innovative practices and APs are quite autonomous in a way which wouldn't have necessarily been expected when the role was first introduced, and they do have a lot of responsibility and are able to transcend those professional boundaries in a ways that a registered practitioner may not be able to do.'

HEI

'We employ two Associate Practitioners in our small minor injuries unit and outpatient department. Within their role they run outpatient clinics, phlebotomy clinics and dressings clinics. They run these clinics independently, reporting back if there are any specific issues to be addressed.'

Employer

While the majority of skill development related to areas of clinical practice, some of the interviews revealed cases in which additional responsibilities had been taken on in other areas. There were accounts of Assistant Practitioners being assigned a supervisory role with first year trainee Assistant Practitioners, another who had taken on a mentoring/buddying role for students and (amongst those who had completed an NVQ prior to entering the foundation degree programme) of being trained to become NVQ assessors and who were now assessing Healthcare Assistants:

'We've had three decide to become assessors for the NVQ. The assessor training has been provided in house and it's very handy to have that as they have gone through the system themselves.'

Employer

In one case the additional role taken on by the Assistant Practitioner had helped further persuade managers of the utility of the role:

'Her off the ward training involved undertaking the Personal Development Reviewer (PDR) course so that she could undertake the role of doing PDR's in her own ward environment and her role was then 'sold' to the manager because she could do PDRs for the band 2 and 3s in her area – ie take this role off the manager. After that we started to sell the role differently.'

Employer

Assistant Practitioner roles have also been used to improve services in the community. In one case roles equivalent to Band 4 had been introduced as part of an initiative to provide integrated care for people leaving hospital and returning to their own homes. Although these roles (re-ablement officers) were employed by the Local Authority, not the NHS, they were employed on a salary scale aligned with the NHS (and on a band broadly equivalent to

that of an Assistant Practitioner), and delivered combined health and social care to help with re-ablement. In another region District Nurse Services had also used Band 4 roles to improve the service received by people in their own homes.

'There are four re-ablement officers in the re-ablement service. Initially the RO will go out with the Social Worker or OT to look at what is best for the individual, they may do a bit of goal-setting. The officer does a risk assessment, it is not domiciliary care exactly but similar. The service allows the individual to plan what needs to take place to get them back to their optimal level and improve their health and well-being and enable them to live in their own home for as long as possible. It is new but the manager can give examples of people who have been able to return to independent living. It's about how you manage highly complex cases at home with high levels of need.'

'The District Nurses were keen to develop the role. Patients were seeing a procession of people from the same service as they couldn't do routine tasks. [Introducing the Assistant Practitioners] was an 'easy win' in this team. [It gave us] enhanced skills mix. There will be more flex in team for provision of direct healthcare.'

Employers

In line with the findings from the literature, employers reported that Assistant Practitioners helped them to provide services more cost-effectively. Several pointed to the challenges they faced in maintaining services in the face of increased demand and tightened finances. Assistant Practitioners (or Associate Practitioners, as one employer had decided to call this post) were seen as vital to sustaining a quality service.

'If it weren't for Assistant Practitioners they would not have been able to keep the [breast screening] service going. There are not enough Radiographers.'

'Since I came in our workload has increased by 400%. So it's seen [internally] as a good thing. Once you get good staff [into these roles], the senior staff see that they are good and are more positive about relying on them. Band 4s are a great post [that have allowed us] to be able to make changes to how we provide our service and enable learning. The title Associate Practitioner gave it kudos that helped them to attract good staff.'

'The AP's are definitely an asset to our team. They possess the same clinical skills that we would expect from a staff nurse. It puts me in mind of the enrolled nurse role, very hands on and practical. From a manager's perspective the AP's are cost effective to employ. Both of ours work to an exceptionally high standard.'

Employers

In one case the service had been struggling with very high turnover rates for qualified nurses. Therefore they decided to re-profile the team and introduce Assistant Practitioners. This had led to a more stable workforce.

'It's gone well in Urology, the Assistant Practitioners developed from the HCA role, they have a wide range of specific skills. In regional rehab they are good too, they [the managers] looked at the difficulty they were having recruiting and retaining Band 5 nurses, [the nurses] wouldn't stay long because the work was not at the pace they were looking for, it was not consolidating their critical care knowledge. So [the managers] looked at the shape of the workforce there. They had a Band 6 leading the team, some Band 5s and some support workers. They decided to lose some of the Band 5s and replace them with Assistant Practitioners who had done the foundation degree. Those Assistant Practitioners have been given their own caseload of patients... The biggest benefit is retention. They were recruited four years ago but they have all stayed.'

Employer

Seeing the benefits brought by the use of Assistant Practitioner posts has in some cases led to other managers seeing the benefit and applying to introduce these posts.

'The APs here also have brought their special care skills and do breastfeeding support and give expressing tips... They are doing different tasks and looking after high care babies. We have extended the Band 4 role further to other teams, when they see what they [Assistant Practitioners] can do they want it, it has rolled out further than we thought it could.'

Employer

In Box 1 we describe the situation in one Trust where there has been a concerted effort by the Practice Development Lead to introduce Assistant Practitioners and to provide further continuing professional development to this group of staff.

#### **Box 1: The impact of Assistant Practitioners**

'The impact is now. One [Assistant Practitioner] leads the ophthalmology service and does pre- and post-op counselling with eye cancer patients and removes sutures. There are three Assistant Practitioners in the eye clinic, we couldn't run the service without them.

'We've got an Assistant Practitioner in oral surgery doing therapy work in the clinic; she also did the British Dental Association X-ray training as well so she does X-rays in the clinic. There are two in fracture clinics, one Assistant Practitioner there is doing plaster technician training. The Assistant Practitioners run the clinics - one Assistant Practitioner runs the 'hot' clinic (triaging, medical assessment) she will see the patient, do general observations, make a decision with the doctor re whether they are ok to be



seen the next day or require admission. We couldn't run the clinics without them.

'Another Assistant Practitioner deals with admissions in the planned orthopaedic ward. Since being appointed complaints have come down. Patients were feeling they were not involved. The admissions Assistant Practitioner admits them, takes them through what will happen, take them to their bed and settles them in, gives them a pre-op talk, accompanies them to theatre, comes to see them afterwards, does the exit chat. So they are now looking to put in more in that area given that complaints have gone down and the feedback is 100 per cent positive.'

Note that in this example the Trust has examined the impact on complaints and feedback and found that their perceptions of improvement were supported by the data. Another Trust had undertaken a pilot in which Assistant Practitioners were trained to administer medicines. The subsequent evaluation had found that the Assistant Practitioners had made fewer errors than registered staff and were contributing to improved safety of medicine administration:

'It's very safe. Those [Assistant Practitioners] who were involved in the administration of medicines pilot, they do not make as many errors as the registered staff as they are more cautious and they take their time over it and make sure they do it properly. No drug errors were made at all during the timescale of the pilot. In one case an AP picked up an error that the registered people had missed.'

Employer

At a time when attention is being necessarily focussed on cost-efficiencies it is not surprising that the opportunities offered by the introduction of Assistant Practitioners were mentioned by some interviewees. In one case, the recent move to a very large hospital had brought the need for an increase in the number of staff on duty in each shift: without Assistant Practitioners the Trust would not have been able to provide adequate staffing:

'We couldn't get the numbers [of staff] required in the skillmix if we didn't have the Band 4s, if we didn't have a Band 4 we would have to have a Band 5 and the costs made it too expensive for the numbers of staff needed [here]. So the safe and affordable way was to upskill some of the Band 3s into Band 4. They took some of the hands-on stuff done by the Band 5 that we couldn't [afford to] have a Band 5 doing.'

Employer

In addition to the responses from employers the research with Assistant Practitioners themselves highlighted the wide range of activities undertaken by Assistant Practitioners in various settings and the benefits arising from these.

In clinical settings Assistant Practitioners are acting as a triage service ensuring smooth hospital admissions by checking prescriptions are in place, blood tests are ordered and liaising between services. Many Assistant Practitioners are specialists in their work-area as they have progressed from Healthcare Assistant to Assistant Practitioner and have a wealth of experience to bring in addition to their academic knowledge through the foundation degree. As a consequence of this they often support other staff, for example new nurses.

'The new RGN's look to me for advice and guidance as they know I have worked in this area for the best part of 7 years.'

Band 4 Assistant Practitioner, Acute Surgical: Colorectal and Urology

Assistant Practitioners can free up the time of registered staff enabling them to focus on key tasks:

'I find my job very rewarding and the Assistant Practitioner role has given me more confidence and increased knowledge about best practice in some clinical skills. This role has provided me with skills that were previously only done by the registered nurse. This means that the registered nurse can provide more specialist care for example give a controlled drug promptly when required.'

Band 4 Assistant Practitioner, In-patient unit

There are also personal benefits for the people in such posts. Trainee Assistant Practitioners reported that they enjoyed the variety of work that they undertook and enjoyed the responsibility they had taken on.

'Becoming an Assistant Practitioner has enabled me to use my experience and skills to work alongside registered practitioners and support patients and their families from a holistic viewpoint.'

### 3.3 A very wide and diverse range of settings and roles

As is indicated in the previous section, Assistant Practitioners have been introduced in a very wide range of settings and occupy a great many roles. The following are some of the examples of settings in which Assistant Practitioner posts were in place that were mentioned during the interviews:

#### **Box 2: Where Assistant Practitioners are found**

Accident and emergency, acute admissions unit, minor injuries unit, acute surgical: colorectal and urology, breast care units, breast screening and diagnostic centre, care pathways (community), community falls service, community mental health team - psychosis pathway, community nursing team, coronary care unit, crisis resolution and home treatment team,

dementia, disablement services, emergency admission units, endoscopy, gastroenterology, gynaecology, haematology and cellular pathology laboratories, HIV ward, in-patient unit, integrated nutrition and communication service (INCS), intermediate care service, intermediate care, ITU, learning disability service, mental health education support, mental health, microbiology department, musculoskeletal outpatients, neurological, neuro-rehabilitation service, nuclear medicine, nursing (community), occupational therapy (community), occupational therapy, older adult care home liaison team, older adults ward, ophthalmology, paediatrics, physiotherapy (community), physiotherapy, podiatry, pre-operative assessment, pulmonary resuscitation, radiology, renal, sexual health, smoking cessation service, speech and language therapy, (community), stroke rehabilitation, stroke unit, theatres, dressings clinics, phlebotomy clinics, urology inpatient ward, urology out-patient care.

In addition to these posts in the NHS, there are now jobs equivalent to these Band 4 posts based within the community and based on health and social care competences, but, as services become increasingly integrated, employed by the local authority (rather than the NHS).

### 3.4 Making more use of Assistant Practitioners

The employers who were interviewed as part of this work reported on the range of benefits introduction of these roles had brought: quality, increased capacity, integrated care and cost efficiencies. However, developments are not uniform and factors that serve to inhibit progress were identified by the interviews.

Views about acceptable areas of work for Assistant Practitioners vary from site to site. What is accepted at one site may be viewed as too risky at another. For example, in two interviews maternity services were cited as an example of where Assistant Practitioner roles have been successful (and indeed Assistant Practitioners in one of the focus groups also said that this was an area in which they were being successfully deployed); however, a third employer said:

'... not in maternity as they don't want them - there are so many rules for this department and it can be quite litigious.'

In addition, there are different views relating to the same activity. Earlier research into the administration of medicines by Assistant Practitioners in the North West in 2012 suggested that this activity was being undertaken by Assistant Practitioners and was taking place in around a third of Trusts by 2012 (Firefly Research, 2012). The current research indicated that administration of medicines remains a contentious area – two employers reported that they wanted Assistant Practitioners to be able to undertake this activity in their Trusts, but were encountering organisational resistance in two cases, while a third had found it impossible to access training for this activity. A fourth interviewee said that the main barrier to the wider use of

Assistant Practitioners was that they could not administer drugs while another felt that the administration of medicines was a 'red line' area - this was unlikely 'ever to be an accepted part of an Assistant Practitioner's role'.

Similarly, other discrepancies came to light during the research. In one Trust, Assistant Practitioners in MRI were allowed to cannulate, but an Assistant Practitioner in Maternity was not allowed to do this. This situation appeared to have arisen because the Maternity unit had considered the issue in terms of roles (this was a midwife's role and therefore only a midwife should do it) rather than considering the issue in terms of the broad range of tasks that needed to be done (and the range of people who potentially could undertake this task). Therefore, while people in other departments had been actively encouraged to gain this competency, it was yet to happen in this department.

### 3.5 Trends and drivers

In many cases the key driver has been one person with the vision to see how these roles could work, and the energy to gain buy-in from the Directors and Board.

'At that time it was [that person in the Trust] who saw the opportunity to make Assistant Practitioners 'dual purpose' roles and give them multiple skills, eg some nursing but with some simple physio work at the weekend, or dietary advice. It was really ahead of its time.'

LETB

In many places – probably the majority - the development of Assistant Practitioner roles has tended to be reactionary rather than as part of workforce planning, for example as a response to the shortage of nurses. Many developments have been in response to national policies such as *18 weeks* and *Liberating the NHS: Developing the Healthcare Workforce*, along with the need to achieve cost efficiencies; because of this they have mostly been seen in secondary care settings to date. As an example, in the South West 87 per cent of the Assistant Practitioner roles are in the acute trust with 14 per cent based in primary care.

'They've got to be able to make the [staff] numbers work and [the introduction of] support worker roles helps them make affordable plans.'

LETB

Alongside such considerations, other drivers have included: the desire to improve services; challenges in recruiting nurses, radiographers and other registered practitioners; high turnover amongst nursing staff; widening participation; and the wish to build in alternative routes to development. All these factors have served to encourage development of Assistant Practitioner roles. As in the earlier work commissioned by Skills for Health examining the use of Assistant Practitioners in Wales, the current research

also found the recognition that technological advances mean that much of the work previously undertaken by registered practitioners now does not need someone with an honours degree:

'Increasingly we are seeing the automation of services, eg blood tests, and so I think we will see more use in Pathology Services, especially as I can't see how or why you would need to have a Band 5 registered scientist working in an automated set up. Why would we need that level of qualification?'

LETB

Many of the drivers mentioned (18 weeks, shortage of registered practitioners, the search for cost-efficiencies) have led to a majority of recent developments taking place in Acute services or planned procedures. However, the shift in policy focus to the need to manage hospital admissions (in particular avoiding the unnecessary admittance of elderly frail people and reducing the numbers of 'frequent flyers'), to improve services for people upon discharge and return home, and, most recently the focus on the provision of integrated health and social care provision (and in particular funding through the Better Together fund) has meant that the focus for developments is now shifting to community and primary care:

'Where there is more dynamism is in the community and general practice sector. Since 2002 most of the developments have been in the Acute sector and now there is a need to look at community and GP services.'

HEI

'In [this area] we are a pilot site for whole system integrated care, there are eight or ten pilots, all with AP roles in the teams.'

LETB

Assistant Practitioners are likely to play an important role too in linking care between the Trust and the community. One of the Assistant Practitioner interviewees described how her role in pulmonary resuscitation had been developed when her employer had identified a gap in services for patients with chronic obstructive pulmonary disease. Usually these patients are assigned to group pulmonary rehabilitation sessions which take place in the hospital twice a week for eight weeks. However, these are seriously ill people and if they fall prey to a cold or infection this can prevent them from leaving the house. The new role was developed to meet the needs of these people who were unable to get to the hospital for the exercise sessions. The Assistant Practitioner now goes into patients' homes to help them with exercises and education on breathing and clearing their chest. The intention is to help get them to a point where they can re-join the group sessions once again.

One of the LETBs said that they now see primary care as an important area for development, and were investing in healthcare systems in primary care

training as well as maternity services, dietetics and some healthcare science. One of the HEI interviewees suggested that a further factor influencing the greater willingness of GPs to take on Assistant Practitioners has been the movement of Assistant Practitioners into areas such as immunology, giving the role greater value.

In addition to these broader regional or national drivers the role played by individuals within organisations is key to success. Strategic support is important in championing the role. In particular if no-one is prepared to consider solutions other than recruitment at Band 5 when reviewing staffing and support levels then there is a much lower probability that Assistant Practitioner roles will gain a foothold.

'It needs someone to champion it and get behind the role development.'

'Where it has progressed well is where a person has a particular interest in this role. It cannot just be a strategic decision, you get traction where people have identified an issue or problem.'

'It's been fairly unfocussed and piecemeal and often where it's progressed well is where the person has a particular interest [in this role] or a particular risk has been identified, for example people recognising the need for investment.'

LETBs

'The AP role is potentially great and we can see the opportunities but it needs someone to pick up the gauntlet and make it right'.

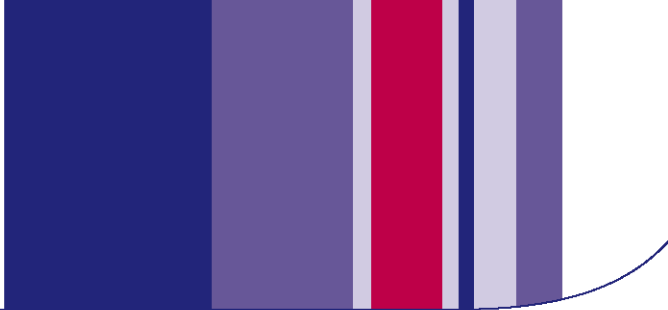
'It needs the top managers to make the middle managers see it, cascade it down and across the clusters'.

Assistant Practitioners, focus groups

## 3.6 Summary

Assistant Practitioner posts succeed where their introduction within a team meets a clearly identified need and where the new roles and responsibilities - both of the Assistant Practitioner and of the wider team - are clear and understood by all.

There is growing recognition of the value of these posts. Support staff with 'time to care' can have immeasurable impact on quality and safety and there were many positive examples of how the Assistant Practitioner role is contributing to improvements in quality, productivity and efficiency. While the focus to date has largely been in acute settings the changes planned for how healthcare is delivered in future will mean that there is likely to be an increasing focus on the need for Assistant Practitioner posts in primary and community care.



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Interviewees pointed to the wide range of settings in which Assistant Practitioners are working and the benefits this can bring. However, there is a lack of consensus regarding the clinical areas in which they are able to practice with variations from Trust to Trust. Within Trusts there can be a lack of agreement on accepted practices between departments.

At this level employers can create roles that really are multi-disciplinary. Ironically this would appear to be because the absence of registration and regulation means there are fewer constraints on what can and can't be done. In some respects, then, this is an example of where non-registration is an enabler of innovation

In the next chapter we further consider the factors that can affect the successful implementation of these posts and inhibit progress.

## 4. Implementation – facilitators and barriers

### 4.1 Key points

- Assistant Practitioner posts are more likely to be successfully introduced where their development is part of local workforce planning
- The introduction of Assistant Practitioner posts often appears to be prompted by the availability of funding rather than planning
- Many people are unaware of the existence of standards for these roles, and those who are aware of these descriptions often find them too vague to be of help
- Where the roles are successfully introduced there has been engagement with key stakeholder groups; however, often this does not happen
- Registration and regulation issues remain a barrier to acceptance; concerns around delegation and supervision largely derive from this
- The focus on registered staff in the NICE 'Safe Staffing' guidance has served to dampen enthusiasm for further extension of support roles in acute in-patient settings
- The wide variation in the roles created for Assistant Practitioners along with lack of oversight of education programmes means that individuals can find their ability to change jobs is constrained

### 4.2 Creating Assistant Practitioner posts – evolution versus planning

In many cases Assistant Practitioner roles appear to have evolved naturally over time, often as a result of Healthcare Assistant post incumbents creating a niche for themselves; elsewhere, they have been created as a result of implementation of the career progression framework or (before that) the four tier hierarchy (Assistant Practitioner, practitioner, advanced practitioner, consultant). Some Trusts had appointed an individual to lead in this area, to provide co-ordination and a coherent programme of development. One region had made early progress with introducing the Assistant Practitioner role but after reaching a peak the initiative had dropped away. They then recruited a project officer to support the further development of Assistant Practitioners, who created a toolkit for managers and a code of conduct for Assistant Practitioners. This region now has Assistant Practitioners in all of



its trusts and service providers and they are looking to roll out into primary care next.

Where these roles have really taken off is where they have been an integral part of a workforce plan. However, employers can struggle with this. In Wessex the LETB is looking at workforce development in terms of integrated care teams and what roles and competences will be required in those teams. They are looking at Bands 2 and 3 as well as those for Assistant Practitioners. In the North West, historically home to the Workforce Modernisation team (then part of the NHS NW Strategic Health Authority) the LETB has established a Workforce Transformation team to support employers with workforce planning and role development. The team has work streams focused on acute, community/integrated care and primary care.

### **Box 3: Helping organisations with workforce planning and role development in the North West**

Historically, the development of health roles in the North West was driven by the Strategic Health Authority (SHA), who ring-fenced funding for the development of new roles and so had a strategic overview of developments. The then Workforce Modernisation team was involved in developing both assistant and advanced practitioner roles across the North West: with the more recent developments a Workforce Transformation team has been established within the LETB Health Education North West (HENW) to help employers develop a workforce responsive to changes in care now and in the future.

Health Education North West have adopted a commissioning approach to enable North West Health & Social Care organisations access funding to support the development for new roles and believe that this in part explains the high numbers of Assistant Practitioners in this region. While in the past Assistant Practitioner roles had been mostly based within nursing service areas now they are seeing increased interest from across health and social care organisations. For 2015 HENW is looking to support improve skill mix across three priority areas of:

- community/integrated care
- primary care and General Practice
- Emergency and Urgent Care.

Within the North West the Assistant Practitioners are developed via a Health & Social Care foundation degree at one of three North West University providers. The HENW process for organisations wishing to access funding to support such role developments requires organisations to have:

- a workforce plan and skill mix
- support for the role development at board level

- job descriptions for the roles
- guaranteed study release and
- the guarantee of an appropriate job role based on service need on successful completion of the training.

*'It was seen as an opportunity to support role development in a service, rather than as individual development/CPD for the individual. It was about changing the service.'*

HENW actively promotes Assistant Practitioner roles and provides support for employers to enable them to embed these roles and transform the way service is delivered. The work-based education facilitator (WBEF) role has been funded through the LETB to support services in developing the roles and job descriptions; the WBEF also supports the students who undertake the foundation degree training which consists of the academic programme and work based learning element.

The LETB is now working with primary care to identify likely levels of demand and look at where the gaps in provision will be and support the development of the Assistant Practitioner and other role development that will need to take place:

*'We are doing some work with Primary and Integrated Care to ensure they are aware of the opportunities and funding available to develop these roles and support workforce transformation.'*

As a result of these activities the organisations in the North West currently send around 160-180 trainee Assistant Practitioners for training a year.

Note that the history to this particular group meant that the North West LETB has particular expertise in this approach, which may not be the case elsewhere. Other areas have decided on different approaches. For instance, while Yorkshire & Humberside has also attempted to understand what the future workforce might look like and the skills and education that will be needed for the future workforce, they have found that rather than focussing on roles per se, people instead tend to refer to skill mix issues. They are less likely to say 'we need lots of Assistant Practitioners' and more likely to say 'we want a workforce with the right skill mix'.

Others though had adopted a far more reactive role, responding to and supporting healthcare providers but not leading and noting variations in implementation of Assistant Practitioners whilst not having a policy regarding development of these posts. However there can be risks attendant upon the decision not to take a strategic view on role development. Two interviewees from the LETBs noted that where support workers are released for training in the absence of a clear role being identified there is the risk that little use will be made of the skills and knowledge developed, meaning that the funding will have been wasted; a similar view emerged during one of the focus groups:

'Part of the problem has been that organisations have failed to take a strategic view. So staff are released from work for two years to do a part time foundation degree, they work very hard to get a foundation degree and when they went back after completing the qualification there was no job for them [*ie they carry on as a Healthcare Assistant*]. So where it hasn't worked so well, you've got the person who goes back and ends up very demotivated, they have got new skills and knowledge that they can't use. And it suggests that the funding that we've put in has been wasted. It's all very well having a well inclined manager having a good idea but without the strategic buy in and the agreement to fund their uplift to Band 4 nothing happens.'

'We are paying for good education for people and not making the most of the talent.'

LETBs

'The lack of willingness to use us in the roles we have trained for is just such a waste, the two years I've done in child health, they won't benefit from it, I'll just go somewhere else'

Assistant Practitioner, focus group

This is more likely to be the case where there appears not to have been the appetite and buy-in within Trusts' management and workforce planning teams needed to make the strategic decisions required to employ Assistant Practitioners across the board, invest in the expansion of this role, review staffing and make space for Band 4 posts:

'Some areas have gone very well, others not so well. The areas in which they have not gone so well are those in which the workforce plan hasn't been as robust as it could have been and so we need to look at development around the role.'

Employer

'Where it's worked well, a Trust has thought of a role as the end point, and has thought, OK, I need somebody to fill this role, these are the competences and skills and knowledge I need you to do, so when that person then goes through the Foundation programme, they have an idea about what they're working towards. Where it's not worked well is where employers haven't really thought through what the end job looks like, so they've often got some good Healthcare Assistants, they want to develop them, they think, OK, that looks like a good course, can you go and do it. But when that person completes the course, they go back to the Trust and they find that there isn't really a job there that's been identified for them to do with their new skills.'

LETB

'We don't fill all the places we allocate for Assistant Practitioner foundation training because we haven't got the career structure right. They can't see the

benefits of sending staff to the training if they haven't got the role for them to progress into when they come back.'

'These individuals [doing the foundation degrees] are supported by the trust, they are paid for by the trust, but how their roles will look like at the end of those two years, that's a question that needs to be addressed through Workforce, and I don't think that's happening at the moment... there is no guarantee that they will be able to move into a Band 4 post once they qualify.'

Employers

As indicated in the last comment, often people see the opportunity presented by a course and send their staff on it without thinking about how any new skills developed might be used following completion. However, in several cases the main driver for decisions about the roles appears to have been the availability (and, typically, the sudden availability) of funding for an education programme, irrespective of how appropriate the line manager considered the programme to be.

'I think perhaps that developments have often been education offer-led.'

LETB

'There is no support [for my role] but they had to release me when they got the place funded, but my manager can't see the benefits for herself.'

Trainee Assistant Practitioner

In at least one case the rationale for the sudden search for candidates had never been made clear:

'The Director of Nursing said we had to pick two areas where we could possible use a Band 4 and I suggested the surgical assessment unit... I don't know why [we were asked this]... I think they needed so many people per cohort, probably the Director of Nursing was tasked with exploring ways in which the Band 4s could be used...'

Employer

In one region the LETB had made having defined band 4 roles in place a pre-condition for receipt of funding to send people onto a foundation degree programme. However, even with this requirement in place they found that the education provision that they had funded had had no subsequent impact on the work undertaken by these trainees:

'We have put hundreds of people through the foundation degree but after they have completed they have come back to band 2 and 3 roles. So there is something there about not getting the workforce planning right at the beginning. It was actually made a precondition for funding the foundation degree in maternity services that the managers were supposed to have

defined the band 4 roles before sending people onto the degree. But we found that in the majority of services, even where this was a pre-condition, it didn't happen. They went back to a traditional support role.'

LETB

This LETB had subsequently done a lot of work around use of the Calderdale Framework. In this approach to the design of new roles the idea is to look at what is needed across the clinical area rather than to look at individual professional areas; after that the skills and knowledge required for the constituent roles are considered. The interviewee noted that this has the additional benefit of helping gain buy-in from the rest of the team, an essential part of successfully introducing new roles:

'... because if you don't have buy in from them, and their input into the education design, then they won't delegate work to them when they return [from training] because they will feel it's not safe to do so.'

This is a good tool because if you look at any new role, everyone in the clinical team will be involved. It's a real discussion with every member of the clinical team, you have full buy in and all of them should feel confident that if the person completes the [specified] education they should be able to do the role. And another important thing is, the support person knows what's in and what's outside their [job] boundary and what they're competent and qualified to do and when they can say 'no'. That's all key. And there is less chance of that person feeling pressurised into saying yes they will do it when they are not confident or competent to do it. So that's another key aspect.'

LETB

For this reason, rather than recommending a foundation degree as the training route of choice this LETB instead had started to recommend that employers use the Calderdale Framework to decide on the skill and knowledge required in a role.

'It isn't for the SHA to say to employers what the educational achievement level should be, it's for the employer to say 'we need this skill and knowledge' then use the Calderdale framework and sit down with the education provider and say "Should it be a foundation degree, a higher apprenticeship, a Cert HE?" It's not our decision.'

#### **Box 4: using the Calderdale framework to identify roles, activities and educational needs**

The Calderdale Framework was first developed and implemented within the Clinical Therapy and Rehabilitation Directorate of Calderdale and Huddersfield NHS Foundation Trust. It has since been adopted by other Trusts and Local Authorities.

It is a transformational tool used to improve the way people work. It aims to provide a clear and systematic method of reviewing skill mix, developing new roles/new ways of working and service redesign to ensure safe and effective patient centred care. Implementing The Calderdale Framework provides a tangible means of addressing the quality, innovation, prevention and productivity (QIPP) agenda.

As well as providing 'a clear and systematic method of reviewing skill mix roles and service design to ensure safe and effective patient centred care' the framework also helps an employer to determine the learning route.

The process of implementing the Calderdale Framework leads to the development of a competency based training programme for staff which assures quality and safety for the patient, whilst maximising workforce capability.

Details of the Framework can be found at:

<http://www.cht.nhs.uk/services/non-clinical-a-z/the-calderdale-framework/>

The Calderdale Framework had been recommended as a way of involving all the key staff within a clinical team. Ideally though planning should involve and engage with groups more widely across a region. One LETB reported that they were talking to all of the professional groups in their region regarding how they will use Assistant Practitioners in their professional group (ie occupational therapists, physiotherapists, nurses, etc) as '*almost every profession has a version of the Assistant Practitioner role.*' Two other LETBs reported on progress made in involving CCGs in their area while a third noted a disconnect between what commissioners are discussing and what providers are doing:

'The CCGs are very keen to think about new ways of working, and innovative ways of delivering services. They are currently reviewing the delivery of health and social care through neighbourhood teams and this could include an AP role.'

'[we are] actively trying to engage with the CCGs to share the opportunities available around the different levels of the career framework and the foundation degree programmes; the opportunities available which previously would have been promoted to Acute Trusts and now to the CCGs, around primary and community care and integrated care and making sure those organisations know what's available.'

'Commissioners are talking about moving care out of hospitals and into the community but the providers are basing their five year forecasts on a traditional model of nursing, so there's a disconnect. There's a whole range of possible reasons for that: 1, commissioners have not fully exerted their commissioning leverage to date; 2, do providers fully support the notion or 3, do Foundation Trusts not want to lose patients to other providers? The language is always at commissioner level but the planning is at provider level.'

LETBs

GP surgeries are independent contractors and so technically operate outside of the NHS. As small businesses they can face particular problems in identifying support to develop their staff and in releasing staff for training. Part of the work of the AvOCET project (the Action on Community Education and Training Project) has been to support GPs to develop their workforce and introduce new roles to increase workforce and service capacity. The project also provides an example of how Assistant Practitioner roles can be introduced as an outcome of developments that allow other staff to benefit, and therefore makes introduction of the role more likely to be successful.

#### **Box 5: Developing advanced nurse practitioners and Assistant Practitioner roles through improved access to learning**

We have a primary care learning network pilot site with a number of GP surgeries participating. They have come together as a group and signed up to work to the workstreams in the project, one of which is workforce.

As in other areas of the UK they are coming to a crisis point with regard to maintaining and generating workforce, so it provided an opportunity to embed this sort of work. We are setting up a primary care network amongst the GP surgeries and this learning environment will enable them to manage education at the scale needed to develop, for example, advanced nurse practitioners. Moving the practice nurses up into that role is then likely to generate work in the Treatment Room that could support Assistant Practitioner roles.

At the moment only two or three of the surgeries employ support roles and these are similar to Band 2 or 3 support worker roles in the NHS. So development for the Assistant Practitioner role will come further down the line.

### **4.3 Roles, standards and guidance**

As we have reported in the earlier sections, often there has been no real thought given to how roles will be used in the clinical setting. Sometimes there have been rushed decisions. Unsurprisingly, then, one of our interviewees reported of the situation she found when she started to try to develop the role in her Trust that:

'There was a disjointed approach to everything for APs: training, deployment, role, CPD, job description (lack of).'

Employer

As we have noted already, there is often no real workforce planning ahead of introduction. This is perhaps understandable, as many people who find themselves in line management roles will not have had any training in such issues. Neither do many people have any prior experience of role design (or re-design). Some receive support from project officers brought in to support the development of support staff, from HR or from a Practice Development Lead, but as we saw from the earlier quotes, often the decision to offer new training and (possibly) new roles was sprung on managers with little or no consultation because funding was made available for education and training.

This might be expected to cause problems in most situations, but there is a particular problem with these roles: there remains real confusion regarding both the title and the job. Given the very wide range of areas in which Assistant Practitioners work, this is hardly surprising, especially given the fact that these roles straddle such a wide range of occupational areas and, in recent times, straddle both health and social care activities.

'People don't always understand what the role is and what it can do... and I think what sometimes doesn't help is that the Assistant Practitioner role was set up as a local solution.'

LETB

'There are still people who don't know about the role, though there are more people aware now. I used to say I was an AP and they didn't know what that was, now at least people have heard of the job title.'

Assistant Practitioner

Many interviewees commented that that the role of Assistant Practitioner in some areas still lacked clarity and consistency, despite efforts to concretise the role, and in part this problem was caused by the fact that the position itself was 'still evolving'. There was a strong consensus amongst trainees that the role definition needed work, or at least work on defining the role in different areas of service.

'My first job was to write a job description for them [for Assistant Practitioners], work out what they could do and couldn't do.... the biggest hindrance is the role is too generic, the idea of the generic worker. People want to be told very clearly what they can and can't do.'

Employer Assistant Practitioner project lead



'We can all see the vision of what an AP could and should do and the skill mix we could accommodate but there are massive inconsistencies even within the same trust.'

Trainee Assistant Practitioner

'Sometimes workplaces don't understand the role, even though you've explained it [and] local education boards are funding it, there's a missing connection.'

HEI

Many interviewees felt it would be helpful to have core competences available nationally as a base for the role, with additional competences available according to job role or specialism. Core competences for Assistant Practitioner roles were developed by Skills for Health several years ago. In stating such requests it appeared that many are unaware of the SfH standards.

It is worth noting that while most HEI interviewees who knew of the standards felt that they were clear and underpinned course learning objectives, employers were less clear. One interviewee who was aware of the existing standards had used these as a basis for some early development work, but now felt that the SfH standards were *'elderly and due for review'*.

Some employers have done a lot of work to develop their own toolkits to help with the development of new roles. United Lincolnshire Hospitals is one of the regions that undertook work early on to agree Assistant Practitioner skills and competencies and assessment frameworks. Since then the East Midlands has developed a Toolkit for developing Assistant Practitioner roles with much of the material derived from the original Lincolnshire material.

#### **Box 6: the United Lincolnshire Hospitals Guide to Assistant Practitioner role development for managers (extract)**

##### **Workforce Planning and Role Development**

Workforce planning is vital in the recruitment process. Development of the role must come prior to any consideration of who may be an appropriate candidate for such a role – remember, **ROLE FIRST!**

It is important to remain focussed on:

##### **1. Why the role is required**

Identify how the appointment of an Assistant Practitioner will contribute to service development and benefit the quality of service for patients. It may be helpful to consider aspects of 'gaps in service' when considering specific skills and competence development, and relate these to patient care or the patient journey/pathway.

## **2. The role relationship with others in the immediate and multi-disciplinary team**

As a team exercise, it is helpful to examine and challenge preconceived ideas of what makes up 'registered practice' against 'non-registered practice' when defining the potential role of the Assistant Practitioner in the clinical area. It is vital that the clinical team as a whole understand the reasons for and are involved in supporting development of the Assistant Practitioner role.

## **3. What the intended outcomes are**

Include skills and competencies necessary to support the role. Identify how these will support the intended outcomes.

## **4. Clarity around duties and responsibilities of the role**

Ensure specific skills and competences are included on the core job description for a qualified Assistant Practitioner at band four.

## **5. Impact on the wider team**

Identify stakeholders (to include close colleagues and team members) who may be affected or who will be required to support the appointment of the Assistant Practitioner role. Consider, for example, the wider multi professional health care team, other wards and departments and community services.

## **6. Cost implications of role development**

Demonstrate that there is adequate and appropriate support for such an appointment. Do not forget that trainee Assistant Practitioners are paid on a band three until completion of training. As such, there may be a little more flexibility in terms of managing staffing establishments during that period.

## **7. Understanding requirements for the training and development of role**

For trainee Assistant Practitioners, this includes:

- day release for distance learning study requirements
- minimum of one supernumerary day in practice
- support in the work place from colleagues and team members
- clinical competence development
- requirement for a work-based mentor.

For qualified Assistant Practitioners, this includes:

- preceptorship
- additional competence development/acquisition of new skills

- CPD and appraisal
- clinical supervision
- career progression.

### **8. Consideration with regard to governance policies, procedures and guidelines**

Consider roles previously undertaken only by registered practitioners and how these are now appropriate as part of Assistant Practitioner role development.

There are challenges and considerations to be aware of when developing the Assistant Practitioner workforce.

Changing the duties of staff can lead to feelings of uncertainty and job insecurity for others in the team, especially if they feel the changes will affect elements of their individual roles.

There may be a need to challenge traditional perceptions and role definitions of how Assistant Practitioner roles may function. Role change in one area may affect service delivery because of changes to supervision or delegation. Making clear identified outcomes of developing appropriate support when starting to plan for Assistant Practitioner role development will assist in engagement of and communication with staff. This will ensure planned changes meet the required outcomes.

Source:

[http://www.ulh.nhs.uk/for\\_staff/education\\_and\\_training/clinical\\_education/assistant\\_practitioner/developing\\_role.asp](http://www.ulh.nhs.uk/for_staff/education_and_training/clinical_education/assistant_practitioner/developing_role.asp)

The research was conducted at the same time that the Trailblazer apprenticeship standards were being developed. Some thought that when published this new standard might effectively become 'the standard' for Assistant Practitioners and obviate the need for any other standards. It is anticipated that the Trailblazer Apprenticeship will be available to the sector in 2015<sup>13</sup>.

In addition to guidance on role development many people felt that a clearly defined Scope of Practice was of key importance in gaining greater traction in rolling out these roles. However, a major stumbling block remains the very wide range of clinical and social care areas in which Assistant Practitioners work and the activities each is likely to engage in.

Radiography is one of the areas in which Assistant Practitioners are most established and its Professional Body, the Society and College of

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<sup>13</sup> Note that in the meanwhile the existing apprenticeship framework for Assistant Practitioners remains in place.

Radiographers, has set out a scope of practice document for Assistant Practitioners. There are separate descriptions for Assistant Practitioners working in therapy and diagnostic settings. Of interest is the fact that the Society has given descriptions of both the activity that is within and that which is outside the accepted scope of practice for Assistant Practitioners.

**Box 7: Extract from the Scope of Practice for assistant practitioners in clinical imaging (Society and College of Radiographers)**

**Assistant Practitioners in clinical imaging**

(i) Radiographic imaging

The Department of Health project that examined skill mix in clinical imaging concluded that the activity of the Assistant Practitioner would be restricted to undertaking plain film radiography (standard radiographic imaging) under the supervision of a registered health care practitioner (radiographer or radiologist).

One précis example from the Scope of Practice in standard radiographic imaging includes:

- appendicular skeleton
- axial skeleton excluding skull and cervical spine (see below)
- chest and thorax
- abdomen and pelvis.

The skull and cervical spine are excluded if they are to be imaged as a result of trauma. Best practice suggests that computed tomography is the most appropriate modality and technique to be employed. Imaging of the cervical spine in trauma poses a specific risk and therefore should be carried out by experienced radiographers.

Imaging of the orbits prior to magnetic resonance imaging (MRI) to exclude the presence of metal foreign bodies is acceptable provided that additional training has been given. Similarly, following additional acceptable training, Assistant Practitioners can be accredited for undertaking dental radiography in adults.

**Practices outside the scope of Assistant Practitioners in radiographic imaging**

There are a number of situations in which the responsibilities related to radiation protection and patient care are considered to be beyond the Scope of Practice and role of the Assistant Practitioner.

**The examination of patients with major trauma**

The scope of practice is limited to the 'adult, ambulant patient' who is 'conscious, co-operative and communicative'. For the severely injured, it

likely that modifications to projections or techniques may be required. This requires that an experienced radiographer undertakes these examinations.

The role of the Assistant Practitioner is restricted to working under the direction and supervision of the radiographer undertaking the examination. This applies equally to working within the main department or within the accident and emergency department.

(Other exclusions under radiographic imaging relate to working in Mobile x-ray units in areas remote from the main department)

Source: [www.sor.org/printpdf/book/export/html/6714](http://www.sor.org/printpdf/book/export/html/6714)

### Recognition of the role

We have noted the fact that many managers are not yet familiar with the role. As numbers increase this is likely to change and improve. However, it should be noted that patients too can be confused by the role.

Some Trusts had introduced uniforms in a different colour to identify the Assistant Practitioner role and help both patients and staff to discriminate between different staff groups.

'They have a differently coloured uniform from HCAs, so they're more visible and they look different.'

Employer

This may appear to be a minor point but several of the Assistant Practitioners and trainees felt this made a real difference: many of the focus group participants felt that a separate uniform would help give them a distinct and separate identity and would make it easier for patients and others to see that they differed from Healthcare Assistants.

'It's not to say you're any bigger or better, it's just having that identity enables other people to know that you can actually do a bit more'.

Assistant Practitioner

## 4.4 Winning hearts and minds

We noted earlier on in this report that there is a mixed picture regarding strategy. In some institutions there are keen and enthusiastic individuals promoting these roles, and, while they may have support from the top, in the absence of a directive developments can be piecemeal and vary from department to department. Even where an organisation has made the decision to introduce these roles, individuals in key roles may have the ultimate say, and thus the situation can fluctuate with personnel change:

'In tissue viability, this started out being good [ie an area in which APs were to be introduced], then a new Tissue Viability lead came in and said no, they don't even think nurses trained to a diploma can do this, only nurses with a degree. But now she's left, so we're off again [ie progressing APs in this area].'

Employer

There remains an issue around professional boundaries. One Assistant Practitioner said that 'real resistance' had come from the sisters on her ward and her manager, who initially did not understand the role and '*the more they understood, the more against it they were*'.

Such resistance is seen even in the absence of any real threat. As several interviewees noted:

'We are approaching a perfect storm in nursing – we can't increase commissions but we need more nurses. We are crying out for experienced people in the workforce, what about APs?'

'People were saying 'they'll steal our jobs' and I said 'what jobs? We can't recruit nurses!'

Employers

It is true that in some cases Assistant Practitioners have been used to undertake tasks that have traditionally been the remit of nurses and other senior staff (as we reported in the earlier sections above). However, more interviewees reported on the challenges faced across England in recruiting nurses and saw Assistant Practitioners as a way to resolve that challenge, rather than primarily seeking to replace nurse posts (and indeed some saw Assistant Practitioners as potential future nurses, although there was not consistency on this point).

It is therefore unclear whether there has been a failure to reassure nurses in such situations or if fears remain despite assurances. Irrespective of which is the more likely explanation, clearly there is a need for more effort to be made to communicate the way in which managers plan to incorporate Assistant Practitioner roles into existing teams and, perhaps more importantly, the opportunities these changes would bring for development and involvement in higher added value activities for the registered staff.

'[Our] awareness of the future shortage of registered staff and our workforce risk assessment had identified the problem with ageing staff. And nursing is becoming increasingly clinically professionalised so a skills gap was emerging at higher levels, I think we don't articulate that very much. So it's not about cost cutting.'

Employer

Regarding the potential for more involvement in higher level activities, one interviewee reported that it has been estimated that around 60 per cent of a nurse's role does not need a degree-level qualification. It is hard to believe that nurses would prefer to retain responsibility for those tasks if there is an opportunity to take on more work requiring advanced skills. There is clearly more work to be done to communicate the opportunities that could arise from some tasks being devolved downwards.

## 4.5 Registration, regulation and scope of practice

Within the health service, most<sup>14</sup> clinical personnel at Band 5 and above are registered and regulated. After following an approved programme of education a practitioner can apply to their relevant body for registration. At this point they are given a personal identifying number from the register. An employer or client can check the practitioner's credentials and licence to practice via this 'PIN'. A practitioner who breaks their professional code of practice can be brought before a disciplinary board and, if found guilty, can have their personal number removed. At this point, they lose their ability to practice.

Although the Francis Review recommended registration of Healthcare Assistants and Assistant Practitioners the UK Government's response was that they not feel this was necessary. They felt this was best left to employers to arrange, should they wish to do so. In light of Government policy, Skills for Health's position on registration remains one of neutrality.

The views of many in the health sector, however, remain at odds with that of the Government. As in the work in Wales, many of the interviewees – LETBs, employers and Assistant Practitioners and trainees – pointed to the lack of registration (and hence regulation) as a major obstacle – sometimes the major obstacle - to acceptance and establishment<sup>15</sup>.

'They should be [registered]. They need to be, for their own and for the public's safety. The care certificate will mean nothing unless there is a way of maintaining a register. There is nothing to stop a person [who has behaved badly] just moving to another organisation.'

LETB

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<sup>14</sup> We understand that following introduction of AfC some support staff were appointed to Band 5. We have been unable to ascertain whether this remains the case.

<sup>15</sup> Whilst the comments from respondents were elicited in relation to Assistant Practitioners, it should be noted that many are applicable to all support workers in clinical settings not just those working as Assistant Practitioners.

'Any of the nurses, they would say registration and regulation. No matter how much education we give them they still would like registration.'

'If they don't regulate it they're never going to be accepted. All of my Assistant Practitioners would like to be regulated. Otherwise they will always be at the mercy of the organisation and the line manager deciding what they can or can't do.'

'The one really crucial issue is governance and accountability, and people got very hung up on the fact that the Assistant Practitioner wasn't regulated.'

Employers

Although it was not a direct focus of this research, in the interviews and focus groups with trainees and Assistant Practitioners the participants spontaneously referred to the problems that lack of registration brought. There was unanimity that accountability and not being registered are the biggest issues holding back acceptance of the Assistant Practitioner role. There are several components to this point.

First, all support staff have to be supervised by a member of registered staff. Questions are still asked about the extent of supervision required for Assistant Practitioners and whether this has to be direct or can be indirect. Arising from the supervisory requirement there remains concern amongst many professionals that this means that they would be held legally accountable should the unregistered staff member make a serious mistake and, in extreme situations, could lose their own registration. Thirdly, there is uncertainty about the nature of the tasks that may be delegated. And fourthly, there is a view that registered staff feel that education or training that does not lead to registration lacks credibility.

What emerged from the current work that has not previously been raised as an issue is that without registration and regulation of an occupation it is difficult to exert control over the education and training that is provided and thereby ensure consistency. Where a professional body regulates a profession they can control the content of education programmes through a process of validation.

It was the LETBs who regularly referred to this point, and the fact that in the absence of registration it is not possible to prescribe content. In addition, they believed that registration would help with better integration and progression between foundation and honours degree programmes:

'Overall there is access to the role, progression and competences for the AP but how we deliver that education varies. And nursing and therapy education have much more rigidity because of their professional requirements, what education for a registered nurse or therapist has to deliver. So if APs were regulated it would help tie it together because it would have a governing body that would help specify what needs to be delivered.'

LETB



The Society and College of Radiographers has led progress in regard to a public voluntary register. They have had a system of voluntary registration for Assistant Practitioners in place for some time and this continues to be developed.

**Box 8: Society and College of Radiographers voluntary registration for Assistant Practitioners**

All members of the SoR benefit from Professional Indemnity Insurance (PII) as an element of their membership. Following a review of arrangements with their insurance provider the Society of Radiographers felt it was prudent to ensure that details of assistant practitioner members' scope of practice was an accurate and up to date reflection of their clinical duties and in particular provided assurance that Assistant Practitioners were working within their scope of practice (see Box 6).

To achieve this, the SCoR announced that any Assistant Practitioner in membership not accredited and with their name on the public voluntary register after September 2014 would not be designated as an Assistant Practitioner on the membership database; they could only be designated as a radiographic assistant, and if they were not registered their Indemnity insurance would be restricted to the activities of a radiographic assistant, thus limiting the activities for which their PII would be valid. This would largely, though not exclusively, pertain to the irradiation of patients.

*'This was followed by a campaign to get all the Assistant Practitioners registered. It was widely publicised, with managers in particular being targeted as well as to APs and other members. Initially the managers questioned why we were doing this but once they had more information they were very supportive of it - they feel this is the right way to go and fits in with their own assurance processes. From the perspective of registered radiographers, too, there was a benefit, as for their indemnity insurance to be adequate they have to be confident that they are supported by people working within their scope of practice. Assistant practitioners who are not members are able to apply to be accredited and have their name retained on the public voluntary register for a fee. They do not benefit from the PII or other SoR membership benefits.'*

The Society did receive some comments from a minority of APs, along the lines of 'what if I don't do it, you can't make me' but, as the organisation observes, their managers can require them join the register (short of becoming a member) if they deem this necessary for departmental quality assurance. In fact, though, the Society is unaware of any manager having to use formal sanctions. The organisation received around 500 applications for registration up to September 2014.

As a result, they have brought in a system of voluntary registration that is growing and brings benefits to patients, individual staff and employers through a quality assurance process that provides evidence of original training and demonstrates continuous professional development. Indemnity

insurance was raised as a relevant issue by employers too. One interviewee noted that:

‘Once an Associate Practitioner is qualified they are autonomous on a defined group of processes. Some of the Biomedical Science staff do biopsy transfer and specimen description but a Band 4 could not do this - if they have the competency they should perhaps be able to do it but we don’t allow them to do this until they [have progressed to] B5 and are HCPC registered. It’s to do with our indemnity insurance as much as anything. So there is autonomy within the line management structure – the HCPC registration shows you’re safe, you can be left to work on your own.’

Employer

Not everyone felt that it was necessary to have registration in order to ensure safe or consistent practice however. One LETB observed that:

‘There are a lot of industries where people aren’t regulated but they are very well trained to do their job. But the issue of regulation is still where clinicians, regulated staff and organisations such as the unions etc still are not as flexible as they should be.’

LETB

Nonetheless many of the professions and employers did recognise these concerns about the lack of registration and had attempted to counter them by making sure they have clear governance structures in place or by making it clear what decisions can be made by the Assistant Practitioner. For example, one LETB reported that:

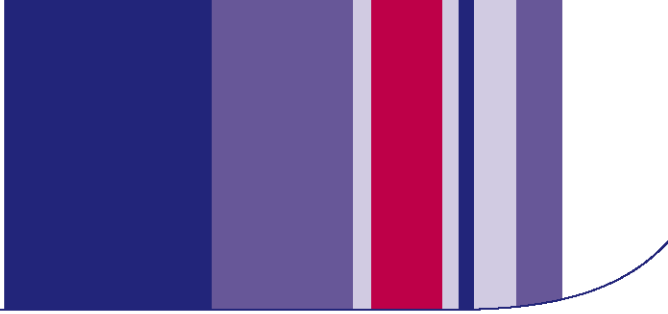
‘The Assistant Practitioner in the community can only visit certain people who are stable, or they can only do so many visits before they must have a registered practitioner reassess what’s going on.’

LETB

This mirrors the directions set out in the Radiography Scope of Practice which limits Assistant Practitioner working to those lower risk patients. In Occupational Therapy, following training an OT assistant would similarly be allocated low risk assessments. They would not be allocated complex or higher risk patients such as the frail elderly. The OT would then meet with the assistant every two weeks or so to go through their cases, make sure there are no problems. It is also emphasised that assistants should understand that if they are ever unsure about anything then they must check with their supervising OT.

#### **4.5.1 Achieving consensus on scope of practice**

Employers within the health sector operate in an environment where they are required to minimise clinical risk and as such the introduction of new



innovative roles can be difficult, particularly where people are ‘breaking new ground’ for organisations. Many participants provided anecdotal evidence of where clarity around the scope of practice for Assistant Practitioners would be helpful.

Piecemeal developments of Assistant Practitioner roles mean little joined up thinking about provision of specialist training and wariness regarding what would be considered acceptable if the decision is made to design internal training.<sup>16</sup>

One such example is administration of medicines. This had been successfully introduced in one of the Trusts we spoke to, and a report of the introduction of this activity as an agreed Assistant Practitioner role in Manchester was published in 2012, so this is neither a new nor an isolated development. Despite this, there were two sites where this area of activity was proving difficult to introduce. In one there had been an initial successful pilot, only for the work to be stopped after that point following objections from the Pharmacy department; another was still at the point of *‘fighting with the trust to develop a medicines administration module, but need to get it through Governance’*.

In another case, a manager who had been asked to release a Band 3 to attend the foundation degree had said she would do so providing the programme included a module on administration of medicines and was given that assurance. The Healthcare Assistant in question had now completed the programme, moved into the Band 4 role but the promised training in medicines had still not been provided, making it impossible for the individual to act in the role that had been planned for them.

The lack of national consensus regarding specialist activities is likely to impede planning for provision of specialist training.

## 4.6 Supervision and delegation

As we have indicated in the earlier sections, Assistant Practitioners work under the day to day supervision of a registered member of staff. This can vary in nature and does not necessarily mean direct ‘line of sight’ supervision. A typical model would see the Assistant Practitioner undertaking tasks for which it has previously been agreed that they are competent to do, possibly with sign off at the end by a registered practitioner (as in the diagnostic imaging example) or reporting back to the supervisor if there are any specific issues that need clarification or confirmation (as in the community-based model). This latter model is often referred to as indirect or proximal supervision.

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<sup>16</sup> We note that the Calderdale Framework encourages employers to decide on training ‘from scratch’ but recognise that the reason for many employers seeking Foundation degrees is that these are accredited and therefore are viewed as having more credibility than internally-designed programmes.

In addition, in most settings clinical supervision is also often available. In contrast to day-to-day supervision clinical supervision is focussed on the development of clinical practice.

In the absence of a clear scope of practice departments and/or individuals are required to agree the tasks that will be delegated. A registered staff member will then typically be responsible for supervision of the individual who has taken on the delegated tasks. Some employers have also taken steps to counter concerns by making sure they have clear governance structures in place or by making it clear what decisions can be made by the Assistant Practitioner and which by the supervisor.

Nonetheless the RCN has particular fears on this point. They believe that Assistant Practitioners are being asked to make clinical decisions that should only be undertaken by nurses. They feel that the way in which the role was originally set out means that there is '*lots that is up for interpretation*':

'APs are being told to make too many judgement calls, on their own – the only decisions they should be handling is where it is a choice. This all needs unpicking and clarifying. It is all about the context.'

Nurses were believed to have particular fears that some of the activities they were being asked to delegate were at the riskier end of the spectrum and in particular that they would be held accountable if the unregistered practitioner made a mistake. This is not helped by the fact that supervision appears not to be adequately covered in undergraduate programmes, and later development varies from trust to trust:

'... partly, I think people felt uncomfortable that as a registered nurse you would be delegating potentially quite significant decision making or administration of drugs and things like that to somebody who wasn't regulated in any way.

LETB

'Because they are not registered and regulated they don't have anything that tells them what they can or can't do and they [the nurses] do not understand appropriate delegation. We spend a lot of time feeding back to the HEIs that they need to say a lot more about clear and appropriate delegation, but they don't seem to do anything and the nurses still come out not understanding it.'

Employer

There appears to be a difference between nurses and the allied health professions regarding supervision, with allied health professions appearing to be better able to deal with the issues around delegation and supervision (and note that in the case of radiographers this is aided by the scope of practice policy).

'In undergraduate courses, supervision is a huge issue, [But] if you compare nurses with newly qualified allied health professionals, the AHPs have a clear understanding of what supervision is whereas nurses don't, so there's something around the training. But it's not necessarily to do with the university. Where nurses are going through preceptorship they would get guidance at that point, but [what they get] it's dependent on an individual trust or organisation defining how to deliver training to qualified staff.'

Employer

The College of Occupational Therapists has a section on delegation in its code of ethics, which was developed jointly with the College of Physiotherapists. The NMC also has a statement on delegation<sup>17</sup>.

**Box 9: Delegation – extract from the College of Occupational Therapists' Code of Ethics**

5.2 If you delegate interventions or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating occupational therapist, retain responsibility for the occupational therapy care provided to the service user (HPC 2008, standard 8).

5.2.1 You should provide appropriate supervision for the individual to whom you have delegated the responsibility.

The College expects supervision to vary with the level of experience of the support worker in question and recognise that some are mature people 'who have been doing the job for years and are competent and often support newly qualified staff'. In the majority of cases it is the OT supervisor who will have trained up OT support workers/Assistant Practitioners. Therefore the judgement regarding the competence of the person to whom the task is delegated is usually made by the member of staff who would have been responsible for the training in the first place, '*so if they were not competent it would have been dealt with earlier*'.

The previous comments relate to day-to-day supervision of activities. One employer was also beginning to explore possible alternatives to the one-to-one clinical supervision model for Assistant Practitioners. They said:

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<sup>17</sup> <http://www.nmc-uk.org/Nurses-and-midwives/advice-by-topic/a/advice/Delegation/>

'We are developing a different approach. What we are thinking about at the moment is trying to move to group supervision. Well, a mix of 1:1 and peer supervision - it is almost like a learning set. The thing is, because the workplace is so busy, they can't really become self-sustaining unless you have a facilitator role. As a group they need facilitation so my team performs this role. So we engender peer support and they recognise when they need more support [and seek guidance].'

Employer

Note that the CQC has recently published guidance on clinical supervision<sup>18</sup>.

## 4.7 Safe staffing

Just before this research commenced NICE (the National Institute for Health and Care Excellence) published its review of safe staffing levels in adult in-patient wards in acute hospitals. These are the wards in which much of the role development for Assistant Practitioners has taken place. The review focussed exclusively on the numbers of registered nurses that should be available during a shift to ensure patient safety.

While the report had sections that advised on the organisational strategy and principles that should be adopted to ensure safe staffing levels, these focussed purely on nurse numbers. It is unsurprising then that many interviewees alluded to the impact that the safe staffing review had had on decision making around Assistant Practitioners:

'They look for reassurance that they are running a safe organisation. What gives them that, it's looking at bed ratios. It's not wrong but it is simplistic, a simple way of giving evidence of compliance with the 1:8 ratio. At some stage the Nursing Director is going to be put on the spot and asked 'do we have a 1:8 ratio?' Boards are always looking over their shoulder but it is partly looking for reassurance and if the Nursing Director says 'Actually, no, we're doing something different' it will make their hair turn white.'

LETB

This sole focus on nurse staffing levels in some areas has consequently had a negative impact on the roll-out of Assistant Practitioner roles:

'It's meant that people have asked for more registered nurses, because what our Trusts have tended to do is to look at the guidance of one nurse to eight patients, review their skill mix and said actually we're really short on registered nurses and that's the area we need to develop.'

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[http://www.cqc.org.uk/sites/default/files/documents/20130625\\_800734\\_v1\\_00\\_suppoting\\_information-effective\\_clinical\\_supervision\\_for\\_publication.pdf](http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_suppoting_information-effective_clinical_supervision_for_publication.pdf)

'We started with reasonably large cohorts [of Assistant Practitioners], they dwindled as the priority focussed on developing nurses not APs, and it lost momentum. We are concentrating on increasing nurse numbers and the media has not helped in promoting the AP role because of the derogatory comments on healthcare support workers.'

'[The NICE guidance has] been interpreted as setting a new currency around the registered nurse. So arguing for a different staffing mix, increasing the number of B4s is difficult and it is a case of swimming against the tide at the moment. But we still have a shortage of Registered Nurses, so they are going to have a bit of a problem if they are now setting out to have more Registered Nurses while not keeping up with [existing] recruitment.'

LETBs

Many interviewees believed that Assistant Practitioners could make a real contribution to ensuring safe staffing levels. However, in line with our initial hypothesis, the impact of the NICE guidance does appear to be making Trusts wary of looking at total skill mix rather than nurse numbers per se.

#### **4.8 Transferability (portability of qualifications and experience) and testing the job market**

Very few of the employers reported that they had attempted to recruit Assistant Practitioners directly (ie recruit people already working as Assistant Practitioners, perhaps from neighbouring employers); to date most organisations had nearly always 'trained up' existing staff. Assistant Practitioners and trainees also commented on the rarity of Assistant Practitioner posts being advertised.

One problem arising from this is that there is little learning or 'cross fertilisation' of Assistant Practitioners from different departments, organisations or areas. One LETB interviewee observed that:

'Normally these workers are not as fluid as the regulated workforce [ie they are not as mobile as other staff groups]. If they were to move you wonder how transferable the employers would think their skills and qualifications were.'

LETB

We found only a few examples where employers had experience of taking on Assistant Practitioners and it was not possible to gain a clear view on the current transferability of training and qualifications.

Because of the lack of experience of recruiting to these posts, few employers had a policy regarding ensuring the competence of external recruits: one said that they had initially just routinely re-trained and '*gone through all the necessary*' but now they observed performance using a log of

performance and evidence. One of the best developed examples of policy and practice regarding recruitment and ensuring competence is shown in Box 10, below:

**Box 10: Ensuring competence in the Cellular Pathology Laboratories at University College London Hospitals Foundation Trust**

*'If we recruited an associate practitioner or other qualified member of staff we would skill test the recruit when they came in. We would not do a full competency development procedure but would do [the equivalent of] an end assessment. We would also ensure that they understood the equipment they're using.*

*'We also have a system of refreshing competences if someone is off for say six months, on maternity or sick leave. This is part of our accreditation requirements under the Clinical Pathology Accreditation scheme.'*

Similarly, another employer said:

*'Yes we do verify [their competence]. We have a couple of schemes to do this. One is a programme called the fast track programme, it's like the preceptor package for the newly qualified nurses, looking at all aspects of patient care and what we want them to achieve in 3, 6, 9 or 12 months. We recruit them as an HCA and then put them on the fast track. They have to reflect on what they do, produce a portfolio of evidence, take part in action learning sets, we meet with them one to one and they meet with their mentor, and then once they get through we pay them as a Band 4.'*

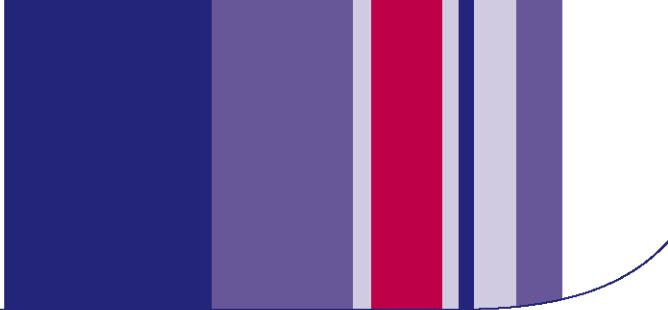
Employer

Given the shortage of evidence at present, and the issues around lack of oversight of these programmes given that they are mostly not accredited by the relevant professional bodies (note that the College of Radiographers has accredited foundation degrees in the past but the number of accredited courses is declining) it is not possible to comment on the extent of transferability of these roles.

### **Impact of non-transferability**

The primary problem arising from the non-transferability of these posts is that the Band 4 role is viewed primarily as a development opportunity for individuals rather than as a result of workforce planning (ie, having meaning in and of its own right). With training typically taking at least two years to complete, and in this era of organisational change, interviewees pointed to the danger that roles planned at the outset may have disappeared by the time the training is completed. Increasing the movement of existing Assistant Practitioners would therefore also bring benefits in that people could be recruited quickly, removing the chance that the role will disappear before a candidate is trained.





The relatively stable staff base for these roles has further implications. A stable staff base (low turnover) results in less demand for training, which in turn has implications for the sustainability of training. There are already relatively small numbers on the foundation degrees and we note in section 5.1 the decline in specialist programmes such as those for radiography and the questions this raises regarding the appropriateness and relevance of some of these programmes. While staff churn has cost implications for employers, some churn is needed to ensure that training routes remain viable.

Lastly, the lack of movement of Assistant Practitioners means that the only option for many may be to become very specialised - perhaps over specialised - in just one role. This serves to make it even more difficult for them to move roles. Several commented that with no further progression available other than through pre-registration training, some Assistant Practitioners were being paid less than their level of expertise would suggest was appropriate.

### **The involvement of CCGs**

We started this work thinking that CCGs would be key players in promoting these roles, through their commissioning responsibilities. Indeed, some of our employers agreed with this point of view, whilst noting the challenges:

‘CCGs are critical to these developments – we work with all eight in North West London. We have got to join up workforce planning and education and service commissioning. But it is hard work.’

‘Managers are missing a trick in not considering Assistant Practitioners, commissioners will soon start asking questions about them.’

One LETB reported that it was:

‘... actively trying to engage with the CCGs to share the opportunities available around the different levels of the career framework and the foundation degree programmes; the opportunities available which previously would have been promoted to Acute Trusts and now to the CCGs, around primary and community care and integrated care and making sure those organisations know what’s available.’

Another LETB said that in their region the CCGs are very keen to think about new ways of working and innovative ways of delivering services. They are currently reviewing the delivery of health and social care through neighbourhood teams and this could include an Assistant Practitioner role.

Despite these comments, though, the great majority of employers and LETB interviewees reported little current involvement of CCGs, with a typical comment being that ‘*Links with CCGs as service commissioners are at an early stage.*’

## 4.9 Summary

The research confirmed many of the findings from previous research: implementation is more likely to be successful where role design is as part of an overall workforce planning procedure. In particular, ensuring staff engagement with the process, and ensuring that all grades of staff benefit from the changes, are central to success. However, the research indicated that very often these roles are introduced as individual initiatives and often those who lead the initiative have a battle to persuade key gatekeepers of their value.

At present, some employers are able to choose an education route that is right for their service: foundation degree, Higher Apprenticeship, HE Certificate. However, some employers are concerned that those making decisions about the education pathways to fund, or not, do not fully understand the Assistant Practitioner role and what route would be best for their service. As with the variety of settings that Assistant Practitioners work within, similarly there is a variety of routes that potentially might be suitable.

The research revealed that there remain concerns around delegation and supervision and the lack of registration and regulation, although there are notable differences between occupational groups. Some organisations have started to make real steps to address these issues, with a great deal of success and these potentially provide a model for further developments in future.

Arguments in support of regulation and registration put forward by our research participants included:

- parity of esteem, credibility
- accountability and protection for the organisation (as staff could be removed from a register)
- management of risk
- to exert control over content of training.

One impact of the piecemeal approach often seen to development of these jobs is that they are viewed as development opportunities for individuals rather than roles required by teams. Consequently there appears to be very little movement between Assistant Practitioner jobs at present. A lack of oversight or validation at national level of foundation degree programmes for these roles is suspected by many of further inhibiting movement of qualified staff.

## 5. Education and training

- There is a wide range of education and training routes available; foundation degrees appear to be the qualification of choice at the moment. Other options include apprenticeships, HE Certificates and Diplomas and NVQs
- Employers' decisions about the optimal education or training route are largely informed by funding availability
- Employers seeking to introduce Assistant Practitioner roles would like information about the education routes chosen by other employers but find it difficult to obtain this information
- Several LETBs have concerns regarding the value of foundation degrees; some have ended funding for this route
- Specialist foundation degrees are being closed by HEIs and replaced by programmes with common cores and specialist modules; however, fluctuations in trainee numbers, changes in commissioning and reductions in funding have led to some of these programmes closing and fears about future sustainability

There is no standard route to becoming an Assistant Practitioner. As the role is not regulated there is no prescribed education or training route, although there are the recommendations associated with the career development framework. Consequently:

'There are lots of people working at Band 4 without qualifications and lots of people with the qualification without a Band 4.'

Assistant Practitioner

Because there is no prescribed education or training route there is a very wide range of approaches taken to developing individuals for these roles. It is also one of the issues that causes concern for institutions wishing to introduce or extend Assistant Practitioners. One of the employers to whom we spoke during the research had a small number of Assistant Practitioners and was hoping to expand their use. In order to support these developments they had appointed a project officer to investigate the education and training options provided by other organisations so that they could identify the optimal training route. This organisation had previously made use of the foundation degree route but had found this to be 'a bit generic'. Therefore they wanted to find out:

'... if there is any good practice/evidence of what works 'out there'. I am trying to evaluate the options, what other training people have had to have, to pull out that information to inform our planning.'

While there has certainly been great progress made in terms of improving the access to development for support staff (and this is of course the focus of current HEE policy<sup>19</sup>) there remain areas that have not done very much in this regard. One LETB suggested that this is linked to cultural issues:

'There is still an issue around education and training of support staff, we've done a lot of good stuff in the region but there are still cultural issues [they think] 'We don't really need to invest in them, should we be creating higher level support staff, they're not regulated'.... From a productivity point of view we need to start to think differently, as for example with introducing Physicians Assistants in primary care, as we can't recruit GPs. How do you meet that demand, we have to start getting people to think differently, get over the hang up on regulation, and professional boundaries are barriers to that.'

LETB

However, it is just as likely that managers may not know how best to approach training. As two interviewees noted:

'Managers might say 'I want to recruit a qualified AP, what do I need to put in the advert?' and then we might not hear from them until they realise they're not getting the level [of performance] they want. Then we issue the competency pack. Now for every new person that comes in we work out what education and training level they're at and what they need.'

'I think we have to every time support the line manager in understanding what's involved in these roles.'

Employers

## 5.1 Foundation degrees

On the basis of the current interviews undertaken for this research it would appear that the predominant development route at the moment is the foundation degree. It was believed that in part this had been encouraged by recommendations made by Hefce regarding the appropriate education for 'technical and associate professional' level staff. As noted earlier in this report, the policy in the North West has resulted in hundreds of Assistant Practitioners going through foundation degree programmes; in the South West there are around 200 in the foundation degree cohort; in the East of England they have trained 'hundreds' and in the East Midlands they have trained around 130 Assistant Practitioners on the foundation degree over seven years. As two interviewees commented:

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<sup>19</sup> See, for example, the HEE Business Plan for 2014-15

'They are still sending them on foundation degrees as this is the only game in town, although I am not sure if that's what is needed.'

VET provider

'We pay for these courses but we don't necessarily know the details of them.'

LETB

There has been a decline in specialist programmes (eg focussed on occupational therapy or radiography) and an accompanying increasing trend for generic foundation degrees to be offered with specialist modules available to suit different occupational groups. While there may be pragmatic business reasons for adopting this approach it is unclear whether generic courses with specialist options do in fact meet the needs sufficiently of either the trainees or the employers:

'The course is generic and quite 'nurse-y'. It's not useful for most people as most are therapy based. And it reflects in our results. We were 'sold' it as having more flexibility to allow relevant options. But there is no choice and little flexibility. That's where the resistance comes from for some managers [such as mine], as she doesn't see it as appropriate for the role.'

'We do not work with patients so a lot of the subject matter is not applicable in our practice.'

Trainee Assistant Practitioners

The professional bodies also expressed concern about the decline of the more specialised programmes:

'That's a challenge in moving from professional to generic FDs, how do you ensure they are competent in these specialised areas? The specialised courses in radiography are starting to disappear, a number of courses were accredited but the number has decreased and in some cases the accredited courses have ceased to run.'

SCOR

Given the trend for fewer occupationally-specific and increasing numbers of generic programmes' some employers and LETBs are questioning the suitability of foundation degrees. One LETB has stopped all funding for foundation degrees because they were unconvinced of their value in aiding progression to pre-registration programmes. In particular the current situation leaves employers who lack previous (or much) experience with Assistant Practitioners unsure of their options. As we noted earlier, one employer was just starting to undertake research because of the current lack of clarity regarding the optimal training for this staff group. One of their concerns was to discover the current state of play regarding the preferred qualification; this question was repeated by another employer too:

'Are most places now using foundation degrees? We are keen to find out what is 'best practice' in terms of education and training and don't know if foundation degrees are optimal. We have found the foundation degree to be a bit generic and then we have to do specialist training in house afterwards.'

'I have been asked to look at potential band 4 roles and training opportunities in Sonography and Cardiac Physiology for our trust, but don't want to re-invent the wheel, and I feel sure that there is a great deal of work currently going on at the moment in this area.'

Employers

It is fair to say that several employers and stakeholders felt that if the correct education or training had been identified (and provided) then further training should not be necessary. However, that said, several employers and other stakeholders considered it reasonable to expect employers to provide work-specific training following on from a more general degree programme:

'At the moment individuals go through the foundation degree then there are extra competences (specific to their job) done in house through CPD provided through the in house team.'

Employer

'You can have a generic foundation degree course that covers lots of different basics but inevitably if you get into a hospital you will need training on the specifics of what the job involves.'

College of Occupational Therapists

A project established to help with the development of the non-medical community and primary care workforce in the Wessex region provides an example of how programmes can be developed to meet the needs of new and emerging roles.

**Box 11: The AVOCET project: identifying the skills, knowledge and development needs for a new Assistant Practitioner role**

As part of a project to develop the non-medical community and primary care workforce the AvOCET project (which is funded by Health Education Wessex and hosted by South Eastern Hampshire Clinical Commissioning Group) is currently undertaking work to identify the generic skills for an Assistant Practitioner in health and social care whose role would be to support frailty and those living with dementia.

It is intended that the role will involve activities drawn from across health and social care rather than being based on one occupational area such as nursing. The first action was to identify the tasks that this individual would need to undertake. To do this, a series of hypothetical mini-scenarios were drafted which were circulated to a group of practitioners, educators, and Assistant Practitioners from across health and social care, and a patient

carer. This group then met as a focus group to discuss and confirm the competences that the role would require. The next stage is to identify the skills and knowledge the new Assistant Practitioner role would require. The Institute of Vocational Learning and Workforce Research at Bucks New University undertook this scoping work.

This is as far as the project has reached to date. The next piece of work will be to map the identified requirements against the current provision offered by internal (health and social care) and external education providers and then identify any new provision that may be required to meet the needs of the role.

The other side of this issue is the extent to which a programme will develop transferable skills. If a degree is too specific to the needs of a particular employer, then the Assistant Practitioner may find it difficult to move jobs:

'[If] the training is too integrated and the training is too specific for the role and hospital, then there is the question of how transferable is it.'

'It's not very easy to move from an Assistant Practitioner role into nurse training, because your content of your foundation degree will be very bespoke to the role that you've been asked to do.'

LETBs

Course leaders noted that the foundation degree was seen by some employers as too lengthy and HEIs as too slow to react and introduce up-to-the-minute courses. This meant that courses were failing to fulfil expectations and this was hindering employer buy-in. In line with the views of some of the LETBs and employers HEI interviewees believed there was likely to be a shift towards increasingly employer-led, work-based training in response to this need.

'Foundation degrees take too long. Whilst [trainees have] got academic support and they're doing well academically, what we're getting from the organisations that we're working with is that they want people who are able to hit the ground running, be able to make decisions within a sort of framework and boundaries and guidelines, do that very quickly.'

HEI

However, HEIs were able to cite examples where adaptations had been successfully implemented in response to the needs of employers. This included increasing the amount of specialisations offered to better support a very mixed cohort, or changing to a more generalised offering to imbue a more mobile workforce with more transferrable skills.

For the current cohorts of trainees, the foundation degree was broadly viewed as a successful and useful form of training which prepared them well not only to complete tasks competently but which provided a strong underpinning knowledge as well. Despite expressing some criticisms, they

felt that they had gained a good breadth of knowledge, the majority of which they could put into practice. There was some concern that there may be Band 4 staff currently in post who would not have received this academic grounding to support them in their work.

### 5.1.1 Costs and funding of degree programmes

We have already noted some of the emerging issues concerning the funding of training. There is extreme regional variation between LETBs, and as we noted earlier, at least one was not funding foundation degrees at all, some, while continuing to fund the programmes had withdrawn salary support while others were continuing to fund both programmes and salary support (funding to cover the cost of the learner being away from the workplace).

In addition to these variations there had been a change in the way funding was allocated. Therefore some LETBs believed that there was money in the system, it was just that the employers did not utilise it appropriately:

‘Previously we did ring-fence the money for these staff but now it comes down to strategy at employer level. There’s lots of funds in the system and every member of staff has an allocation of money for their development. The question is does the employer know what to do with them?’

LETB

However, this clearly wasn’t line managers’ experience. Somewhere between the LETB and the line manager the message about money being available for support staff development was being lost:

‘The Trust does not fund any training – I have had to fund the training programme by slicing off a proportion of the funding generated by the laboratory and consultant staff which is not part of the department diagnostic budget.’

‘We have no funding for training Assistant Practitioners since the LETB removed funding for the foundation degree.’

Employers

It would appear that sometimes senior staff who would be responsible for releasing trainees have less knowledge about the existence of potential funding (or possibly less incentive to investigate this), than did the prospective applicants. Participants in one focus group said that they had done much of the work to identify funding.

‘It was like, “We don’t know where to get it”. They didn’t know where to apply for the actual funding... we had to basically do our own research ourselves’

Trainee Assistant Practitioners, focus group



Those involved in training and development at organisational level were more likely to have an understanding of the multiple potential sources of money to support training. In this position they were more likely to be able to maximise their opportunities to draw on the various funding streams. However, only a few employers have the level of sophistication of the following interviewee in understanding funding and qualifications:

'Most of the APs have undertaken the foundation degree at [name of] University in partnership with local further education colleges. We have also previously delivered the City & Guilds Higher Professional Diploma – but [now] all APs [do] the foundation degree. Also we have our own SFA contract (to deliver NVQs and apprenticeships) which gives us a different development opportunity/route. So we are 'stepping up' our activity around the design of development pathways. The reason we liked the HPD was that it was helpful for some learners as it was more practical, more doable. But the foundation degree is Hefce funded. And in [our] region HEE has had a strategy for widening participation and have now really embraced apprenticeships. So we have three options: apprenticeships, HEE funded programmes and Hefce funded programmes.'

Employer

For many employers, their decisions are currently primarily led by the funding strategies of their local LETB. Some employers reported that they had changed providers primarily because of cost issues while others were considering changing their approach to development because they believed that they could get more favourable rates through these routes. It should be noted that quite a few interviewees raised points relating to funding that we could not explore in further depth in this project. For example, one reported that they could get a cheaper rate for foundation degrees where these formed the knowledge certificate for an apprenticeship. Another believed that it would be cheaper in future to use the forthcoming Trailblazer apprenticeship (when it is available) as the development route for Assistant Practitioners, believing they would obtain full funding for this, rather than the 80 per cent funding they received for the foundation degree.<sup>20</sup>

Quite aside from concerns about suitability of programme content and cost, there is the question of whether healthcare providers can afford to lose an employee for one day a week, especially with the removal of salary support and with increased work pressures.

'The biggest issue is with regard to release time to study, the system is so busy. We used to talk about winter pressures, now it's winter all year round. It's a huge challenge to release people. The other big challenge to us as a

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<sup>20</sup> Our understanding is that employers will pay 33 per cent of the costs of an apprenticeship in future. It is unclear whether the LETB will fund the employer contribution (which would effectively render the apprenticeship free to the NHS employer).

system is I don't think the education system has caught up quick enough with having people who need to be educated in 'the new world'. We don't have the freedom to send people to university one day a week.'

LETB

Often the emerging message was of options that had existed previously but which were no longer available. Very many people, across all the interviewee groups, commented on the loss of part-time degree pathways and the impact this might have on the opportunities for Assistant Practitioners to progress into undergraduate study and professional clinical roles. Access to part time provision is a particular issue for this staff group given what we know about their profile: they tend to be older and consequently have domestic and financial commitments making it difficult to take up full time education. The part-time option allows them to continue working whilst studying, thus enabling them to take care of their existing financial commitments etc.

Several reasons were suggested for the loss of part-time courses: one was that the increase in numbers of people applying for full-time degree programmes had led some universities to realise that they no longer needed to offer part-time provision to supplement their income; others were dropping part-time provision as part of their strategy to improve their market standing (ie they believe that offering part-time provision detracts from their perceived status). While sandwich degrees were still available in some areas of practice we were told that they were no longer available in biomedical sciences. The Professional Bodies had noticed the decline in provision of courses focussed on their subjects, mostly attributed to the small numbers of trainees involved and HEI's desire to find a more cost-effective way of offering programmes, leading to 'core and option' models. One LETB noted that many universities are moving more towards delivering higher end qualifications, introducing more master's courses.

The majority of HEIs to which we spoke reported that their foundation degree programmes were open only to those in employment, through employer nomination. Cohort numbers were therefore linked to the employers' willingness to fund staff. Where services were being reconfigured and Trusts were reassessing their plans for workforce development, the dependence on employer sponsors can lead to notable fluctuations.

'In terms of getting them released we are heavily reliant on service providers agreeing to release them.'

HEI

However, many had seen an increasing number of individual applicants to such 'closed' courses. With many potential trainees lacking the financial backing of employers, some HEIs had nonetheless elected to maintain their mainly or wholly employer-funded model despite its limiting impact. Others however had decided either to open up programmes to self-funded students,

or to create new streams for these trainees (although still retaining the need for students to be employed in the sector).

Course leaders believed that, at an individual level, lack of funding availability does not necessarily quash desire for career progression and some expected that development of the self-funded option might generate greater interest and so an increase in numbers, although the extent to which prospective trainees feel they can or want to pay was uncertain<sup>21</sup>.

‘People in that sector wanted to develop, but didn’t have the sponsorship... from the organisation to actually come on the programme... a lot of students are doing it in their own time.’

‘It’s a shame as there is a need, we get inquiries for that pathway, but so few access it. It has to be the money that is holding people back.’

HEIs

## 5.2 Other training routes

There were several other routes to training that we identified during the research: NVQs, apprenticeships and diplomas. There was optimism that the new Trailblazer apprenticeship (in development at the time of the research) would provide useful options.

‘It is now a quite exciting time as the new Higher Apprenticeship in nursing will open up progression into a registered nurse position.’

LETB

However, against that background, a prevailing message was again one of loss and disappearance of what had been useful and valued options.

A range of examples were identified and very little commonality. One Trust had run an in-house Level 4 Higher Professional Diploma in Health and Social Care. They had subsequently worked with City & Guilds to develop a new Level 5 Professional Diploma for Assistant Practitioners and were now frustrated that, while other Trusts were now offering this diploma, they could not, as the Trust had opted in favour of the foundation degree:

‘The reason we liked the Higher Professional Diploma was that it was helpful for some learners as it was possibly more practical, more ‘doable’. But the foundation degree is Hefce funded.’

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<sup>21</sup> Note that while this report was in preparation it was reported that Lancashire Teaching Hospitals Foundation Trust had launched the first nursing degree programme to be self-funded via the student loan system (Hazell, W, 7 January 2015, ‘Trust launches first self-funded nursing course to tackle shortage’ Health Service Journal, <http://m.hsj.co.uk/5077979.article>)

One LETB reported that in the early days a local Trust had used a BTEC qualification and did an in-house rotation '*so they went for example from ward to day care*'. In more recent years the Trust had moved away from that model and now Assistant Practitioners work in the purer therapies. Some Trusts were approved to offer NVQs and apprenticeships in house (sometimes in partnership with an HEI and with the foundation degree providing the knowledge component of the apprenticeship).

One of the LETBs reported that a new diploma programme aimed at Healthcare Assistants was being piloted at Middlesex University. They believed that this was more likely to offer trainees the option of successful progression at completion. In addition it ensured they gained a qualification (a Cert HE) if they decided that they did not want to continue beyond the first year.

### 5.3 Support in work

For trainees going through academic or work based programmes of learning support in the workplace is essential to their progress. In previous sections we have noted the support that some employers provide in the workplace, including examples where existing qualified Assistant Practitioners play a role in buddying, mentoring or assessing current trainees.

The current trainees reported that the level of support they received in the workplace was highly variable, even within the same workplace. This was particularly the case when it came to having the space, time and opportunity to gain new competences. For example, trainee Assistant Practitioners in Theatres said that while they were learning to scrub competently multiple times on a shift whilst being monitored by Band 5 and 6 staff, colleagues training for the Clinician's Assistant role did not receive the same support.

For those trainees who were not in post or who did not have guaranteed jobs at the end of their course, the work-based side of their learning could prove highly contentious and difficult. They may not be afforded the opportunity to gain competences outside of their Band 2 or 3 role and furthermore some found it difficult to decide which competences were and were not relevant to their role as there was no job description to refer to.

The extent to which trainees were able to get the most out of their work-based learning also depended on where they were working, the individual relationship they had with their mentor, their mentor's attitude to Band 4 staff and even which shifts they were assigned to. Some found that they may rarely be on the same shift as their mentor, and when they were '*it was clear she wasn't interested in helping me. It got to the point where I got knocked back so many times I did not even want to ask questions any more*'. Many other trainees felt that their managers were not interested in helping their development.

'Our managers won't support us with anything... apart from the competences and mentoring... we don't get time to study or anything. If I'm not here, I have to be at work... we don't get any study days. My manager and her manager have made it quite clear that I'm an inconvenience to them.'

'I think everybody in this room could honestly say we're not as well supported at work as what we are in the uni.'

Assistant Practitioners, focus groups

In contrast some reported that they were well supported by their managers. It is worth noting that typically this is found where managers do have an understanding of the utility of the Assistant Practitioner role:

'[My trust] was quite good at promoting Assistant Practitioner roles and there was a good understanding on the part of managers about the benefits that the AP role can bring, and this was reflected in the generally receptive organisational culture.'

Assistant Practitioner, interview

One employer has used band 4 roles to create a training band within the department. They are supported to undertake further study and achieve professional registration. Their experience is set out in Box 12.

**Box 12: University College London Hospitals Foundation Trust: training associate practitioners to achieve professional registration**

The Histopathology Department has had Assistant Practitioners for just over two years. The Department had been keen to look at ways of bringing in less highly-qualified staff to do routine tasks as it would be difficult to justify the banding in years to come, re-introducing a training band and reducing their costs, as they had had a static workforce for some time and had not been able to create training posts.

*'If you don't lose any staff, then you can't bring people in to the trainee grades. And labs do go through cycles – the staff are stable for years, then you will get some leaving as they look to advance in their careers. So we looked at our funding to see if we could replace the two BMS band 6 posts and convert these to four associate practitioner band 4s. It helped us save some money and allowed us to reinstate HCPC training posts in the department. Plus it meant we would be able to fill vacant posts as we lost higher band staff further down the line.'*

The Department advertised the posts on 'NHS jobs' and looked for two different types of applicant.

*'We were looking to recruit two existing graduates with Biomedical Science degrees and two others who were doing part time foundation degrees in Biomedical Sciences and already worked in NHS laboratories. We wanted*

*people with around two years' work experience in a histopathology lab in addition to the degree qualified people who had no work experience.'*

The department has a defined training policy and competency based training programme, and maintains a training record for all grades of staff. Trainees coming in have to sign up to a learning contract with learning objectives and defined sign off points as part of their training. For graduates there is a prescribed training programme and registration training portfolio designed within the department that enables recruits to reach the standard that allows them to become HCPC-registered.

The training programme and the HCPC portfolio contains all the training documents and assessment forms and the training process involves tutorials, a monthly review and sign off against the specified competences as well as the trainees supplying relevant written pieces of work. There are 28 academic competences and 15 equipment competences used within the department to reinforce the work trainees generate for their HCPC portfolio. The trainee has to be signed off against these before they can be signed off as proficient to undertake relevant departmental protocols. There is a strong feedback loop and if an error is made there is a separate re-training and verification process and the individual is made aware of where they are failing.

While the graduates completed their registration training portfolio the two trainees with foundation degrees are completing their additional years' study to enable them to graduate with an honours degree and undertake the registration training portfolio in parallel.

*'So in their case 50 per cent of that is carried within the department and 50 per cent at their University by the portfolio trainer at the college compared to 100 per cent being carried out here for those who are already degree-qualified when they come in.'*

The Department has a full time Training Officer and part of their role is to take trainees through the specific laboratory and portfolio training so that they achieve their competences and produce evidence for their HCPC portfolios.

Some places find it difficult to develop a heavily structured and defined training manual. This Department has a defined training policy for all grades and training record developed by their training committee which was also involved in developing the Registration Portfolio for the Medical Laboratory Assistants.

*'At the moment the Biomedical Science (BMS) workforce is shrinking. There are huge numbers of degree qualified people who can't get training posts. We allow our assistants to do the portfolio so that they can get onto the first rung of the ladder as a BMS, but with no assurance that they will get a BMS band 5 post in our department at the end.'*

*'However, fortunately for two of the trainees, two qualified BMS band 6 members of staff left at around the same time as they qualified. As we now had a pool of HCPC registered associate practitioners we were able to place the band 4 associate practitioners into BMS band 5 posts which they achieved through competitive application and interview. These posts were not downgraded and they will be able to progress to BMS band 6 when they complete their specialist portfolios (usually 18 months) and are then fully qualified as specialist biomedical scientists in histology. Obviously this also helps with our finances as the leavers were at the top of the BMS band 6 grading and it was a saving and we have a better breadth of staff with the BMS band 5's now becoming the specialist training grade.'*

Norfolk and Suffolk have designed a series of study days to provide support and further development for their trainees and Assistant Practitioners. The events have been co-designed by the HEE East of England Norfolk and Suffolk Lead for Assistant Practitioners, the Leads for Assistant Practitioners (based in the education teams within NHS Service Provider organisations) and local Education Providers. The courses are centrally funded by HEE East of England and are intended for individuals in their first year of an Assistant Practitioner role. The programme is shown in Box 13, below.

#### **Box 13: Norfolk & Suffolk Assistant Practitioner Study Days 014/15 CPD Year**

**1. Transitioning in the Assistant Practitioner role** – for Assistant Practitioners that are new in post, this Study Day explores the challenges associated with changing roles, sometimes within the same team, and enables the individuals to look at different approaches for successful adoption of their new role. The course includes practical activities such as role play to help the individuals discuss the challenges and opportunities created by role change - including making full use of their extended skillset and managing initial resistance from other staff members.

**2. Managing your Continuous Professional Development (CPD)** – to help Assistant Practitioners focus on their personal and professional responsibilities for continuous professional development and to consider how this can be achieved using a combination of support in the workplace and personal drive. It will also update the participants on current issues for Assistant Practitioners and enable the participants to identify credible research sources for their CPD activities.

**3. Effective communications for practice** – building on the knowledge and experience built up during the foundation degree and work-based learning, Assistant Practitioners explore using a range of communications techniques appropriate for their day to day working lives. Participants consider values and behaviours and how different communications approaches result in different (and sometimes unexpected) responses from individuals. The participants learn how to recognise when they reach the boundaries of their professional responsibilities and how to proactively pass their communications responsibility onto more appropriate staff if needed.

4. **Service Innovation and Improvement** – builds on learning from the foundation degree about service improvement. Participants will practice using common service innovation and improvement techniques and will consider how to implement them in their workplace to deliver small changes. Participants will be expected to identify a suitable small-scale change to discuss during the course and will develop a follow-on action plan for implementation with support from their mentor.

5. **Introduction to the role of Practice Educator** – designed for individuals that have completed the foundation degree and are considering becoming a Practice Educator to support others through the course and their practice competency elements. During the course the participants will explore the different aspects of the Practice Educator role including the potential challenges that they may face. The day uses role play activities to help participants practice delivering service improvement messages to peers and colleagues.

*Source: Assistant Practitioner Lead, Norfolk & Suffolk Workforce Partnership, HEE East of England*

## 5.4 Sustainability

The numbers of Assistant Practitioners enrolling on courses varies both nationally and over time. Some course leaders were able to map out clear trends, while others saw demand fluctuate due to unpredictable market demand (including falls in demand).

Where Assistant Practitioners had been well established in a region, a stumbling block emerged where the role had '*reached saturation level*', and ensuing numbers dramatically decreased. Once an appropriate number of staff were in place in these roles, there was no need for further Band 4 roles (or the development of new trainees) and – given the stable nature of this part of the workforce, noted by many interviewees – little staff turnover, meaning little need to train up or recruit replacement staff. In some cases, the potential for growth in numbers of trainees had been over-anticipated – in other words, the role had not significantly developed and the numbers coming forward had not materialised.

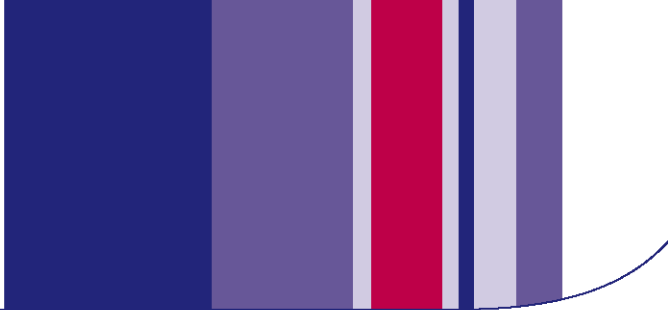
For all these various reasons, some courses were coming to an end or suffering falls in numbers that meant the course became financially unviable.

'There is only a finite number of those needed, so that only lasted four and five years until they had as many as they needed so we stopped that particular route.'

HEI

In addition, many HEIs reported that changes in contracting arrangements had led them with no option other than to close foundation degree programmes. In one region there had been a shift from offering provision





across three HEIs to contracting with just one. Other LETBs and employers too spoke of shifts in their decisions about the optimal provider arrangement. While it is easy to see the economies that can arise from contracting with just one provider, there are issues in terms of access. One of the LETBs retained contracts with two universities because it was aware that the geography of their region meant that reduction to just one would cause difficulties for learners living in half the county.

As we reported earlier in this section, the falls in numbers had resulted in the loss of some specialist courses. Availability of funding, rather than the optimal training route, has driven employer decisions in some cases. Taken together several factors were driving HEIs to rethink their offer and employers to rethink their training options.

## 5.5 Summary

The Francis and Cavendish reviews have led employers to be wary of providing training that might be challenged as being of insufficient quality. While there clearly is a great deal of training activity taking place, many LETBs and some employers are questioning the optimal training that should be provided for this staff group. The research revealed a desire amongst employers to hear more about what other employers were doing regarding the training of these staff. Several LETBs had decided to end support for foundation degrees.

The question of the optimal qualification route is key given the issues identified to do with registration and regulation. In the absence of regulation there is no national validation of programmes. In addition, concerns about qualifying an individual to undertake new activities recently devolved to a lower level staff group has led employers to question the sufficiency of training provided in house (and not externally accredited) and, for some employers, to challenges in gaining agreement or approval from Governance for training in certain areas.

Concerns appear to be emerging that courses are neither one thing nor the other – not generalised enough for all the students being sent on them and not specialist enough for the specific occupational areas in which Assistant Practitioners work. There is a tension between those who want foundation degrees to be tailored to meet the needs of specific roles and employment requirements, while others could see that making these qualifications too tightly focussed on a specific role would make it even more difficult for Assistant Practitioners to move into other jobs or progress into pre-registration programmes. A wide range of other training options – NVQs and apprenticeships offered in house or externally, HE certificates and diplomas – were in use, and there was optimism that new developments for a higher apprenticeship may soon provide a useful alternative training route.

At the same time, the lack of an agreed training route (and indeed, the lack of consensus on the extent of training the employer should be expected to provide in order to make the trainee work-ready) was giving rise to anxiety

amongst some employers who were trying to find the best option for future Assistant Practitioners.

While in some areas the numbers of trainee Assistant Practitioners undergoing training has increased, elsewhere numbers are declining. It is particularly in those areas in which large numbers were originally trained that decreases are being seen; in other words, either steady state – or in some cases saturation point - has been reached. While the stability of the Assistant Practitioner workforce is one of their particularly attractive features from the employer point of view, the lack of churn necessarily means a decline in demand for education and training. Any drop off in number of potential trainees has implications for longer term sustainability of education programmes.

## 6. Progression

- The research confirmed that many learners on healthcare-related foundation degrees had difficulty gaining credit when entering a pre-registration honours programme.
- Some universities gave preference to A level students over Assistant Practitioners with a foundation degree and experience
- Many trainee Assistant Practitioners reported a lack of progression opportunities at work; some were unlikely to obtain a band 4 post after completing their foundation degree
- Where progression at work or further specialisation post-qualification was possible, this relied on the availability of CPD opportunities and this is variable.

Before considering issues to do with progression it is worth noting that for many the Assistant Practitioner role is a destination role of value in its own right. The majority of those who spoke of considering further progression – primarily into pre-registration degree programmes – were contemplating that additional training only out of frustration at the lack of an Assistant Practitioner post for them to move into after completion of their foundation degree.

There are two aspects to progression – progression within the employing organisation, in terms of taking on wider or different responsibilities and perhaps moving between departments or employers; and the accessibility of further education or training programmes to support pre-registration development. These are considered in the two sections that follow.

### 6.1 Progression at work

It was by no means certain that trainees completing a course would gain a Band 4 position at the end. Within learner cohorts there could be some trainees with guaranteed Band 4 posts awaiting them after qualification, some who had been down-graded to Band 2 due either to service re-organisation or as a policy requirement in exchange for day release and training, others in Band 3 posts and likely to stay there after course completion and still others who may be at Band 4 already.

Mostly learners had undertaken the study programmes because they wanted progression to a Band 4 role. However, it should be noted that many – probably the majority – of Assistant Practitioners (and trainees) were not particularly looking for progression into a registered practitioner role or undergraduate course. The great majority would be happy to stay as a Band 4, provided they were allowed to use the skills they have developed during their training.

That said, many are interested in gaining more skills and taking on more responsibilities. Often these were clinical specialisms, but there was a range of other development options: we heard of, variously, Assistant Practitioners being assigned a supervisory role to first year trainee Assistant Practitioners, one who had taken on a mentoring/buddying role for students and (amongst those who had completed an NVQ prior to entering the foundation degree programme) of Assistant Practitioners being trained to become NVQ assessors and who were now assessing Healthcare Assistants. In one case an Assistant Practitioner had taken on the responsibility for reviewing personal development plans for other support workers in her department.

If there is little consistency in approaches to educating and training Assistant Practitioners there is even less in respect of continuing development post-qualification. We were told of several ways in which employers were helping to facilitate further development. For example, one employer had arranged for Assistant Practitioners to undertake a one year preceptorship in order to help them to become competent in a new area of work.

The range of situations was described by one of the LETBs. This is an extensive quote and reveals the links between employer approaches to CPD and the options for progression (or at least specialisation) at work, and the implications for transferability of the training and the personnel in these posts.

'Quite a lot of the people who have done the FD want to move on, either horizontally or upwards. Horizontal progression [ie role expansion, or move into new specialisms] is difficult without CPD. We are trying to organise a work rotation scheme to help with this. At the moment it's just an idea but they have agreed to look at a work rotation project and agreed a model so we are halfway there.

'There are slightly different models of CPD for different organisations. The big hospitals get APs to do their competence portfolio alongside their FD and while working full-time. That evidence [competence PF] is against the SfH/SfC 23 competence units. They may still have to do some competences for their specialist area eg help with renal dialysis. Or in more general settings they may do general competences then specific competences as their role develops. Sometimes it's backed up by education provision, eg a course on end of life care, although this may not be fully accredited. And some do training that's designed by their employer. It's not uniform across the piece. The issue for HEE is that on the one hand, in some ways it's about tailoring the education for the needs of the service provider and as we have about twelve in the main organisation and others too, so it would be hard to specify [training that met all their needs]. We give them a lot of autonomy in developing their CPD framework, we give them a budget to spend and... it's up to them to negotiate what it's spent on. It's more of an issue for the APs, as when they meet up with other APs they compare notes

and say what development they've had. And there's an issue about when they move jobs [and the training may not be transferable]. And not all organisations use the competence portfolio.'

## LETB, Assistant Practitioner lead

There is one final aspect to the progression issue that can be overlooked. Whilst the Assistant Practitioner post constitutes a valuable progression option for HCAs at Bands 2 and 3, there are no further progression opportunities above Band 4 for individuals without pre-registration training.

The main problem with AP's is the lack of career progression. They do all that work to qualify and work in their chosen area but apart from in-house opportunities they will remain at band 4. This, I feel could put some off from becoming AP's. One of our AP's has said that with hindsight she wishes she had done her nurse training, so that she could have both the career opportunities and subsequent financial benefits that this would enable.

Employer

## 6.2 Academic progression

Significant problems confront Assistant Practitioners who choose to progress into pre-registration programmes:

As we noted earlier, the provision of part time degree programmes is shrinking. Programmes that previously existed are being withdrawn, for a range of reasons. Part-time provision has ceased at some institutions because, with rising numbers of full time students, they have no need to offer the part time option; others are removing part-time programmes because they believe this will enhance their standing in the market (ie there is a perception that it is mostly the post-1993 institutions that have traditionally offered part time programmes and by removing them they will be seen as a 'better' university).

Removal of part time programmes leaves potential learners with the options of leaving their job (and this is not feasible given the typical profile of this staff group – older, and with domestic responsibilities) or seeking salary support in order to retain their job while they train. However, many of the LETBs have closed off salary support schemes in the past few years or restrict support for certain HEI programmes.

There were many accounts from LETBs, employers and Assistant Practitioners of the content of foundation degrees failing to map onto pre-registration degree content, meaning that students could not receive any significant credit through APEL for relevant degree programmes. This means that individuals have to complete a further full three year programme after already having completed two years of study at levels 4-5 if they wish to progress to registered status. This compares poorly with the experiences of the wider foundation degree student body, for whom data reported by Hefce (2010) indicates that 80 per cent have progressed into honours degrees with two years' credit, entering directly into the third year. Respondents repeatedly reported that trainees on healthcare-related foundation degrees

were unlikely to receive more than one years' credit and some received none.

Some Trusts had undertaken lengthy work with their local HEIs to ensure that the foundation degree mapped to the pre-registration degree but found that they were then limited to using those HEIs.

Students were more likely to be able to be APELled into the second year of a programme where the degree programme ran at the same university as the foundation degree they had completed. However, respondents reported that while the foundation degrees often included functional skill modules<sup>22</sup> in recognition that some Assistant Practitioners do not have a level 2 literacy or numeracy qualification (ie they lack a GCSE, GCE or CSE in these subjects) some pre-registration degree programmes do not accept functional skill units as part of the entry requirements, meaning that the students are not accepted for progression onto these programmes, even where the foundation degree and pre-registration programme were offered by the same institution<sup>23</sup>.

In some universities (typically the redbricks and universities considered to be in the top ranking universities) both LETBs and employers reported finding that students entering with 'A' levels were given preference over Assistant Practitioners with foundation degrees. Furthermore, the focus on improving retention in HEIs has led to a decrease in the number of places available in second year courses, reducing the places available for potential direct entry through APEL.

'The other issue is - and I am working on this now - is that the foundation degree is not considered appropriate to qualify someone to go on and train as a registered nurse. We've had some problems with that. In one or two cases we have the same university offering the foundation degree and the nursing degree but then preferring to take on students with A levels. That's a whole agenda in its own right but it's nonsense to have trained staff who can't progress'

LETB

'That's the big nub – universities not accepting people with 7 or 8 years' experience in Acute care, saying 'go away and do a maths O level' when they have functional skills.'

Employer

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<sup>22</sup> While this is what interviewees said, we believe that this mainly arises from the fact that some were undertaking the foundation degree as part of an apprenticeship, and it may be that the functional skills are offered elsewhere in that development route.

<sup>23</sup> We understand that this is a wider problem often encountered by those wishing to use an apprenticeship to progress into higher education.

In radiography, typically the first year of the undergraduate programme focusses on skeletal imaging. As this is not part of the foundation degree for Assistant Practitioners, accelerated entry into the second year is not possible (similar issues apply in some therapies too).

In addition, in some cases the amount of credit given under APEL rules amounts to a part-, rather than full, year's exemption. Rather than join partway through the programme, interviewees had found that students often chose to join the programme at its start rather than try to join a group partway through the year.

One of the issues we were particularly asked to consider in the research was whether there is a need for further guidance to ensure better development of progression routes. There was a mixed view regarding the need for guidance and to be fair, most of the barriers to progression arose from specific policies (e.g. preferring students with an academic background; seeking to improve institutional profile or esteem) rather than a lack of consideration of the need to map provision to ensure overlap (although this did also appear to be an issue in some cases). There did not appear to be much support for the idea of guidance on this topic:

'If problems (blockages) arise with people's progression up the skills escalator then this should be addressed, whether national guidance would fix these issues is uncertain.'

'I have no idea what other organisations are doing, it seems it's lacking an evidence base as to what's effective and value for money [ie in supporting progression]. Other issues affect these decisions [about who to admit], widening participation, values, these may also be reasons but there's a lack of evidence regarding how successful it is and value for money. A more national, evidence based approach, a more structured, step on, step off, approach would be good.'

LETBs

The current situation brings problems beyond those for the individual or institution: the second of the two LETBs cited above said that they *'now don't support these [foundation degrees] as we are not convinced there's the evidence that it supports onward progression into professional degrees'*. While it is questionable whether progression should be seen as a primary aim of recruitment to the foundation degree – or indeed for funding it – the fact remains that this issue has already informed at least one regional funding decision.

However, as a result of those concerns, that LETB was now involved in piloting a university programme that takes existing Healthcare Assistants from community settings and offers them a programme that takes the form of a series of 'steps':

'In the first year there is a part time Cert HE at Level 4, then they can go on to Level 5 Dip HE<sup>24</sup>, again after the end of that they can ...go on to a nursing degree in adult or mental health. That approach ensures they are ready to progress. So we are keen on that, it has the potential to be a more sustainable means to progress than the blanket staff support option and foundation degree.'

While several interviewees commented on the potential for Assistant Practitioners to move into pre-registration programmes following on from completion of their initial training, it should be noted that there are very different views on the desirability or otherwise of using the Assistant Practitioner post as a route to recruitment of registered personnel (most often, nurses).

Several LETBs and employers noted that this type of approach was not the most cost-effective way to develop registered staff.

'There's a new bridging course that brings the cost up to around £12,000 – it's an expensive way to get into nursing.'

LETB

However, set against this, many of the LETBs and employers believed that using the 'pull through' model to develop Healthcare Assistants into Assistant Practitioners and, ultimately, registered staff (and again, it was most often nursing posts they were referring to, driven by the challenges in recruiting to these posts) would lead to development of a more stable group of registered staff with reduced turnover, since Healthcare Assistants tend to be older with strong reasons for remaining in the locality).

'One of the benefits in developing new roles in the non-regulated workforce relates to the current shortage of RNs in most parts of the country except London. Many Trusts are going overseas to recruit RNs, but that's a short term fix. So in that context the development of Band 4 workforce is a really positive thing. When you look at what a RN does, about 60 per cent of the work they do does not require registered status. So potentially we could change the staffing structure to make more use of Assistant Practitioners.'

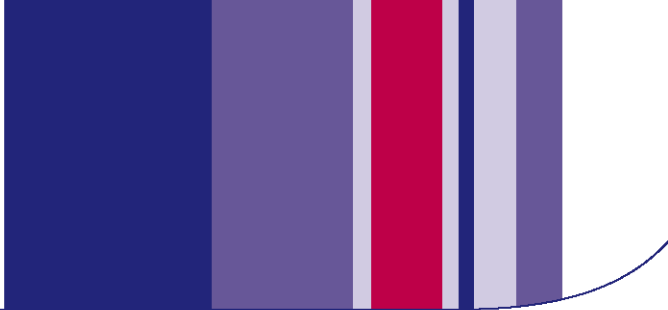
'There is an opportunity now and I believe the climate will change as the RN issue [i.e. the shortage] becomes more extreme and trusts find that they can spend hundreds of thousands of pounds trying to recruit people [to RN posts] who don't exist or don't stay and all that will do is perpetuate the status quo.'

LETBs

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<sup>24</sup> See <http://www.mdx.ac.uk/courses/cpd/healthcare-support-worker> for more details





If the savings to be made from reducing churn are factored in then it is debatable whether developing registered personnel via an Assistant Practitioner role is actually very much more expensive, especially given their value to the employer whilst in the Assistant Practitioner role. It is worth repeating, though, that for many of the trainees and Assistant Practitioners, it was often only frustration at the lack of opportunity to use skills developed during their training that drove them to consider pre-registration training.

### **6.3 Summary**

The research was not quantitative and was based on voluntary participation; therefore it is not possible to state with any certainty how trainees' experiences of gaining credit for progression into an honours programme compared with the 80 per cent of foundation degree graduates that Hefce (2010) have reported gain two years' credit. However, many employers and LETB representatives and the Assistant Practitioners themselves reported that foundation degree graduates were unlikely to gain more than a year's credit on applying to a pre-registration programme; in some cases they were offered six months and in others none. There was also the perception that some universities decline applications from foundation-degree-qualified individuals in favour of those applicants with A-levels.

Employers understandably wanted programme content to be appropriate for the job the individual was undertaking but where programmes had a relatively narrow focus this could further constrain the qualification's ability to support academic progression into pre-registration programmes. Many employers recognised that a programme of study such as a foundation degree would not make a learner job-ready and it was the role of employers to provide job-specific training. Several examples of good practice were identified in which employers had developed training for Assistant Practitioners.

## 7. Conclusions and recommendations

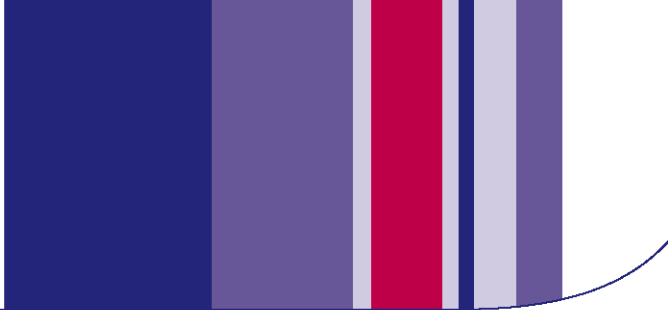
The research was required to answer the following questions:

1. **Review the usage and transferability** of Assistant Practitioner roles across employers throughout England.
2. **Explore how Assistant Practitioners are recruited** to the roles and career progression routes for those in these roles.
3. **Review the perception, expectations, recognition and actions of HEIs** in relation to portability of foundation degrees.
4. **Explore the current use of ‘other’ qualifications and training provision** to assist in the effective development and deployment of these roles in England.
5. Where possible **draw some comparisons with** the development of Assistant/Associate Practitioner roles in Scotland and Wales.
6. **Build on our understanding of opportunities and barriers in order to develop recommendations to take forward the development of Assistant/Associate Practitioner roles in England**, taking into account broad trends in the development of this role.

The **review of the use and transferability** of Assistant Practitioner roles across employers in England confirmed that they are being deployed in an increasingly wide range of situations and roles. While past developments have tended mostly to be in acute care, policy focus has led to attention being switched to their use in community and primary care settings.

The work also explored how **Assistant Practitioners are recruited to the roles** and the **career progression opportunities** available to people in those roles. The research revealed that currently Assistant Practitioners continue to be mostly recruited to these roles internally and to have previously been employed as health care support workers. The majority of employers still choose to train the individuals recruited to Assistant Practitioner or trainee posts rather than recruit individuals who are already qualified and working in a similar role either internally or within other health sector organisations.

This means there are currently relatively few opportunities for Assistant Practitioners to transfer across employers, although some advertisements are to be seen for these posts. A particular difficulty, though, is the specificity of experience gained from working in roles often designed for a particular niche in a specific team and with a particular patient population.



Because there is currently little experience amongst employers in recruiting directly to these posts few have developed policy in this area. The few employers that had experience in recruiting external candidates directly to these posts did usually have procedures that ensured the competence of such individuals. Some assessment of competence was felt to be necessary given the differences between education and training routes and experience.

The tendency for employers to train anew when they developed these posts also contributes to the lack of opportunities for career progression between Assistant Practitioner roles in different organisations. In some cases employers sent people for training even where it was unlikely there would be an Assistant Practitioner post for them to take up.

As a result in many cases individuals who were sent on training programmes that should have prepared them for an Assistant Practitioner post were returning to jobs at the same level at which they were previously employed and, in a few cases were returning to lower band posts having been temporarily promoted for the duration of the training. That said, there were, nonetheless, opportunities for individuals to take on additional responsibilities within their Assistant Practitioner role and the research found cases where Assistant Practitioners were taking on roles as mentors and coaches, NVQ assessors and staff trainers in addition to their extended range of clinical and/or social skills.

The research also reviewed the **perceptions, expectations, recognition and actions of HEIs** in relation to portability of foundation degrees. A first point to make here is that HEIs were more focussed on designing programmes that met the needs of local employers than consideration of portability of these qualifications. Secondly, many were struggling to maintain provision in the face of (in some cases) declining trainee numbers and the loss of employer contracts and/or LETB commissions.

The (relatively) small numbers of Assistant Practitioners and the stability of this section of the workforce means that except where employers had adopted the policy of putting staff through a foundation degree irrespective of their job prospects there was only low demand for foundation degrees (in comparison with pre-registration programmes). All HEIs were attempting to offer cost-efficient provision that was nonetheless sufficiently flexible to cater for several small specialist groups of trainees. HEIs believed that they had designed courses that met employer needs and, by offering a combination of 'core' modules designed to be relevant to all learners and specialist modules that met particular occupational needs were of value to the various sub-groups of learners within a cohort.

The trainees did not share this perception and many LETBs were unconvinced of the utility of these programmes. Several LETBs had reduced or ended support for foundation degree programmes, questioning their utility. Employers and LETBs alike were keen to understand what the optimal qualification routes might be for this group of staff.

The work also **explored the current use of other qualifications and training** provision to assist in the effective development and deployment of these roles in England. Some employers were delivering NVQs or apprenticeships in house. There was significant interest in the Trailblazer developments and anticipation that these new apprenticeships would prove useful as a developmental option in future, but they were not yet in use. Several employers had developed their own schemes to provide CPD for Assistant Practitioners, in one case aimed at helping the individuals achieve professional registration.

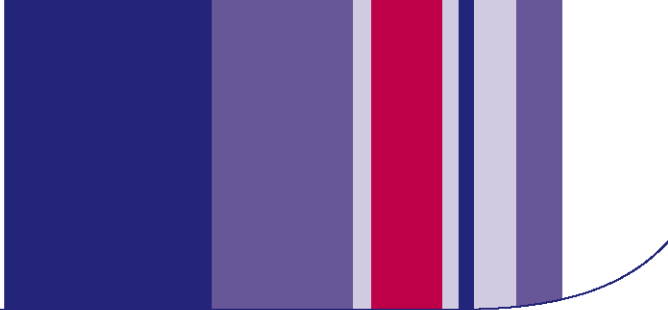
The work revealed many **similarities with** issues that have emerged in earlier research into the development and deployment of Assistant/Associate Practitioner roles in **Scotland and Wales**.

One issue is the extent to which the content of foundation degree programmes is viewed as being relevant. As in Wales the learners themselves expressed doubt that the qualification was appropriate for their work setting. What distinguishes the current work is that there is evidence that some LETBS and employers share these doubts.

As in Wales we found that many trainees are being sent on training programmes with few prospects of attaining a Band 4 post at the end of the training. As in Wales, we found that often the decision to send individuals for training had been funding-driven, with a failure to persuade some managers of the relevance of either the training or the Assistant Practitioner role. Unsurprisingly, then, as in Wales we found high levels of frustration amongst many of the trainees to whom we spoke. Several felt that their only option for progression at work was to undertake pre-registration training while their real desire was to be able to use the skills and knowledge they had acquired in an Assistant Practitioner role. As in both Wales and Scotland, many had considered progression into a pre-registration programme but the absence of part-time provision constituted a barrier to these potential learners, given that many had significant domestic responsibilities that precluded giving up full time employment. Many employers and HEIs pointed to the loss of part time pre-registration routes in recent years as having increased this barrier to progression.

While there were reports of hostility from colleagues (as was found in Scotland and Wales) this appears to be lessening. At least some of the trainees and Assistant Practitioners reported that their colleagues had grown used to the roles and valued their contribution to the team. Others, though, spoke of continuing hostility from other staff focussed on their lack of registration and the perception that their qualification therefore lacked value as it did not lead to registration and a 'PIN'. It is worth noting that in several of the focus groups participants spoke of the totemic importance of a PIN, something that we have not previously heard in discussions with this group of workers. One possibility is that this may have arisen as an issue out of the Francis enquiry and its focus on registration.

The interviews with employers and with LETBs revealed that there remain fears amongst nurses that Assistant Practitioners will 'steal' registered



practitioners' jobs, despite their introduction in many cases being attributable to current difficulties in recruiting nurses and organisations putting significant effort (and money) into attempts to recruit registered staff in parallel with the introduction of Assistant Practitioners. It is possible that these fears have achieved the status of 'urban legend' but equally it suggests a failure on the part of organisations to adequately communicate to nurses and other registered practitioners the anticipated benefits for their staff group in terms of release of their time for involvement in further development and activities requiring higher level skills.

In Wales, concerns about supervision had inhibited the use of Assistant Practitioners in the community; in England while supervision remains a topic for debate and concern this appears to be less of an issue in regard to Assistant Practitioners working in the community. In England there had been allocation of funding under the Better Care fund to drive integrated care and this is one area in which growth is likely to be seen. Within Trusts, though, there remain some concerns about responsibility for devolved and supervised activities, as was found in Wales, and again employers indicated that this was an area in which clearer guidance would be valuable<sup>25</sup>.

The final stage of the work was to build on our understanding of opportunities and barriers in order to develop recommendations to take forward the development of Assistant/Associate Practitioner roles in England. We do this in the following two sections. In section 7.1 we discuss the various findings in more depth and in section 7.2 we make recommendations for the sector and for Skills for Health.

## 7.1 Discussion

The work confirms that Assistant Practitioners are being deployed in an increasingly wide range of situations and roles. While past developments have mostly been in acute care, policy focus has led to attention being switched to their use in community and primary care settings. There is growing recognition of the value of Assistant Practitioner posts and the changes planned for how healthcare is delivered in future (increasing automation, integrated health and social care) will mean that there is likely to be an increased need for Assistant Practitioner posts. The research also found that while Assistant Practitioners are generally increasing in number the pace of implementation has slowed in some areas that were early pioneers.

**Benefits** include increased clinical competence and knowledge following training to complement the, often, years of experience acquired as Healthcare Assistants. Assistant Practitioners can take responsibility for

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<sup>25</sup> As we indicated in the introduction, there is an expectation that the CQC may be producing national guidance on supervision but a copy was unavailable at time of writing.

work areas or clinics, are reportedly more patient-focussed, can take a holistic approach to care in community practice and in all settings can work across professional boundaries. They can have supervisory and mentoring responsibilities assessing the NVQs of Healthcare Assistants and undertaking Personal Development Reviews. They tend to be a stable workforce with little turnover. This stability, however, can be a benefit or a challenge, due to the potential impact on demand for, and hence sustainability of, education and training programmes.

**Developments are still unlikely to be part of a long term workforce plan.**

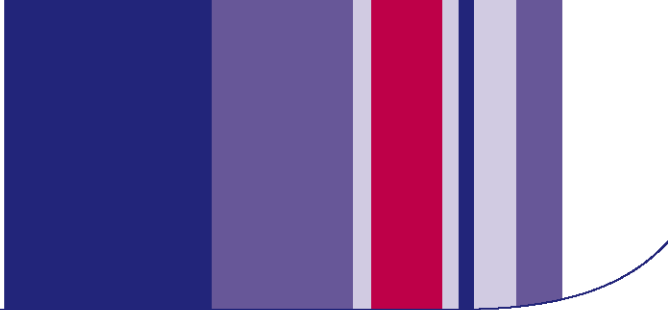
The development of Assistant Practitioner roles still mostly tends to be **reactive**, responding mainly to shortage of registered professionals or drives for cost-efficiencies rather than as part of workforce planning. However this research has also found that there has also been an element of 'chasing the funding' where funding for Assistant Practitioner education is suddenly made available and promoted so organisations/managers look to see who they can then develop. The most successful examples of implementation of Assistant Practitioner roles comes where there is both a '**push**' from strategic leads such as workforce development or HEE funding and '**pull**' from managers or clinics that identify a need for a new skill mix.

Linked to this, much of the discussion around implementation of Assistant Practitioner roles can be viewed in terms of **change management**. As with the introduction of a new role in any organisation, there needs to be strong leadership, communication, clarity of the role and role recognition. In the context of Assistant Practitioners it is apparent in this research that another important success factor is to determine and communicate what the role will and will not do. Helping staff to deal with change, such as where the roles and responsibilities of the existing workforce are altered in order to make the best use of the new role, is also important.

**Development into posts, rather than recruitment, remains the norm.**

The work found that at the moment, Assistant Practitioners continue to be mostly recruited to these roles internally and have previously been employed as health care support workers. The majority of employers are still training the individuals recruited to Assistant Practitioner posts (or trainee posts) rather than recruiting qualified individuals. There is little opportunity to move between employers or even departments within a Trust at this level. Transferability of skills is seen by some as an issue. Because there is currently little experience amongst employers in recruiting directly to these posts few have developed policy or practice in this area. Two employers that had experience in recruiting external candidates directly to these posts reported on how they had ensured the competence of such individuals, and one of these was reported as a good practice example.

**Training and progression.** A balance needs to be struck between developing staff and providing progression pathways and meeting the needs of the organisation that requires people trained for specific roles. Although some employers saw value in encouraging Assistant Practitioners to progress into pre-registration training, in some cases employers were dissatisfied because Healthcare Assistants that had been through the



Assistant Practitioner training had immediately moved on into nurse training, so that the employer failed to gain the anticipated benefit of having Assistant Practitioners in post and had to start the cycle again. The use of learning contracts/training agreements would help employers address this problem.

Conversely, some trainees are dissatisfied because there are no Assistant Practitioner posts for them to apply for in their workplace following training. If the education of Assistant Practitioners is not properly managed it can be counterproductive when people find they cannot subsequently put their learning into practice and become demoralised. While in many cases value may be seen in having a group of better-qualified individuals potentially able to move into higher grade posts when they become available, where cost savings are a priority it would not appear to be sensible to spend money on training that in the majority of cases cannot be used – especially given that we know that skills that are not applied and practiced regularly after training atrophy rapidly.

While some employers were disappointed at the loss of Assistant Practitioners to pre-registration programmes, some saw this as a way of securing an alternative source of registered personnel, in particular nurses, who would then be far less likely to move away than other recruits. Ideally employers need to make talent management decisions early on in the process and, depending on whether they want Assistant Practitioners to stay in post or progress into pre-registration training, to make plans (and give incentives) accordingly.

**Barriers to progression.** Employers, Assistant Practitioners and HEIs, along with two of the professional associations, noted the loss of part time pre-registration programmes. These had been more numerous in the past and now were a rarity. The HEE Talent for Care strategic framework has noted the current barriers to access to training and the need for access to become more open; these recent developments are achieving the opposite.

**Risk** is a recurring theme. The language of risk and how it is managed is key to understanding the concerns about registration and regulation that have been raised. Concerns around regulation are essentially a form of shorthand for assurance. Queries concerning the delegation of tasks are essentially to do with risk and where the locus of responsibility would lie should a problem arise. While guidance exists, many employers feel that firmer and clearer guidance on this issue would be valuable.

However, set against the issues of registration and regulation (and the apparent security some employers believe these would bring) are two further points: would this serve to stifle the creation of innovative roles that cut across disciplines; and if registration were to be brought in, who would be responsible for registering and regulating cross-disciplinary roles? Would roles crossing professional boundaries require multiple registrations?

Closely allied to this is the issue of the requirement for day-to-day supervision and the question of whether this needs to be on-going or as needed and direct, proximal or indirect. There are differences between the

occupations here. There appears to be less anxiety about day-to-day supervision as an issue in occupational therapy – where OT assistants are typically trained by their supervising OT and so any issues around competence would have been picked up earlier – and in radiography, where the professional body has set out a scope of practice for Assistant Practitioners.

**Scoping the role.** Related to these issues of risk, delegation and supervision is a lack of consensus regarding the clinical areas in which Assistant Practitioners are able to practice. What is considered to be within their remit in one department may be restricted to registered staff only in another. While a report in the North West reported that Assistant Practitioners were administering medicines several years ago, in at least three of the Trusts to which we spoke this was an area presenting challenges to staff trying to introduce it as an agreed activity for Assistant Practitioners. There is a tension between the desire of many employers to see an agreed national scope of practice and the diversity of roles and areas in which Assistant Practitioners are employed.

**Critical mass and sustainable education.** In some places, Assistant Practitioner numbers have reached a 'steady state'. One of the key questions for this research was to look at whether there needed to be a critical mass of Assistant Practitioners in order for the role to become fully incorporated in organisations' staff plans. The research suggests that **critical mass** may not be a key factor **apart from** when considering the sustainability and availability of educational programmes, and with these it is churn that is a critical factor in determining demand. Rather, what seems to be a key factor determining value, longevity and sustainability of these roles is that the role fulfils a niche within the team or the overall service model and is seen as having impact.

## 7.2 Recommendations for the sector

This report concludes by looking at recommendations for how the Assistant Practitioner role can be further embedded and taken further in the future. The following recommendations are presented as a challenge to the sector, staff working in workforce planning and development, and for Skills for Health to take forward.

- The Talent for Care strategic framework document identified the **lack of transferable standards** as an issue currently inhibiting progress and recommended that there need to be agreement between service provider organisations and higher education. While core standards for the Assistant Practitioner role have been developed<sup>26</sup> their existence

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<sup>26</sup> These can be viewed at [https://www.rcn.org.uk/\\_data/assets/pdf\\_file/0004/286825/Core-Standards-for-APs.pdf](https://www.rcn.org.uk/_data/assets/pdf_file/0004/286825/Core-Standards-for-APs.pdf)



was not well known and, amongst those who were aware of them there was a view that they could be more useful. The standards are no longer viewed by SfH as 'live'. The new Apprenticeship Standard for Assistant Practitioners is considered by SfH to be in reality more suited for current use. **We therefore recommend that the sector adopts the apprenticeship standards as the basis for describing Assistant Practitioner roles.**

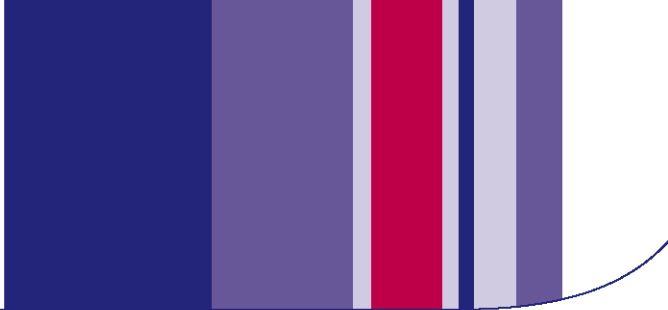
- There needs to be a discussion about the nature of the role and the education required. If it is agreed that **qualifications should be more portable** then there needs to be a debate concerning the desirability or otherwise of incorporating core standards/competences within all initial training programmes in line with the suggestion made in the Talent for Care strategic framework. **Skills for Health could work with HEE to facilitate that discussion with employers and HEIs.**
- Supplementary to this, there should be more work to support employers to **develop training programmes** to follow on from (or run in parallel with) initial training for Assistant Practitioners in specific occupational roles. Ideally there should be some debate around the development of standards for any emerging common areas in order to enable the potential for validation and/or accreditation of in-house programmes to help alleviate difficulties in demonstrating credibility to organisations' governance structures. In addition, support could be provided to help employers develop policies for the use of existing staff (including Assistant Practitioners) as mentors or preceptors to help ensure that any qualified Assistant Practitioners recruited are fully competent in the new setting. Related to this employers should consider putting policies in place to offer continuing professional development to existing Assistant Practitioners to ensure movement within the Trust is possible.
- In addition to the issues around role definition and the use of standards the findings from the primary research reflected those from the literature review in finding that the **absence or presence of guidance on defining and developing Assistant Practitioner posts** remains an impediment to progress. The lack of national consensus regarding specialist activities is also impeding planning for provision of specialist training. Where role implementation has had better success there is often guidance, codes of practice and toolkits developed by Trusts. While in an ideal world these would be developed by each trust, it is unlikely that all – or even many - trusts will have the resources available to them to produce such materials from scratch. This report has identified some existing examples of guidance that is already in the public domain. SfH can support employers by **identifying as wide a range of employer toolkits as possible and facilitate the sharing of examples of practice** and existing toolkits through its website.
- **Training agreements** were mentioned by only a few employers but those who did use them found them useful. We recommend that Skills for Health provides exemplar templates for the design of training

agreements, to help more employers use this mechanism to ensure that they reap the full benefits of the training and the staff in which they have invested.

- **Inclusion of Assistant Practitioner posts within workforce planning** is still not the norm. The focus remains very much on registered clinical staff (although we recognise that the Talent for Care strategic framework may help drive developments). We recommend that **Skills for Health further publicises** the support that they can offer to employers in workforce planning. Again, it is worth emphasising that publicity for such a resource needs to be **repeatedly publicised**.
- Several employers commented that they were keen to **learn from the experience of others**. In some areas Assistant Practitioners have forums where they can share their experiences. Forums for managers would help share practice and experience. There are networks dedicated to the development of Assistant Practitioner roles and the development of bands 1 – 4 on MyHealthSkills and NHS Networks and **Skills for Health might usefully help publicise these**.
- A lead for one of these online groups mentioned during the interviews that such fora do not have the same value as face to face meetings. However it can be difficult for groups to find accommodation for such occasional meetings. **Skills for Health might explore whether it can offer facilities for such meetings on an occasional basis**.
- We have provided examples of good practice in this report. They are just a small subset of past and current work. It is likely that there are many more examples of practice in developing and implementing Assistant Practitioner roles (and their benefits) in many different settings<sup>27</sup>. SfH could play a key role here, either by **hosting examples of such developments on the SfH website (and by updating and publicising these on a regular basis) or by sharing information via the MyHealthSkills website**.
- The conversation about registration and regulation could be started with a **discussion around delegation risk**. The arguments for regulation and registration raised in this report by participants can be addressed through clear governance structures and policy but employers may need guidance and support to help them address this. There is also a role for the Royal Colleges and Professional Bodies to play in this discussion. **Skills for Health could help facilitate these discussions**.
- There is no optimal education pathway for Assistant Practitioners; each of the routes has merits for different settings. No matter the education

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<sup>27</sup> We note that there are also case studies available on the Workforce Modernisation archive site, but for how much longer that site will be maintained, and how many new managers would be aware of this resource, is unclear.



route taken to train Assistant Practitioners, it should include **work-based learning** and employers need to understand that this will require **commitment and support** on their part. There is an appetite for more information on what works in terms of training people for these roles. **Skills for Health could usefully facilitate discussions or an on-line discussion forum** for employers to share information and practice in this matter.

- For managers in the sector who wish to introduce the Assistant Practitioner role we would emphasise the need to ensure that they communicate fully with the whole team. In particular we would recommend that they **start** by communicating the opportunities that will arise for registered staff from tasks being devolved downwards and how the role will be incorporated into existing teams
- Furthermore the research identified some very simple ideas that people felt made a real difference in terms of making Assistant Practitioners more readily identifiable. A different coloured uniform to those provided for Healthcare Assistants was felt to be a small but important step. Therefore our last recommendation is that employers consider **small actions** that may have a large impact.

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## Appendix 2: Discussion Guide - Employer interviews

**Introduction:** research for SfH, IES an independent research organisation, interviews confidential but information will be used to inform research report, which will be published early in 2015. Research aimed at supporting development and introduction of Assistant Practitioner roles.

Name

Role

Organisation

1. Does your organisation employ people in Assistant Practitioner roles, or has it done so in the past?

*Potential answers:* 'No' 'yes, do employ them', 'no, used to employ them but no longer do so'

- **(If no)** Is there a reason for that? What is it? [Explore further if any barriers mentioned] **Jump to Q8.**
- **(If yes, do employ)**
  - In what posts are they employed?
  - Is this in your unit/ward/department or across the organisation more widely?
  - What was the reason for their introduction/use?
- (If did employ but no longer do) In what posts were they employed?
  - Was this in your unit/ward/department or across the organisation more widely?
  - What was the reason they were introduced?
  - What was the reason you stopped using these posts?

**NOTE:** if interviewee does not employ people in Assistant Practitioner roles please tailor the following questions – and skip those that are not relevant.

2. What training do/did you provide for Assistant Practitioners in your organisation – and does/did the type of course/qualification (ie NVQs/apprenticeships in some areas, FDs in others) vary by professional area?

3. How is/was training developed/commissioned/procured for new and emerging roles (eg community rehabilitation assistants, healthcare navigators)
  - Any issues with minimum numbers to keep courses running, sustainability of courses, successional cohorts of trainees?
  - Any issues with quality/relevance/timing of courses?
4. How are/were Assistant Practitioners recruited to the roles? [from existing Healthcare Assistants? By invitation or applications? Externally advertised?]
5. Is/was there any career progression routes for people in these roles?
6. Do/did you have a policy regarding the recruitment of people who have been working as Assistant Practitioners elsewhere? Ie, do/did you try to verify the nature of the training and experience they've gained?
  - If yes, how do you do this?
  - [If not mentioned previously] Do/did you have a policy of compulsory retraining in any particular areas, activities or tasks?
  - How acceptable do/did you find other colleges' qualifications (ie those gained from colleges that you do not use or are not familiar with) in other words, how relevant do you find the knowledge and skills gained from other organisations' training arrangements/qualifications (ie how well does the training meet the needs of Assistant Practitioners working in your dept)?
7. **Are/Were there any benefits from having the Assistant Practitioners in post? [ask them to describe them if they don't do so automatically]. If they don't know, ask if there is any particular difficulty in estimating their impact.**
8. Has the recent focus on safe staffing levels led you to review your policy on employing Assistant Practitioners (or proportions in comparison with numbers of registered staff)
  - If yes, what is your policy?
  - Has there been any impact on the supervisory model you use, or on span of supervision?

**With those who do not currently employ Assistant Practitioners jump to Q10**

9. Do/did you encourage your Assistant Practitioners to consider further progression?

Yes    No



- If yes, what is or are the progression routes?
    - Do you have training/education provision in place to support that progression?
    - Is it part time (ie can they continue working while they continue to learn?)
  - If no, why not?
10. Do you feel that your Assistant Practitioners are/were accepted by the registered staff or are there any issues around professional barriers?
11. Has either your CCG or your local LETB discussed utilisation of Assistant Practitioners with you as part of current or future workforce development planning?
- If yes, have they discussed development options for Assistant Practitioners with you?
  - If yes, what sorts of options have you discussed?
  - (If yes to above) Is anyone leading on Assistant Practitioner developments at the CCG or LETB?
12. [version for those who **currently** employ Assistant Practitioners] Are there any barriers to further utilisation of Assistant Practitioners in your organisation?
- [version for those who **previously** employed Assistant Practitioners; skip if answered earlier in discussion] What were the main barriers to utilising Assistant Practitioners in your organisation?
13. Is there anything else you'd like to say about Assistant Practitioners that we haven't covered?
- Is there anyone who provides training for your Assistant Practitioners who you would recommend we speak to?
  - Is there anyone in your CCG who you would recommend we speak to regarding Assistant Practitioner roles?
14. [For those with Assistant Practitioners] We are asking Assistant Practitioners to take part in a survey as well as focus groups or interviews. Might you be able to forward an email on our behalf to your Assistant Practitioners to alert them to the survey?

**If yes**, arrange to send email with message for interviewee to forward to Assistant Practitioners.

The report will be published in early 2015. Would you like us to notify you when it is available? **If yes**, add their details to the project folder.

Thank and close.

## Appendix 3: Discussion Guide - Focus Group

Thank you all for coming along today. My name is --- and these are my colleagues ---- and -----,

This discussion today is part of SfH research aimed at supporting employers to make more use of Assistant Practitioner roles. These FGs are part of that work and we're also talking to tutors in universities and colleges, to employers, people in health education England, and in professional bodies.

Confidential, no right or wrong answers. It's ok to talk about what you discussed in these meetings outside, but if you do so then please don't identify any other individuals nor attribute any comments to them.

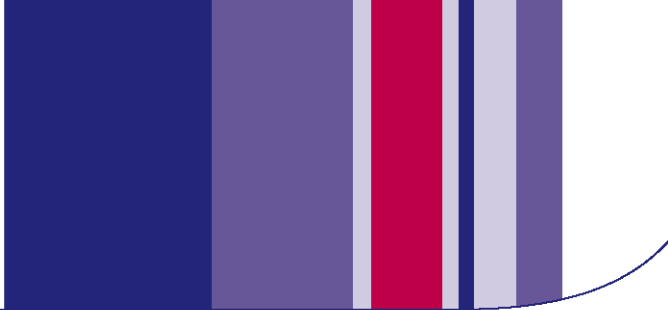
We have to ask you to give your personal details on the receipts for the reward tokens, that's actually so the Inland Revenue can check up on us not on you – it's to prove we're not running off and spending them ourselves! They'll be stored securely in our Accounts office, and won't be used to contact you. PASS RECEIPTS ROUND FOR SIGNING, FOLLOWED BY VOUCHERS.

A report of this work will be published early next year, so if you'd like us to tell you when that's reported then please write your name and email address on this separate piece of paper and we'll get in touch then to let you know that it's available.

Please briefly introduce yourself and say a little bit about the role you are currently working in and what band you are on (if in the NHS; or equivalent if outside). *Note split between B4 and B3s.*

- Could you tell me a little bit about how you came to be on this course? [did you get nominated, did you volunteer, did your manager mention it]. How's it going? Have you been able to use the knowledge and skills gained in this course in your work so far?
- **All** - Are Assistant Practitioner roles **quite widespread** in your organisation? (Try to note which grades say yes/no – is it mainly the Band 3s who say no.)
- **Yes** - What sorts of Assistant Practitioner roles are there (if appropriate: in addition to yours)?
- **No**, ask those on Band 4 do you know why your posts were created? (probe for funding, pilot activity, workforce planning) Were any of you involved in the discussions ahead of your roles being created?

- Ask those on Band 3, do you know why this is the case? Have you been involved in any discussions around the potential creation of these roles?
- **[If this has emerged in previous section skip) Those not on B4 –** Do you have Assistant Practitioner positions (band 4s/Senior Healthcare Support Workers) posts in your department/ward/unit?
- What sorts of things do they do? How do their roles differ from yours?
- Will you be moving into a Band 4 post when you complete this course? Has a Band 4 (or equivalent) post been identified for you when you complete this course? **Record approx number who will be going/not going into B4 post. If yes, what is that post? Do you know how it differs from your current post?)**
- **Those likely to remain on B3 –** Do you have any expectation that you will move onto a Band 4 post in the near future?
  - What is stopping you from progressing – what are the barriers?
  - Would you be interested in moving into an Assistant Practitioner role if they were introduced into your dept/organisation?
- **Those with B4s in their organisation -** Do all band 4s in your organisation have the same education and training – do they all do the FD, or do some do an NVQ or diploma or just internal training?
- **All –** What are your opinions on your course so far? In what ways do you feel that it is contributing to your development?
- **All –** (if appropriate ‘recognising that some of you feel that B4 posts won’t necessarily be available’) What are your career progression opportunities after you complete this course? What would you like to do? Do you have any plans for further progression into a registered position after completing this course? (note how many want to go on to pre-registration training). **If any of the B3s say they want to go into pre-reg training, ask ‘Would you do this if a Band 4 option existed?’**
- **Those who want to do pre-reg training –** How likely it is that you will be able to access the education and training required in order to progress to a band 5 position? If not, why not?
  - Was it your intention to try to get onto a pre-reg programme before you started the FD?
  - Do you think your employer will support you in going for pre-reg training? Will there be any barriers to your progression into a registered post at work? (skip if covered under training above).
- Anything else you’d like to say about your current role or your career opportunities or the education and training you’re receiving?



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**Thank and remind that the report will be available in early 2015 and anyone who wants to be notified should let us have their email address if they haven't done so already.**

## Appendix 4: Discussion Guide - Stakeholders

**Introduction:** research for SfH examining the development of Assistant Practitioner roles. We are examining the reasons for using - or not using - Assistant or Associate Practitioners, what has helped or hindered in introducing these roles and what the main outcomes have been of introducing these roles. The research is being conducted for SfH by the Institute for Employment Studies is an independent research organisation. Interviews are confidential but information will be used to inform research report, which will be published early in 2015. The research is aimed at supporting the further development and introduction of Assistant Practitioner roles.

*Name of interviewee*

*Organisation*

*Role*

*Brief description of their role in relation to Assistant Practitioners*

1. To what extent have Assistant Practitioner roles been a focus of developments in your region, either in the past or currently?
  - not
  - some
  - quite a lot
  - a lot
  - have been in the past but not now
  - **'Not'**: Why is that?
  - **'Have been in the past'**: Why is that?
  - Were there any particular occupational areas in which employers tried to introduce Assistant Practitioners?
  - (If not explained earlier in responses to this question) Did any issues particularly hamper or impede the development or use of Assistant Practitioner roles?

**Now go to Q8A**

If 'some', 'quite a lot', 'a lot', probe:

- Who has led on these developments (the CCGs, the Trusts, GPs, leads of integrated H&SC services)?
    - If CCGs/Trusts, is it all of the CCGs/Trusts in your area or some of them? All/Some.
    - If 'some', is there a reason why some are more interested in development and use of these roles than others? (prompts: better HR/workforce planning in some CCGs; different patient profile (more elderly people, more impact of dementia in some areas etc.)
  - (If not covered in reply to question above) Are developments focussed on a particular area/client group: elderly, dementia, hospice at home etc?)
2. Is there a focus on Assistant Practitioner roles in particular occupational/professional areas and if so which area(s)?
- What development work is underway/planned?
  - Is/are the relevant professional body/ies involved in these developments?
  - Are there any areas in which the organisation has tried to introduce Assistant Practitioners but it's been unsuccessful or expansion has been slower or more difficult than expected? Yes/No
    - If 'Yes' What area(s)?
    - Why is that?
3. What factors do you see as having influenced the introduction and use of these roles to date?
- Do you think the same issues are affecting further introduction and use of these roles, or have other factors started to influence more recent developments?
  - How well do you think employers understand the role of Assistant Practitioners?

(For questions 4 – 6, if these issues have been raised in response to earlier questions, use judgement re whether to pursue further or not – ie, if already answered, skip.)

4. Are there any areas where you have tried to promote or introduce Assistant Practitioners but have been unsuccessful?
5. Have you encountered any issues that you feel are hampering or impeding the development of new Assistant Practitioner roles or the continued growth in the number of Assistant Practitioners?

6. Have any issues emerged regarding the use of Assistant Practitioners following the review of safe staffing levels?

- If 'yes', what are these?

7. Is the Better Care Fund and the drive for integrated health and social care impacting on planning for and use of Assistant Practitioners?

**DG returns to 'ask all' mode here:**

8. A (**For those who do not currently have Assistant Practitioners or are not developing them**): Is there any education and training provision that would be suitable for Assistant Practitioners in your region?

- If yes, what provision is there?

**Now go to Q9**

8. B (**For those who do have Assistant Practitioners**) Is there adequate provision of education and training or qualifications for Assistant Practitioners in your region?

- **If yes**, What are the main qualifications/education or training routes available for Assistant Practitioners (FD, HNC, CertHE, QCF Diploma/ NVQ/apprenticeship etc). Note if different for different roles.

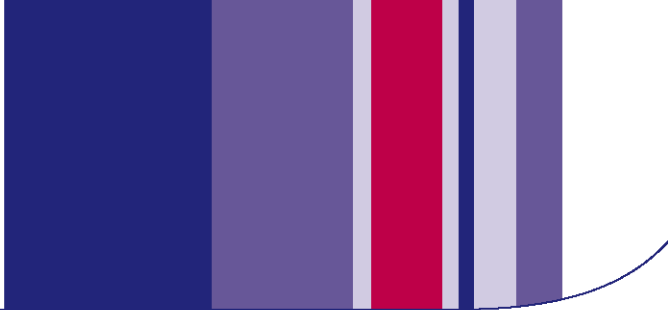
- **If no**, what/where are the gaps?

- Are you working on the development of qualifications to meet this need?
- **If yes**, can you tell me about this work (what qualifications, who is involved in development, who will deliver)
- **If no**, is there a reason for this?

9. For Assistant Practitioners who wish to progress into a professional role, is there a progression route? Yes/No (Note any differences between professions.)

- **If yes**, can you tell me about the nature of that provision – is it full/ part time/ work based/ Access to HE?
  - Does it enable progression through to professional status (registration; ie, completion of a degree programme)?
- **If no**, are you/the LETB involved in work to support the development of progression pathways?
- **(Both yes and no) Should there be national guidance regarding the development and nature of progression pathways?**





10. Is there anything else you'd like to say about the issues around development, introduction and progression of Assistant Practitioners in your region?

11. We are also speaking to other stakeholders, employers and HEIs as part of this work. Are there any people within the local CCG(s), trusts or HEIs you think it would be useful for us to speak to? If yes, get contact details.

The report will be available in early 2015. Would you like us to notify you when it is published?

If yes, add contact details to folder.

Thank and close.

A decorative horizontal band with a curved top and bottom edge, containing vertical stripes in various shades of blue and red.

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