Assistant Practitioners: scoping exercise

A report to Skills for Health

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This report was prepared for Skills for Health by
Iain Mackinnon and James Kearney

2A Walpole Court, Ealing Green, London W5 5ED

020 8799 3120

iain@themackinnonpartnership.co.uk

www.themackinnonpartnership.co.uk

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Background to the Commissioning of the Assistant Practitioner Scoping Exercise

Skills for Health has undertaken several projects which have included the development of the Assistant Practitioner role. We are aware of other projects in this area, for example, NHS North West has taken a uniform approach to the development of the Assistant Practitioner role across their Strategic Health Authority area. Other organisations have taken a different approach where the development of the role has been more ad hoc.

With the support of Chris Mullen, Assistant Director of Workforce Development at NHS North West, and following the raising of a number of concerns with Skills for Health about the perceived variation in the role of the Assistant Practitioner, Skills for Health set up a Task and Finish Group to develop core standards for Assistant Practitioners in England. (We are aware of other work which has been undertaken in Wales and Scotland).

The time frame for the work is as follows:

November 2008	First stakeholder meeting
January to March 2009	Scoping exercise to identify characteristics of existing roles
April 2009	Draft standards developed
May – July 2009	Public Consultation in relation to the standards
August 2009	Analysis of consultation responses
September 2009	Final meeting of the stakeholder group to modify standards
October 2009	Standards published

This document reports on the Scoping Exercise which we have commissioned from The Mackinnon Partnership. It was not possible for them to consider every Assistant Practitioner role but they have included a wide range. They have investigated the education and training of Assistant Practitioners, assessed job descriptions and identified the services and professions they support.

The information generated by this report adds to the body of evidence upon which the core standards for Assistant Practitioners will be based. Skills for Health and our stakeholder partners have found the information contained in this report interesting and helpful. It has confirmed those things that we thought we already knew but where the formal evidence was less clear. We believe this work will be of interest to those involved in role development and workforce planning. We hope that you will find it useful too.

Kathryn Halford
Divisional Manager
Skills for Health

1. Introduction

Background

1.1 The New Ways of Working team at Skills for Health has formed a group to determine National Standards for assistant practitioners working at Level 4 of the career framework (known variously as ‘assistant’ and ‘associate’ practitioners) in England. Whilst identifying membership for this group it became apparent that various initiatives have been introduced in relation to Assistant or Associate Practitioners in some areas of the country. Skills for Health therefore took the view that it was likely that there are other initiatives in areas of the country not canvassed for members of the standards group.

1.2 For the work of the group to be adopted throughout England, it needs to take into account all the work that has been undertaken in this area:

- to avoid duplication of work already done;
- to harmonise the outputs of the standards group, wherever possible, with work previously undertaken;
- to identify a range of champions who will pilot the standards.

1.3 In December 2008 Skills for Health therefore commissioned The Mackinnon Partnership to prepare a brief report scoping the extent of work that has been undertaken around the introduction of the Assistant or Associate Practitioners, including identifying where possible job descriptions, required or recommended education and training to support the role, and who has sponsored the role.

Methodology

1.4 Our research involved:

- interviewing individuals from the Workforce Development teams in each of the ten Strategic Health Authorities in England, as follows:

Interviewee	Region	Interviewee	Region
Paul Holmes	East of England	Emma Wilton	South Central
Cate Hollinshead	East Midlands	Julie Toulson	South East Coast
Annette Keen	London	Tricia Ellis	South West
Rob White	North East	Anne O’Leary	West Midlands
Helen Kilgannon	North West	Ian Wragg	Yorkshire and the Humber

- checking emerging findings with Skills for Health Regional Directors;
- collecting job descriptions where we could get them;
- assessing those job descriptions, particularly to identify common features.

1.5 In a number of regions we were also given, or came across, reports on the development of Assistant Practitioner roles within that region. We have therefore taken the opportunity to summarise them in an initial section of this report, which helps to set the context for what we have found.

Definition

1.6 There is no universally accepted definition of an Assistant (or Associate) Practitioner. That caused us some difficulty because although the terms are in common use, everyone recognises that the lack of an agreed definition made it harder to be sure whether or not to include particular roles in our survey. Moreover, many roles identified as Assistant or Associate Practitioners have neither term in their title - a point which we develop in the next section: titles matter to people.

1.7 Resolving difficulties caused by this variety is, of course, part of the point of the project and in practice we were not forced into any awkward choices.

1.8 The definitions we found were as follows:

A *'An Assistant Practitioner is a health and social care worker who delivers health and social care to patients with a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. He or she would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. In many cases this healthcare delivery role would also transcend many of the boundaries that have hitherto been strictly demarcated between different professions. He or she would also have the underpinning knowledge and assessed level of competence to undertake such a role*'.[1]

B *'In NHS South Central, APs are defined as being involved in the delivery of healthcare with a level of knowledge, skill and competence beyond that of a traditional healthcare assistant/support worker. They assume responsibility for delegated aspects of healthcare delivery which may previously have only been within the remit of registered practitioners. The AP works within a scope of practice under the direction or supervision of a registered practitioner within relevant legal and ethical frameworks and in accordance with organisational protocols and policies. They are educated to Foundation Degree level or equivalent and employed at a minimum of Agenda for Change band four.'*[2]

[1] North West Workforce Development Confederation, 2003
[2] Evaluation of Assistant/Associate Practitioner Roles across NHS South Central, 2008

C *'Based at Level 4 of the Careers Framework. They are unregistered, and probably assist registered practitioners in a specific range of tasks limited by scope of practice or level of complexity, although they can work with a degree of autonomy not accorded to support workers at Level 3 or 4 of the Careers Framework. Whilst the specific education required will vary according to the role, it is usually at the level of a Certificate of Higher Education, or a Foundation Degree.'*[3]

D *"Someone probably studying for a Foundation degree or equivalent. Their remit will involve them in delivering protocol-based care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner".*[4]

E *'An Assistant Practitioner performs protocol-limited clinical tasks under the direction and supervision of a state registered practitioner.'*
[It should be noted that at the time of publication the term 'state registered' was still valid].[5]

1.9 It is striking how frequently these definitions are set in terms of what Assistant Practitioners are *not*: they are, for example, *not* healthcare assistants and *not* registered professionals.

1.10 From this point on we will use the more common of the two terms, Assistant Practitioner, for simplicity.

[3] Briefing paper on Associate Practitioners developments, East of England, 2006
[4] Foundation Degrees: Developing the Workforce of the Future in the Health and Social Care Sector, Skills for Health, 2005
[5] The Scope of Practice of Assistant Practitioners in Clinical Imaging, the College of Radiographers, 2007

2. Context

2.1 In this initial section we set the context for what follows by reviewing briefly the various reports which we have come across focusing on Assistant Practitioners: we have not attempted to make this analysis comprehensive. Those reports are these:

Table 2.1: Reports on Assistant or Associate Practitioners identified through this study

Region	Report Title	Published
NW	Assistant Practitioner Foundation Degree Evaluation Project	2007
NW	Foundation Degrees: Developing the Workforce of the Future in the Health and Social Care Sector	2008
South Central	Evaluation of Assistant / Associate Practitioner Roles across NHS South Central	2008
SE Coast	*fdf* Review for South East Coast Strategic Health Authority regarding Assistant / Associate Practitioner provision in the region and Foundation Degree provision	2008
EE	Demand for Assistant Practitioners	unpublished
EE	Scoping Work	unpublished
EE	Briefing paper on Associate Practitioners developments	unpublished
Nationa l	Mapping the introduction of Assistant Practitioner roles in Acute NHS (Hospital) Trusts in England[6] (University of York)	2008
Nationa l	Assistant or substitute: Exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions[7] (University of York)	2008
Wales	A Strategy for a Flexible and Sustainable Workforce	?2008

2.2 The role is commonly placed at Band 4 on the NHS Agenda for Change job evaluation framework. This means that Assistant Practitioners work below registered practitioners such as nurses and physiotherapists, and at a level above healthcare assistants and support workers.

[6] Journal of Nursing Management, 2008
[7] Wakefield A, et al. Assistant or substitute: Exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions, Health Policy, 2008

2.3 National research carried out at the University of York in 2008 showed that 46% of trusts had Assistant Practitioner roles in nursing, with a further 22% planning to introduce such roles before 2009. The national average masks wide variation between regions, with 84% of trusts in the North West employing Assistant Practitioners, and 25% in the South East Coast, West Midlands and Yorkshire and Humber.

2.4 The York researchers looked into the job descriptions of these Assistant Practitioners and found some ambiguity around the role they were being asked to fill, particularly around the degree of autonomy available to them.

2.5 Evaluation by the University of Central Lancashire (UCLAN) of the introduction and implementation of the new Assistant Practitioner roles in the North West, however, found that though there was a good deal of variety, Assistant Practitioners' job descriptions were "underpinned by the same core characteristics."[8]

2.6 The UCLAN researchers used questionnaires, case studies and focus groups to discover the impact which Assistant Practitioners were having. From this they concluded that Assistant Practitioners were having a positive impact in the region, allowing some substitution of roles with registered practitioners, with several examples of good practice highlighted. These included reduced waiting times in nail surgery clinic and providing more 'hands-on' nursing experience. Service users also noted positive effects, including greater continuity of care and development of a stronger relationship between them and staff. The Foundation Degrees available were found to offer a very good grounding for Assistant Practitioners, who were also judged to be fitting-in well to service teams.

2.7 A review of the role in South Central region notes that where the Assistant Practitioner roles have been established, they are "contributing greatly to the skills mix of the team."[9] The report also makes the same claim as in the North West, that there is a substitution of roles with registered practitioners, freeing-up their time to concentrate on more complex clinical tasks. It also points out that the introduction of the role has increased the opportunities for career progression, leading to a happier and more motivated workforce.

2.8 The South Central research also highlighted issues round job title, and perhaps why many people who are considered to have Assistant Practitioner roles do not have the term in their job title. The following quotation is illuminating:

> *"I prefer it* [the term 'Associate Practitioner'] *because 'Assistant' often signifies that you are not qualified in an area. But as an 'Associate', we are qualified to a certain degree because we've done the course, we were able to go through all the*

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[8] North West Evaluation Executive Summary, p3

[9] Evaluation of Assistant/Associate Practitioner Roles across NHS South Central, p4

modules and pass them and come out with a foundation degree … The only thing that we don't do are the drugs at the moment, but we do an awful lot of the other things that the nurses used to do or do do. So I feel that we're 'associated' with them rather than just assisting them."[10]

2.9 The research from the South East Coast mainly focuses on the education side, and Foundation Degrees in particular. The researchers discovered that over half of the trusts which responded already employed Assistant Practitioners, and there were plans to double the number of Assistant Practitioners in these trusts over the next three to five years. The report recommends that the partnerships between some trusts and universities be promoted across the region, more information be made available about how Assistant Practitioners with Foundation Degrees can improve their service, and that a five year strategy is put in place as part of the SHA's workforce development and education commissioning strategy.

2.10 Demand for Assistant Practitioners has been mapped in the East of England, identifying the key areas where Assistant Practitioners are required: notably community and primary care, mental health, emergency and critical care, secondary care, diagnostics, women and children. The various sub regions' strategies differ as well, indicating differing responses to locally-identified need, and supporting the view that Assistant Practitioners can be trained quickly to help shortage sectors.

2.11 Development of Assistant Practitioner roles in Wales flowed from a strategic review of the changing workforce structure, notably conclusions that there were fewer Band 4 roles than expected, that there were changing needs (for example because of the ageing population), and that some of the expertise among Band 5 staff was no longer needed. The option was therefore developed to replace some existing roles with Assistant Practitioners.

2.12 If a theme emerges it is that though development has followed different paths in different areas in response to locally-identified need, there are many common threads – though threads not yet drawn together for wider benefit.

[10] Evaluation of Assistant/Associate Practitioner Roles across NHS South Central, p7

3. Interviews

3.1 We initially contacted Strategic Health Authority workforce leads in each region, and began our research by interviewing either them or their nominees. In this section we report their comments. In every case, and throughout this document, we report what we have been told, quoting directly where we can and using the language which others use. For example, some roles have developed with a broad remit, such as ‘healthcare science’, where others focus on a particular aspect of healthcare science, such as ‘diagnostic testing’.

3.2 Our aim here is therefore to report things *as they are*: it is for the Skills for Health working group to consider whether things are as they should be.

Development of Assistant Practitioner roles in different regions

3.3 Assistant Practitioner roles have developed at different times and in different ways in different regions, with a more structured approach emerging in some than others. The role appears to have been formalised first in the North West, where it has become linked explicitly to Foundation Degrees. The first intake on to a Foundation Degree course for Assistant Practitioners was in 2002, more than six years ago, and at an early stage in the development of Foundation Degrees.

3.4 The formalisation of the link with Foundation Degrees in the North West makes it relatively easy to chart the history of the Assistant Practitioner role in that region, but in others the development of the roles has taken a less structured form, characterised by one interviewee who said:

> *“They have been knocking around in one form or another for a while now.”*

3.5 *Explicit* and *purposeful* development of the role appears to be more recent, however, and in few cases do regions appear to have a written strategy for Assistant Practitioners.

Service Areas

3.6 As we have said, by no means every job which is regarded as an Assistant Practitioner job has the term in its title. However, those that have been identified work in a wide variety of service areas, “from conception to the morgue” as one of our interviewees put it. As we indicated above, some roles are cast quite broadly and others are much more focused.

3.7 We have identified over 60 Assistant Practitioners roles, working in different service areas and associated with different professional roles. The full list is in Table 3.1 over the page.

Table 3.1: Assistant Practitioner roles identified	
Acute Care	Microbiology
Accident	Multi Therapies
Admin & Clerical	Nursing & Midwifery
AHP	Occupational Therapy
Andrology	Operating Department
Audiology	Ophthamology
Biochemistry	Other Scientific, Technical & Therapeutic
Blood Transfusion	Others
Cardiology	Paramedic
CardioRespiratory	Pathology
Cellular Pathology	Pharmacy
Child Services	Physiotherapy
Children's Haematology	Point of Care Testing
Clinical Psychology	Primary Care
Cytology	Public Health
Dentistry	Radiography
Diagnostic Testing	Radiology
Dietetics	Radiotherapy
Elderly Care	Rehabilitation
Emergency Care	Renal
Gastrointestinal Physiology	Reproductive Medicine
Haematology	Respiratory
Health & Social Care	Sample Reception
Healthcare Scientists	Scrubs
Histology	Social Care
Histopathology	Social Services
Imaging & Breast Screening	Speech & Language Therapy
Immunology	Theatre staff
Laboratory Medicine	Therapies & Community Nursing
Maternity Care	Virology
Mental Health	

3.8 There may well be more: our purpose was to scope the role, not undertake a census.

3.9 The table therefore shows simply the range of roles we identified, not the number of posts or post-holders: though our search identified many more roles in some regions than others, by agreement with Skills for Health we made no attempt to quantify how many Assistant Practitioners there are.

3.10 The spread is considerable, however, and clearly indicates some regional differences. No role appears in more than five of the 10 regions; six appear in four regions and another five in three. 40 (two thirds) appear in only one region. Role titles also vary a good deal, indicating that some are cats much more broadly than others.

Qualifications, Experience and Training

3.11 There is a good deal of difference between regions in what qualifications and prior experience they require of staff before becoming a qualified Assistant Practitioner, and also in what training they subsequently get. Moreover, we were told that there are further differences *between* Trusts within regions, and indeed *within* Trusts.

3.12 There is a good deal of variety over required entry qualifications. Some roles require relevant academic qualifications, such as a Trainee Assistant Practitioner role in histopathology and cytology in the University Hospital of South Manchester, which requires an A level in a science subject. Other acceptable qualifications include a Diploma in Higher Education, or BTEC Diplomas or Certificates.

3.13 In the North West every Assistant Practitioner is required to have a Foundation Degree, and there seems to be an understanding elsewhere that Foundation Degrees should be the normal entry requirement for Band 4 positions. (It is worth noting in passing that many Foundation Degrees are broadly-based as “health and social care”).

3.14 Interviewees gave a number of reasons why Foundation Degrees are not always used. One was simple availability, explained in terms of there being no university nearby (though Foundation Degrees are typically delivered by further education colleges) – in which case NVQs are used.

3.15 Another reason given was that some people, particularly those who had been out of education for a while, would be unlikely to want to do a two year “academic course”[11], but would accept shorter, particularly in-house, training (again usually an NVQ, and at Level 3). To combat this problem, access courses leading to Foundation Degree entry have been offered in the East Midlands and in South East Coast (and perhaps other regions too) to people who had been out of education for some time, or who lack the qualifications for direct entry.

3.16 In Yorkshire and the Humber, the SHA, on behalf of a network of interested parties, has taken job descriptions and person specifications to an education provider, inviting it to say which course would produce most cost effectively a person who was “fit for purpose”. This is commonly, but not always, a Foundation Degree.

3.17 Qualifications quoted as being required of those entering Assistant Practitioner posts were:

- Foundation Degree (various subjects)

- Diploma of Higher Education
- NVQs (at level 3) (typically through in-house training)
- BTEC
- City & Guilds Higher Professional Diploma
- Apprenticeships
- CPD modules added to a NVQ level 3 qualification.

3.18 Some caution is needed here because though the norm is for Assistant Practitioner posts to be at Band 4, a number are currently placed at Band 3, and some at Band 5. In other words, some roles described to us as "Assistant Practitioner" roles may cease to be regarded as such in time, if and when a shared national approach to the role is developed.

3.19 There is a further complication here. Some interviewees highlighted poor practice within trusts, for example leaving an individual in a Band 3 position, their substantive grade, after they had successfully completed a Foundation Degree, on the basis that no Band 4 job was available. The suggestion from an interviewee was that a trust had reneged on a promise to regrade. We were also told about other people qualifying for posts at Band 4 through other qualification routes, and doing what was effectively an Assistant Practitioner job, but not being recognised at Band 4. Any informal practice of this nature is more likely to occur where there are no standards, and no definitions.

3.20 On the training itself, interviewees commented on the value of having more than one person from each trust learning together: they are more likely to complete the course, and more likely to be influential within their work teams when they have done so. Others noted the value of support from mentors.

3.21 Interviewees also commented (favourably) that formally-trained Assistant Practitioners are more aware of their limitations, and feel better able to challenge senior colleagues who ask them to undertake tasks for which they have not been trained.

[11] Foundation Degrees are, of course, designed to be anything but "academic", with flexible, work-based, delivery common.

3.22 In Wales, a slightly different approach is used. Work last year under the ‘Flexible and Sustainable Workforce’ banner looked at the whole workforce in the sector, including Band 4 workers and Assistant Practitioners. Educational standards were set for these roles, requiring all to have basic education to NVQ level 3, and education at a higher level specifically in the area which they are working in. The higher level qualifications must be referenced in the Credit and Qualifications Framework for Wales.

Managing Initial Training

3.23 We heard of concerns about the cost of courses and about securing funding for them. In one example we were told that pilot Foundation Degree courses ceased to run when Trusts had to pick up the cost themselves, because they were not persuaded of its value.

3.24 We also heard concerns about the difficulty of ensuring that enough people could be enrolled to make a course a viable business opportunity for awarding bodies. An example of this, coupled with funding being diverted to new priorities, led to a planned Foundation Degree in endoscopy failing to be validated in London. Courses cancelled by the provider for this reason have led to staff shortages in key areas.

3.25 Regions have found it most cost effective and more straightforward to secure funding by using a ‘core and options’ approach, with everyone doing the same core modules of a Foundation Degree together, and specialist modules taught separately. This approach is being used in the North West and London, and other regions are considering it[12].

Recruitment and Progression

3.26 Though the culture of the NHS generally supports progression, the extent to which regions have formally considered progression options for Assistant Practitioners also varied.

3.27 Some regions prefer to recruit people for Assistant Practitioner roles who have previous experience working in Bands 1–3. In one region people recruited to do a course for an Assistant Practitioner role were first placed in a role in the trust for six months before the course started, to give them a feel of the job.

[12] As Foundation Degrees are designed to allow for a good deal of flexibility in how they are delivered, precisely to address the needs of workers with busy jobs, there may be more behind the apparent problem than was indicated.

3.28 To aid this recruitment, the regions offered a variety of flexibility and support, running part-time and access courses. For the qualifying courses themselves regions have offered ‘twilight learning’ and e-learning (through the employer’s Virtual Learning Environment), financial support, and they have supported Accreditation of Prior Learning. Some regions offer mentors, typically practitioners at Band 5, to help the individual through their course.

3.29 In other regions, identification for development appears to be more informal, relying on a manager to spot ability and enthusiasm, and then to encourage an individual to take training and progress.

3.30 Progression onwards from the Assistant Practitioner raised interesting issues. Several people pointed out to us that that the position of Assistant Practitioner is a legitimate role in itself: many in the role will not want to move on to a full practitioner role. We also heard that the jump to Band 5 role is not easy – though we heard of no case where formal obstacles have been put in the way of an Assistant Practitioner wanting to progress.

3.31 Some regions have strategies in place, such as the ‘Skills Escalator’ in Yorkshire and the Humber (which allows people to “start at the bottom and progress to the top if they put in the relevant work, and have the ambition and skill”) and a ‘Blockbuster’ type model in London (allowing both horizontal and vertical progress, named after the television show, *Blockbusters*). Both models allow people to get the skills they need, both to move upwards and sideways, through branching out.

3.32 Such ‘horizontal’ progression may well be the preferred route for many Assistant Practitioners, whether as a recognition of the greater difficulty of breaking into the recognised professions, or for reasons of personal preference.

3.33 Wales offers an interesting example of upwards career progression. Support is through the various stages from basic skills, through NVQs and on to Healthcare Support Workers progressing into the registered professions. An example of this is the work at Swansea University, which is being replicated at other universities in Wales. The university linked the NVQ level 3 in Healthcare Science and related Open University courses, and a Higher Level Study Skills bridging module with APL, so that individuals could be credited with the first year pre-registration nursing course.

3.34 Post-qualification training for most Assistant Practitioners is through continuing professional development (CPD). We identified no cases where further formal training is required.

3.35 However, we heard of an example of good CPD in the South West, where an Assistant Practitioner in physiotherapy was identified as enthusiastic and good at their job. Through mentoring and in-house CPD training, they were trained for and took a new, more senior, post created after a colleague retired. Also in the South West, CPD training is used to allow Assistant Practitioners to conduct more specialised work, such as teaching.

3.36 In addition to the small number known to progress into professional roles, we heard of examples of people, particularly in the North West, who have moved on from an Assistant Practitioner role to Band 5 and 6 roles, in management or in clinical positions.

Success of the role

3.37 The overwhelming message we have had from all regions is very positive about the introduction of Assistant Practitioners.

3.38 It is clear – most powerfully from the research in the North West which quotes Assistant Practitioners in their own words[13] – that people moving up into these roles feel a great sense of pride in what they have achieved. For example:

> *"I feel we provide a role to support the qualified staff and take some of the more mundane tasks off them like CPA documentation. I feel we provide a role in providing a more effective service for the client and at the end of the day we are here for that aren't we?"*

3.39 And this from a colleague indicating how Assistant Practitioners free up time to enable the professionals with whom they work to use their time more effectively:

> *"There's a massive impact just in terms of how long it physically takes to do a risk assessment, especially if you're doing all the research behind it and to do one properly, it's very helpful having [Assistant Practitioner] there when she's co-working 'cos it's one less thing that you have to do. She'll help me with writing up visits as well. I mean for me personally it frees me up to do some cognitive behaviour therapy with some of my clients which if I wasn't co-working with [Assistant Practitioner] I'd be bogged down in terms of paperwork."*

[13] Assistant Practitioner Foundation Degree Evaluation Project (2007)

3.40 Assistant Practitioners are clearly thrilled to be more useful to their patients and hence to be able to provide a greater level of care. They are pleased to have overcome demanding challenges, particularly where people with modest educational achievement in the past have studied for and been awarded Foundation Degrees (often with the added complication of juggling formal study with work and family responsibilities). Though we did not identify any study which has sought to quantify the benefits to patients, it would be very surprising if this great sense of pride and achievement did not work to the good of patients.

3.41 It is also clear in management terms that Assistant Practitioners are filling a gap between healthcare assistants and registered professionals. For patients, filling that gap is commonly reported as providing greater continuity of care: patients have less need to see a succession of people as one individual can do more for them unaided.

3.42 We have, however, picked up two particular issues, which will come as no surprise to Skills for Health. We heard, from several regions, that some more senior staff are not yet entirely comfortable with Assistant Practitioners and are not clear either about how they might be used, or how to value their qualifications: they “stick with what they know”, as one interviewee put it. We also heard that some qualified practitioners worry that Assistant Practitioners “dilute” their professional qualifications though we have not seen that worry articulated further). These are symptoms of a system in transition, we suggest, not fundamental problems inherent in the nature of an Assistant Practitioner.

4. Core Competences and Requirements

4.1 In the previous section we saw that Assistant Practitioners operate in a wide variety of service areas, and work with a wide variety of professionals. Analysis of the job descriptions which we have collected shows that, despite this variety, there are common strands. In this section we explore those common strands. We make no pretence however that this analysis is comprehensive, or holds good for every Assistant Practitioner role in the country.

4.2 Interviewees cautioned that we should treat job descriptions with care, because the reality of a job may include carrying-out tasks that are not on the job description, and omitting some which are. We would add that different employers choose different approaches to writing job descriptions, commonly with more emphasis on the requirements of the recruitment process, or perhaps with an eye on grading, than on shaping what employees actually do.

Generic requirements

4.3 Most employers have a number of generic requirements in their job descriptions which apply to every member of staff, or to every member of staff in certain occupational groups, such as those working directly with patients (and commonly linked to the Knowledge and Skills Framework). Examples include health and safety, attitude towards patients, responsibility to follow Trust procedures and for record-keeping, responsibility for one's own learning and development, and communication skills.

Requirements particular to Assistant Practitioners

4.4 Of more interest are the requirements in job descriptions which are particular to Assistant Practitioner roles. These include the following for roles with access to patients:

- supporting the work of the registered practitioner, in terms of preparation / assistance for clinical / therapeutic treatments
- perform patient assessment and (under supervision) plan and deliver care
- assess patients' well-being and health needs, including temperature, blood pressure, pulse respiration rate, peak flow, oxygen saturation and early warning score
- following the appropriate training, the following can also be done by an Assistant Practitioner: venepuncture, electro-cardiology, removal of clips and sutures, removal of peripheral venous cannule, and blood glucose level and monitoring

- health education, specific to the clinical area and in line with trust policies
- support patients in activities of daily living
- implement and evaluate care plans, under the supervision of a practitioner.

4.5 There are two themes here:

- supporting the work of a registered professional, usually in ways determined by that professional *at the time*, rather than codified in advance;
- undertaking particular tasks identified in advance, always under the supervision of a registered professional, but with a good deal of autonomy. (The degree of autonomy achieved in practice no doubt varies depending on personality and circumstance).

4.6 It is worth noting the lack of precision in some of these descriptions, however: “support” is a vague word, for example, and “under supervision” leaves a good deal of scope for interpretation. As they are not registered professionals, Assistant Practitioners do not have the support of any professional body in interpreting job descriptions, and reliance on local definition may be insufficient, both in terms of patient care and for the professional development of the individual.

4.7 Requirements for Assistant Practitioners who do not come into direct contact with patients are necessarily different. Examples from scientific roles include:

- be responsible for the preparation of specimens
- coverslipping and labelling slides
- safely operate equipment under the supervision of state registered practitioner.

Requirement to follow a Code of Practice

4.8 A number of job descriptions include an obligation to comply with a code of conduct. Some are clearly Trust-wide (ie for all employees), but we have three examples specific to the Assistant Practitioner role, from North Bristol NHS Trust, from the former Greater Manchester SHA (called “Conduct Guidance”) and the other region-wide, from South Central region. Most of this is also generic (eg the preamble to the South Central code advises: “As an Assistant/Associate Practitioner you have a duty of care to your patients and clients, who are entitled to receive safe, competent, high quality care” – all of which applies to many other posts).

4.9 The Manchester guidance, which was published in 2003, is clearly set in the context that ‘Assistant Practitioner’ is a new role:

> *The intention is to have common standards required for Assistant Practitioners across the services and ensure that they know what standards of conduct employers, colleagues, service users, carers and the public expect of them.*

and an expectation that there will be *national* requirements in due course:

> *The guidance is a key step in the introduction of a system of regulation for Assistant Practitioners that is being considered on a national basis. The future proposals discuss the introduction of a national register that will be used as a public record. The aim of registers is to ensure that those on the register have met the requirements for entry onto the register and have agreed to abide by the standards set out in the Guidance of Practice for Assistant Practitioners.*

4.10 The detail lays particular emphasis in four places on the position of Assistant Practitioners, using the introductory phrase 'as an Assistant Practitioner … ':

- As an Assistant Practitioner, you must always strive to establish and maintain the trust and confidence of service users and carers;
- As an Assistant Practitioner, you must promote the independence of service users while protecting them as far as possible from danger or harm;
- As an Assistant Practitioner, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people;
- As an Assistant Practitioner, you must uphold public trust and confidence in health and social care services.

4.11 It also makes a particular point about continuing professional development:

- Undertaking relevant training to maintain and improve your knowledge and skills and contributing to the learning and development of others. This would include undertaking mandatory training, participating in performance appraisal and having an individual personal development plan. It is expected that *continuous performance development and individual improvement is part of the culture and expectations for people who fulfil the role of Assistant Practitioners within Health and Social Care*. [our emphasis]

4.12 The South Central code is not framed as explicitly to support the new role of Assistant Practitioner, though given the context some of its terms take on a different emphasis, for example:

- 'Recognise and work within the limits of your competence, only accepting responsibilities for those activities for which you are competent'

- 'Remedy circumstances in the healthcare environment that could jeopardise safe standards of practice. Where you are unable to do this, report these circumstances to a senior colleague with authority to manage them. A written record must support this report'

4.13 The North Bristol NHS Trust code takes a different tack, and is clearly tailored to the circumstances of the role, for example:

Being accountable

Assistant Practitioners are not yet accountable to a professional body, but they are accountable to themselves, their employer, and, more importantly, their patients. Registered Health Care Professionals are accountable for their roles, including delegation. This means that they must be able to justify why they delegated a task to you.

and …

Taking responsibility yourself

As an Assistant Practitioner you are accountable for the actions you take when work is delegated to you. In addition, you are also accountable for any omissions to act, if it was reasonably foreseeable that a patient might be injured or caused distress or harm by your failure to act.

4.14 A section "how you carry out your duties" contains four points, three of which have particular relevance to Associate Practitioners:

- *Always act under the direction and supervision of a registered practitioner.*
- *Do not take on an activity unless you can carry it out safely and effectively according to your job description.*
- *If you do not feel ready to take on an activity, report this to a registered practitioner and ask them to help you develop the knowledge and skills you need.*

5. Conclusion

5.1 Viewed nationally, this feels like a system in flux. A new role has emerged within the last few years. It has formalised faster in some parts of the country than others, developing differently, with more or less focus on Foundation Degrees as an entry requirement, and more or less breadth to the role. Though some research and evaluation has been done, there is, as yet, little basis for saying that one approach is better than another. It is also probably the case that some roles labelled as "Assistant Practitioner" today will no doubt cease to be accepted as such in time. Others will gain the status as the role becomes more recognised, more accepted, and more understandable to the healthcare sector.

5.2 Within the context of Skills for Health's work on "nationally transferable roles", this feels like a field ripe for development. Most Assistant Practitioner roles have been developed to meet the particular needs of individual employers at a moment in time. But there are clear commonalities and good reasons for both individuals and employers to look for some standardisation: individuals moving between trusts will be more certain that their status and qualifications are recognised, and employers will be better able to trust the qualifications and experience of someone trained elsewhere.

5.3 Standardisation always requires careful attention to the distinction between valuable difference and required standards, but our review of the role and of available job descriptions shows a great deal of commonality, and therefore a strong basis for definition of standards.

5.4 Defining Assistant Practitioners primarily in terms of what they are *not*, however – they are not healthcare assistants, and not registered professionals – feels like an interim step. If the roles are valuable and valued – and all the evidence is that they are both – it surely makes more sense to follow the logic of competence and define them positively, in terms of what they do and what they contribute to patient care.

5.5 It also relates to the status of Assistant Practitioners. We sense that they are expected to behave with a greater degree of professionalism than those in more junior roles, but they are not recognised as full professionals, for they do not belong to any of the registered professions. Individuals moving up to the role seem to be really pleased with it, and employers have found effective ways of integrating them in care teams. As time goes on, however, as more Assistant Practitioners seek upwards progression and more formal learning associated with it, and as the number of Assistant Practitioners increases, it is likely to become more pressing to address this ambiguity. It is interesting that one of the Codes of Practice quoted above uses the phrase "not *yet* accountable to a professional body". Is that the way forward?