



# Assistant Practitioner roles in the Welsh Health Sector

Enhancing the potential for future development  
2014



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# Foreword from Skills for Health

Health sector employers in Wales are under considerable pressure to make efficiency savings and increase the flexibility in the way in which services are provided. Better utilisation of the skills and expertise of professionals and support workers is a key way in which it is believed such improvements can be made.

The development of the Assistant Practitioner role is often cited as an important element in enhancing the sector's skills utilisation. Operating at a higher level of competence than a traditional healthcare support worker, the Assistant Practitioner holds a unique position between registered health professionals and healthcare support worker roles.

Under the guidance of a professional member of staff the Assistant Practitioner is able to ensure plans for care are undertaken. Their effective deployment will help increase the amount of time professional staff are able to spend engaged in higher added-value work, while their broader skill set increases the quality of care given to the patient.

This independent research report has been commissioned by Skills for Health and undertaken by the Institute for Employment Studies supported by funding from the Sector Priorities Fund Pilot programme for Wales. The aim of this research is to better understand the current utilisation of Assistant Practitioners across the health sector in Wales and to identify and explore any barriers that may need to be addressed in order to assist the broader adoption of the Assistant Practitioner role.

The research confirms that the Assistant Practitioner role has been developed in a number of occupational areas. Many respondents indicate that such roles assist in the development of services and indeed increase quality. The transformative potential of this role has not yet been met, however, as take up has not yet reached the 'critical mass' to transform the sector's performance.

It is evident that there are a broad range of challenges confounding the widespread adoption of the Assistant Practitioner role and in many respects the Welsh experience is common to the wider UK sector. Skills for Health look forward to working with employers and partners in the Welsh health sector to explore potential actions in the development and further implementation of what is widely regarded as an important role.



# Acknowledgements

Skills for Health would like to thank colleagues throughout the Welsh Health Sector who gave up time in their busy working lives to participate in this research. Without such generosity this research would not have been possible. We would also like to thank the Sector Priorities Fund Pilot Programme who made this work possible.

Thank you also to Linda Miller, Joy Williams and Hazel Edwards at the Institute for Employment Studies (IES) who undertook this research and developed this report.

We would like to give special thanks to Stephen Griffiths, Director of Workforce Development, NHS Wales Workforce, Education and Development Services (WEDS) and Angie Oliver, Assistant Director of Workforce and OD, Hywel Dda University Health Board whose comments were valuable in the development of these reports.

The opinions expressed in this report are independent and are not intended to represent the position or views of NHS Wales, the Welsh Government, or any of its agencies.

# 1. Executive Summary

Health sector employers are under considerable pressure to make efficiency savings and increase the flexibility in the way in which services are provided. Better utilisation of the skills and expertise of professionals and support workers is a key way in which it is believed such improvements can be made.

The development of the Assistant Practitioner role is often cited as an important element in enhancing the sector's skills utilisation. Operating at a higher level of competence than a traditional healthcare support worker, the Assistant Practitioner holds a unique position between registered health professionals and healthcare support worker roles.

There has been relatively little research conducted to examine the adoption of Assistant Practitioner roles in Wales. For this reason in 2013 Skills for Health commissioned research to explore the use and benefits of assistant practitioners in health settings in Wales, any barriers to their implementation and ways in which they might be used more effectively. The work was commissioned using funding obtained under the Sector Priorities Fund Pilot (SPFP) Programme for Wales.

## **The interviews**


Interviews with 54 professionals across all of the Health Boards and the independent health sector in Wales were undertaken between March and July 2013.

The interviews revealed that implementation of Assistant Practitioner posts was at different stages across the Health Boards, with Aneurin Bevan, Hywel Dda and Cardiff and Vale being amongst the most advanced.

Some occupational areas had posts which mapped readily across to CPF level 4 and appear to be equivalent to Assistant Practitioner roles. However they are not typically referred to as 'Assistant Practitioners' because they are distinctive roles for which the existing titles remain more appropriate. Technician, Technical Instructor and Clinical Engineer are all examples of such posts

Interviewees believed that there should be a clear role and need for Assistant Practitioner posts. Some felt that a potential cost saving alone was insufficient to justify their introduction.

In some rural areas of Wales wards and departments are relatively small. This could provide challenges in providing sufficient work for an Assistant Practitioner role. It is easier to introduce such posts in areas of high work volume. Similarly, role substitution is easier in wards with larger numbers of staff. Typically a minimum complement of two registered personnel is usually deployed in smaller wards or departments. If one of these staff is replaced by an assistant practitioner, this can pose challenges in ensuring cover and supervision across meal breaks or in times of sickness.



Managers had encountered difficulties in accessing appropriate education and training for their Assistant Practitioners. Several managers had experienced the closure of relevant and useful courses. They feared that as universities become ever more focussed on fully covering costs more courses would be lost.

Respondents felt that there was a lack of guidance on what constitutes an Assistant Practitioner post and in particular on differentiating between level 3 and 4, and between level 4 and 5, posts. Those that were aware of the guidance that existed felt that it was insufficiently comprehensive.

While many interviewees were keen to provide a progression pathway for those already in the Assistant Practitioner role, in some cases the 'niche' position of the roles worked against this. Some said the lack of part-time study options prevented any further progression.

In some cases institutions' current cost containment strategies meant that no band 4 posts were being created. However, elsewhere, some managers outlined how they had used band 4 posts to help improve capacity and reduce costs.

### **The Focus Groups**

Four focus groups were facilitated to explore the views of potential and current Assistant Practitioners. Participants in the focus groups comprised 49 Health Care Support Workers enrolled on three study programmes: two Certificate and Diploma programmes in Healthcare Studies and one a Certificate programme for Assistants in Radiographic Practice.

Focus groups were held with health care support workers, mostly employed at band 3, but with a few at band 2 and 4 (or equivalent, where they were employed by GPs or charities). All participants were undertaking university courses that in principle would equip them with an appropriate level of knowledge to progress to an Assistant Practitioner post.

There was generally a lack of knowledge regarding what constituted an Assistant Practitioner role, except amongst the radiography trainees. Mostly participants reported not having level 4 posts in their departments, apart from nursery nurse posts.

Healthcare support workers viewed the Assistant Practitioner post as potentially providing an attractive progression option, were they to be introduced into their department or ward. However, most believed the economic situation made their introduction unlikely in the short term.

The discussion revealed that many of the HCSWs were undertaking complex activities with minimal or no supervision. Some were told they needed to work autonomously in order to be considered for an Assistant Practitioner post.

Some raised concerns at the scope of work they were required to undertake along with the lack of supervision they received in the workplace or in their work experience departments. In part they believed this situation arose because higher band staff were unsure of what work could be delegated to HCSWs or Trainee Assistant Practitioners, but there was a suspicion too that this arose from a lack of interest in the development of HCSWs.

### **The benefits and barriers**

While some interviewees pointed to the improvements in capacity and cost-efficiencies that Assistant Practitioners had enabled them to achieve, at no loss of service quality, others pointed to the difficulties they had encountered when considering whether to introduce such posts.

Lack of clarity regarding the role and supervisory requirements hindered progress in some departments and greater guidance was requested regarding the role of the level 4 HCSW. In addition, the way in which workforce planners plan and allocate duties across staffing levels can impact on how viable the posts are viewed as being; work volume, level and location also affect decision-making, with these issues being linked in turn to size of the staffing establishment. Managers encountered particular problems in ensuring supervision for Assistant Practitioners in small wards or departments in which only two staff are on duty at a time.

Managers had encountered difficulties in identifying appropriate education and training for their trainee Assistant Practitioners and in some cases had found that appropriate provision had been withdrawn because the student cohort could not be guaranteed every year or had been too small to support the course.


Although concerns were raised about the lack of regulation of HCSWs examples were found of ways in which such fears had been allayed through actions taken either by the professional body or by the Health Board. These provide potential ways in which employers can address local concerns on this point.

### **Conclusions**

The research showed there is a role for level 4 posts. Where they are in use they are typically well-regarded. In some high volume areas, level 4 posts were helping to achieve significant cost-efficiencies. In some Boards Assistant Practitioners in nursing-related roles are in place and more are being developed; there are significant developments in the scientific (laboratory-based) disciplines; and radiography remains the area in which the roles are most well-established.

Level 4 roles are often called by titles other than 'Assistant Practitioner'. Those titles are often more meaningful within the specific department, ward or unit, often referring to the functions undertaken by individuals in those roles rather than simply referring to their title in the Career Development Framework. The use of more meaningful job titles may be one of the easier, and more effective, ways to support and encourage greater utilisation of these roles.





The move to increasingly community-based care is viewed by many as leading inexorably to a demand for more level 4 practitioners, with some of these roles straddling health and social care. If such moves are to be supported it will be necessary to ensure that appropriate education and training is in place to develop people for these posts. This currently presents a major challenge.

Beyond this, three key factors influence developments: the nature of the work and its requirements for supervision, the workforce model in place and the current economic climate. Small workforces provide only limited room for changes to skillmix. Where people are working on their own with patients in rural settings supervision can prove challenging and a registered practitioner may be the most cost-effective and flexible option for an employer.

Regarding finance, there appear to be two broad factors in play: one is the potential for cost-efficiencies to be gained by devolving some activities from regulated staff to lower level/band workers, with - potentially - a cost saving as well, if the Assistant Practitioner post is introduced following reduction in the establishment of regulated staff. However, where any change involved upgrading of current staff – i.e. from HCSW to Assistant Practitioner – without loss of other staff, then it can be challenging at present to gain approval for such workforce planning decisions, as the main focus is on the potential increase in staffing costs, irrespective of any potential cost-efficiencies that might follow on from this.

## 2. Introduction

Health sector employers in Wales are under considerable pressure to raise the quality of the services they provide and make efficiency savings. Better utilisation of the skills and expertise of professionals and support workers is a key way in which it is believed such improvements can be made. Table 1 below shows the NHS Career Progression Framework (CPF) and illustrates the nine levels of career bands of occupations within the NHS. These range from jobs involving routine tasks at level 1 through to the complex tasks held by consultant practitioners and specialists roles at levels 7 and beyond.

**Table 1: Nine level career progression framework**


<b>Level</b>	<b>Grade</b>
1	Entry level
2	Support workers
3	Senior healthcare workers, technicians
4	Assistant/Associate Practitioners
5	Practitioners
6	Senior/Specialist Practitioners
7	Advanced Practitioners
8	Consultant Practitioners
9	Senior Staff

*Source: Department of Health*

There has been increasing interest amongst policy makers and workforce planners in the role that health care support workers might have in improving the quality and efficiency of health care. Of particular interest has been the potential contribution of health care support workers at level 4 in the CPF. These are widely referred to as Assistant (or Associate) Practitioners.

The Assistant Practitioner holds a unique position between registered health professionals and the traditional healthcare support worker roles. Operating at a higher level of competence than a traditional healthcare support worker, they are able to undertake the care plans outlined by health professionals and undertake certain tasks that have historically been the remit of professional staff only.

A key hypothesis for the deployment of Assistant Practitioners is that they will be able to undertake many of the more routine tasks that registered professionals undertake. This will free up more time for professional staff to spend engaged in more complex tasks. At the same time, their broad range of caring expertise will enhance the patient experience.



There has also been interest in the development of these roles within the independent sector (both private and charitable), too. While this is mostly due to the value these roles might have for patients and the employers it is also driven by recognition that recruitment is often reliant on individuals moving between the NHS and independent sectors. The independent sector has to broadly match the pay and conditions – and therefore the grades or bands – seen in the NHS. Therefore throughout this report where reference is made to the CPF levels and Agenda for Change (AfC) bands in this report this is taken to imply and include equivalent posts and pay bands outside the NHS.

As in the rest of the UK here has been interest within Wales in the potential use of Assistant practitioners. *Towards a Flexible and Sustainable Workforce*, published in 2008 by NHS Wales, pointed to the potential value of Assistant Practitioners and saw the roles as making a greater contribution towards service delivery in the NHS in Wales in future years.

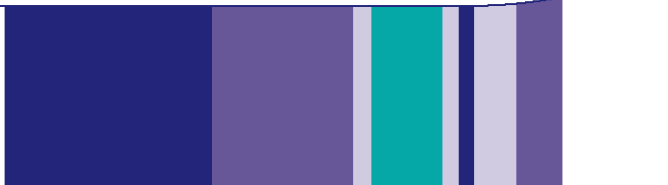
There is evidence that Assistant Practitioners in nursing have been in place across Wales for some years, although early developments were restricted to relatively few sites. A Royal College of Nursing (RCN) survey on Assistant Practitioners conducted in 2010, found three local health boards in Wales reported that they had Assistant Practitioner posts at that time (note though that this pertained only to Assistant Practitioners in nursing).

There have been some significant developments in radiography in Wales, too. One year Certificate of Higher Education courses had been developed at the Universities of Cardiff and Bangor, designed to prepare Assistant Practitioners for working in diagnostic radiography, screening mammography or radiotherapy and oncology and for some time the Welsh Government has funded a number of students to undertake these courses each year.

The then National Leadership and Innovation Agency for Healthcare (NLIAH) website also publicised the existence of the (then very new) Assistant Audiologist and Assistant/Associate Practitioners in Speech and Language Therapy.

In its own examination of the situation regarding Assistant Practitioners, Skills for Health found that *'as relatively emergent roles, there has been some evidence of variations in development and application. Much of this work has focused on the development of these roles throughout the UK; none has had a specific exploration of the development of these roles in Wales.'* In particular, there was relatively sparse information regarding the extent of implementation of Assistant/Associate practitioner roles in Wales.

For this reason SfH wished to gain a better understanding of *'the current implementation of Assistant/Associate Practitioners across the health sector in Wales including both the NHS and the independent/voluntary sector.'* Therefore in 2013, SfH sought funding under the Sector Priorities Fund Pilot (SPFP) Programme for Wales and commissioned this research to examine the use of Assistant Practitioner roles in Wales, along with two parallel projects examining apprenticeships in the health sector in Wales, and small and medium-sized enterprises in the health sector in Wales.



This report sets out the evidence arising from that research. Its aim is to help inform the sector on the implementation and deployment of Assistant Practitioners and shape how the Assistant Practitioner role is developed in Wales.

## **2.1 Method**

The research was conducted in 2013. It consisted of a literature and document review, interviews with 54 professionals across all of the Health Boards and the independent health sector in Wales, and four focus groups to explore the views of potential and current Assistant Practitioners.

The focus groups were conducted with 49 Health Care Support Workers enrolled on three study programmes: two Certificate and Diploma programmes in Healthcare Studies and one a Certificate programme for Assistants in Radiographic Practice.

## **2.2 A note on timing**

The research was undertaken between March and June 2013. This was at the time that media attention was focused on the Francis Inquiry into Mid-Staffordshire Hospitals and, subsequently, the Cavendish Review. While these applied only to England, media across the UK were reporting on these issues and there was interest and discussion relating to these topics across the whole NHS.

While the research was conducted in Wales, which was not covered by these reviews, nonetheless many interviewees referred to issues to do with registration and regulation of HCSWs. While SfH does not have a policy position on registration or regulation (and indeed, since the research was completed the UK government has confirmed its antipathy towards any further regulation of healthcare personnel) we have reported the nature of such comments as this clearly remains an issue of interest – and indeed concern – to individuals within the health sector in Wales and across the UK more widely.

## **2.3 Structure of the report**

The outcomes of the work are set out as follows:

Chapter 3 provides an overview of the development of Assistant/Associate Practitioner posts in Wales. In Chapter 4 we report the outcomes of the interviews with Health Sector Managers and Directors. Chapter 5 describes the experiences and attitudes of HCSWs. In Chapter 6 we set out the benefits of, and barriers to, introducing Assistant Practitioner roles in Wales. Chapter 7 provides a summary and conclusions to the work. Following the report, there are three case studies of approaches to implementation of Assistant Practitioners in three Welsh Health Boards.



## 2.4 A note on terminology

Within the health sector many employers use slightly different terminology to refer to Assistant/Associate Practitioners. Throughout the remainder of this report we use Assistant Practitioner to describe both Assistant and Associate Practitioners.

## 3. The development of Assistant Practitioner posts in Wales

### Key points

- There is increasing interest in new ways of working and the development of new roles. A key focus has been the design of support worker roles
- The Welsh Government strategy for a 'Flexible and Sustainable' workforce noted there were few clinical roles in Wales at band 4 and set out the Welsh Government's intention to make greater use of Assistant Practitioners. It also made recommendations for minimum education levels for these posts
- However, when the Royal College of Nursing conducted a survey of use of Assistant Practitioner roles in 2010, the survey returns showed only limited implementation of these roles and the roles remained grounded in existing occupational areas

### 3.1 Introduction

Across the UK health sector employers are under considerable pressure to seek new ways of working and more effective ways of utilising the skills of the workforce. The creation of new roles, particularly those at the support worker level, has been a significant part of such developments, with particular interest being focussed on the development of Assistant Practitioner roles, which sit at level 4 in the CPF.

Assistant Practitioner roles have been developed through two main routes: by devolving tasks from existing roles to lower level staff (i.e. so that the roles are in essence 'assistants' to the original professional roles); and through the development of entirely new roles, often being based on changes to treatment pathways or emerging as a result of other changes to service provision, the rollout of new technology or in forecasting workforce requirements (for an example of the ways in which need for new roles can emerge see Miller, Fairhurst and Hurley, 2010<sup>1</sup>).

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<sup>1</sup> This project, for Skills for Health, suggested potential future needs for roles such as a Generic Community Worker, Personal Health Navigator and Remote Diagnostic Technician roles. Skills for Health has developed templates for several new and transferable roles and plans to develop further role templates in the future.

Research on the development of these roles reveals there is a significant amount of overlap between what are sometimes specified as the ‘functions’ of Assistant Practitioners and the job titles or roles specified elsewhere, probably as a consequence of the multiplicity of routes to role development (Miller, 2011). A further point to note is that sometimes the roles are specified as relating to a professional area (e.g. nursing, diagnostic radiography), sometimes they relate to organisational location or function (e.g. Main Theatres, Microbiology), and sometimes they are linked to specific conditions (stroke, diabetes, cancer)<sup>2</sup> (Miller, *ibid*). For this reason the Assistant Practitioner role can be either generalist or specialist in nature.

## 3.2 The political and geographical context in Wales

In 2008 NHS Wales published the report of the Flexible and Sustainable Task and Finish Group on a strategy for a flexible and sustainable workforce in Wales. The report noted that the (then) recent Agenda for Change assimilation exercise had revealed that *‘there are few clinical roles in Wales at band 4. This has been identified as a specific issue in relation to nursing, although it applies to all clinical groups’* (NHS Wales, 2008, p. 14).

The report also confirmed that, while all Assistant Practitioner roles in Wales sit at Band 4 in the Agenda for Change framework, there was no agreed all Wales perspective on the role of Band 4 workers (NHS Wales, 2008, p.14). The report indicated that *‘Band 4 roles will carry out delegated tasks supported by protocols to enable them to carry out a number of interventions across the patient care pathway’* (NHS Wales, *ibid*, p15) and concluded that:

*‘The introduction of roles at band 4 will require a redesign of both the registered practitioner and support workers function[s] and contribution to the care of patients and clients... The breadth and depth of competencies required for these roles will vary. They may work uni-professionally, multi-professionally or across sectors.’*

(NHS Wales, 2008, p. 15)

The report highlighted the potential for employers in Wales to expand the number of workers at level 4. However in order to ensure that these roles had maximum impact this expansion would need to be done in a planned and a managed way. The report also noted that (at the time of publication in 2008) no published definitive guidance existed on the development of the role, its educational basis, implementation or evaluation.

<sup>2</sup> Full descriptions of a selection of Assistant Practitioner roles in stroke, nuclear medicine, district nursing, podiatry and radiography can be found at the web site <http://www.nhs.uk/Work/Details/Default.aspx?Id=2030>

The report therefore made a series of recommendations relating to Health Care Support Workers in general and to Assistant Practitioners and role development in particular. Their recommendations are reproduced in Box 1, below:

#### **Box 1: Recommendations of the Task and Finish Group**

The WAG should explore ways of regulating all Health Care Support Workers as the lack of Regulation was inhibiting the development of these roles across NHS Wales. Responsibility for this was assigned to the Welsh Assembly Government (WAG).

It is recommended that any person in a clinical role at Agenda for Change band 4 must possess as a minimum a full qualification equivalent to CQFW educational level 3, plus sufficient educational attainment at higher levels to enable them to competently fulfil the scope of practice of their role. Responsibility for this was assigned to Employers.

The development of new roles should be monitored through the implementation process of Designed to Work. Responsibility for this was jointly assigned to the WAG/NLIAH.

Employers should review the impact of new roles on service improvement; this will be achieved through the Modernisation Assessment. Responsibility for this recommendation was assigned to Employers/NLIAH

There should be a robust and consistent all Wales evaluation framework to demonstrate the value and effectiveness of all new and extended roles. This should include views of the users of the service. Responsibility of the WAG

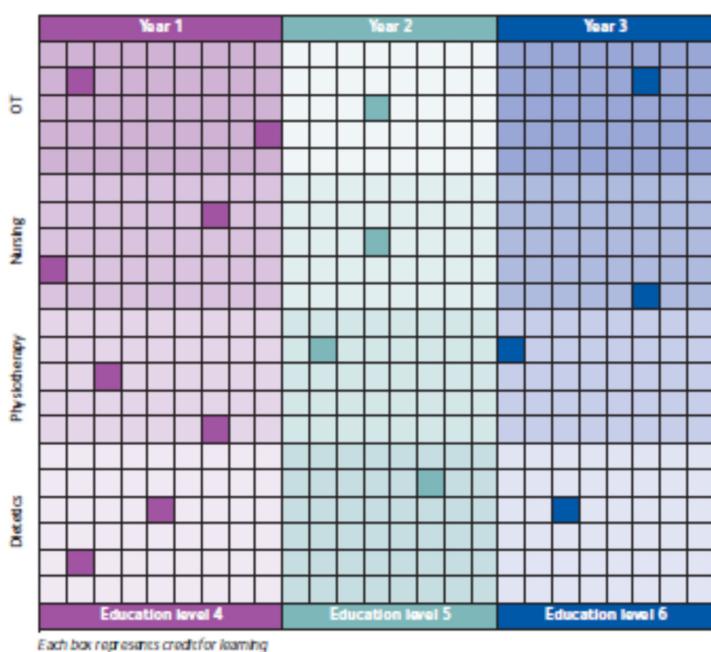
In developing new roles employers should adopt the principles set out in the Standards and Guidelines for Role Redesign in the NHS in Wales and the NHS Career Framework (Appendix B). Responsibility for this lay with employers.

*Source: Section 5, NHS Wales (2008) A strategy for a flexible and sustainable workforce: Report of the Flexible and Sustainable Task and Finish Group*

The range of options for role re-development led the Task and Finish group to suggest that in some cases the roles could be developed to include 'a combination of competencies from across existing professions'. This potentially has implications for the education and training offered to such individuals. The Task and Finish Group report shows how elements or modules of learning from a number of professional pre-registration programmes might be utilised and combined to form part or whole of the education of a Band 4 worker.



**Figure 1: Combination of modules for education programme for Band 4 worker**



Source: NHS Wales (2008) *A strategy for a flexible and sustainable workforce* (Figure 3)

Since publication of the Strategy the more successful areas of development have been in a small number of specific occupational areas. In 2010 Griffiths and Robinson noted that while Wales had Assistant Practitioners in the therapies and in radiography these roles did not exist in nursing. In the same year the Royal College of Nursing (RCN) undertook a survey across the UK asking for information about the use of Assistant Practitioner roles. Four of the seven Boards in Wales replied to the RCN survey and of these, three reported that they either already had Assistant Practitioners in post or made use of Band 4 positions, whilst not necessarily referring to these posts as 'Assistant Practitioners'. The Appendix of this report contains an extract from the RCN report showing the responses from Wales (RCN, 2010).

Therefore the emergence of Assistant Practitioners in Wales appears to have a slightly different focus to that seen in England and Scotland. Within Wales many of the earliest developments were in occupational areas such as radiography<sup>3</sup> (imaging services), audiology, speech and language therapy and pathology<sup>3</sup>, whereas in England and Scotland the majority of the early Assistant Practitioner roles were derived from nursing roles.

<sup>3</sup> The NHS Wales 'Strategy for a Flexible and Sustainable Workforce' report in 2008 noted that developments in these last three areas were underway at that time.

It should be noted that the document *Health Informatics Careers in NHS Wales*<sup>4</sup> had suggested a range of potential Assistant Practitioner roles that might be created: control room duty officer (Ambulance service professions), assistant clinical psychologist, assistant dental technician, critical care technologist (healthcare science), clinical coder (healthcare informatics), general office manager, community care assistant (nursing) and medical secretary. However, despite this range of potential new roles, the information about the training provision for Assistant Practitioner posts that was available in early 2013 suggested that programmes remained focussed on existing occupational areas rather than being customised to meet the needs of combined roles, as the Flexible and Sustainable Workforce document had suggested was required.

### 3.3 Summary

The literature review confirmed that while there had been support from the Welsh Government for the greater use of clinical roles at Assistant Practitioners level progress has not been as rapid as had been hoped.

By the time the Welsh Health Boards were surveyed by the RCN in 2010 there had been only limited progress in Assistant Practitioner roles focused on nursing. Many of the wider Assistant Practitioner developments have led to new roles in existing occupational areas, rather than to the creation of new roles in new niche occupations.

This review established the background for, and informed design of, the discussion guides for use in the interviews and focus groups of this research.

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<sup>4</sup> See

<http://www.wales.nhs.uk/sitesplus/documents/956/NWIS%20HI%20Careers%20in%20NHS%20Wales%20Booklet.pdf>

## 4. Interviews with Health Sector Managers, Directors and Tutors

### Key points

- Implementation of Assistant Practitioner posts was at different stages across the Health Boards, with Aneurin Bevan, Hywel Dda and Cardiff and Vale being amongst the most advanced
- Some occupational areas had posts which mapped readily across to CPF level 4 and appear to be equivalent to Assistant Practitioner roles. However they are not typically referred to as 'Assistant Practitioners' because they are distinctive roles for which the existing titles remain more appropriate. Technician, Technical Instructor and Clinical Engineer are all examples of such posts
- Interviewees believed that there should be a clear role and need for Assistant Practitioner posts. Some felt that a potential cost saving alone was insufficient justification for their introduction
- In some rural areas of Wales wards and departments are relatively small. This could provide challenges in providing sufficient work for an Assistant Practitioner role. It is easier to introduce such posts in areas of high work volume
- Similarly, role substitution is easier in wards or departments with larger numbers of staff. Typically a minimum complement of two registered personnel is usually deployed in smaller wards or departments. If one of these staff is replaced by an assistant practitioner, this can pose challenges in ensuring cover and supervision across meal breaks or in times of sickness.
- Managers had encountered difficulties in accessing appropriate education and training for their Assistant Practitioners. Several managers had experienced the closure of relevant and useful courses. They feared that as universities become ever more focussed on fully covering costs more courses would be lost.
- Respondents felt that there was a lack of guidance on what constitutes an Assistant Practitioner post and in particular on differentiating between level 3 and 4, and between level 4 and 5, posts. Those that were aware of the guidance that existed felt that it was insufficiently comprehensive.
- Several interviewees raised concerns about the non-regulated status of Assistant Practitioners. However, equally, several interviewees believed that regulation would not bring any advantages.

- While many interviewees were keen to provide a progression pathway for those already in the Assistant Practitioner role, in some cases the 'niche' position of the roles worked against this. The lack of part-time study options prevented further progression for others.
- In some cases institutions' current cost containment strategies meant that no band 4 posts were being created. However, others outlined how they had used band 4 posts to help improve capacity and reduce costs.

## 4.1 Introduction

The previous section focused on the intelligence to have emerged from policy developments and previous research. This provided a sense of how the roles have been taken up within the Welsh health sector in the previous few years. In order to gain more current insight into the development of the role a series of interviews were conducted across the health sector.


In total, 54 interviews were conducted with senior level representatives across the health sector in Wales, including individuals in all of the NHS Health Boards (territorial and pan-Wales services) and in the independent sector (private hospitals, hospices and GP practices). Interviewees included Directors of Workforce and Organisational Development, Directors of Nursing, Heads of Laboratory and specialist functions such as Rehabilitation Services, Cardiology, Physiotherapy, Retinal Screening and Radiology, GP Practice Managers and Directors of hospices. Representatives of university courses for Assistant Practitioners were also interviewed.

This section of the report outlines the outcomes from the interviews with these health care practitioners across the public and independent sectors.

## 4.2 An overview and update of Assistant Practitioner positions in Wales

The research revealed just a few areas – in both the geographical and occupational sense - in which Assistant Practitioners were in place in significant numbers.

Three of the Health Boards were particularly advanced in terms of adoption of these posts relative to others: Aneurin Bevan, Hywel Dda and Cardiff and Vale. The reasons for progress in each of these Boards are explored in the case study section of this report.



Radiography is the professional area in which Assistant Practitioner roles had been established the longest, both in Wales and across the UK more widely<sup>5</sup> and the research confirmed that these posts are widely in use in Wales.

In Pathology and Haematology Assistant Practitioner posts were being introduced following on from the Modernising Scientific Careers initiative. Biomedical Science laboratories were making quite extensive use of Assistant Practitioners. At the time the research was conducted, audiology and ambulance/paramedic services were at the point of implementing the new roles, with education programmes about to start in the 2013/14 academic year.

Some occupational areas had posts which, while they mapped readily across to CPF level 4 and appear to be equivalent nonetheless were not typically referred to as Assistant Practitioners because they have distinctive roles for which the existing titles remain more appropriate. Technician, Technical Instructor and Clinical Engineer are all examples of such posts.

However, whether a post continues to be seen as (for example) a technician or is renamed an Assistant Practitioner, varies both between and within professions. For example, in Speech and Language Therapy it emerged that while in most settings CPF level 4 posts in this professional area are referred to as Assistant Practitioners, in Cardiff and Vale they have the title 'Technical Instructor' (see Cardiff and Vale case study). While some employers felt that posts with subject-specific titles should nonetheless be viewed as synonymous with Assistant or Associate Practitioner posts, others felt that their posts at CPF level 4 differed significantly from their understanding of what constituted an Assistant Practitioner.

The above overview shows that while many posts exist in Wales at level 4 not all have the title of Assistant Practitioner and in some cases are not considered to be Assistant Practitioner roles. This is an important point and something we return to later in this report. The central issue is to support the use of level 4 roles that fulfil meaningful functions within the work of the ward, the unit or department, rather than focussing on whether these are referred to as assistant/associate practitioners or not. However, given the focus of the commissioned research, we refer to 'Assistant' or 'Associate' practitioners throughout the sections of this report in which the research outcomes are described.

In the following sections we explore the factors that have influenced the introduction and uptake of these posts across Wales.

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<sup>5</sup> This is due to the Society and College of Radiographers (SCOR) being the first professional body to recommend the 'four tier' Career Progression Framework with assistant practitioners at level 4 to its members.

### 4.3 Factors affecting the introduction and use of Assistant Practitioner posts

The interviewees pointed to several factors which affect decisions regarding the introduction and deployment of Assistant Practitioners in Wales. The following sections summarise the views of the interviewees.

#### A clear role and need for the post

First and foremost, managers and workforce planners said that they had to see a clear role for these posts in their setting and a genuine service need for the posts. Managers had to be convinced that they brought added value over and above mere cost-savings: as one independent sector interviewee put it:

*'Financial concerns should not drive skill developments'.*

However, perceptions of 'need' and 'value' were in turn influenced by several factors including: the workforce model in place and size of workforce, the nature of the patient population, and the volume and nature of the work. These points are explored in more detail in the sections that follow.

In developing Assistant Practitioner roles the prevailing model has been based on the downward devolution of a subset of activities from higher band workers (professional staff) to form a coherent job description for a post at level 4 or below. This is usually accompanied by staff in higher level positions being required to take on a larger proportion of more demanding, complex and high-value-added activities.

Such re-allocation and re-profiling of activities can lead to 'role substitution' of one or more of the professional grades – that is, replacement of a Band 5 or above with a Band 4. However, such an approach depends on there being sufficient work to justify the new role and to allow substitution of a person at level 5 or above by an Assistant Practitioner.

Interviewees pointed to the smaller wards and departments found in some parts of rural Wales. Smaller staff complements were felt to render such role substitution and re-profiling difficult and sometimes unviable, particularly in nursing settings. Although minimum staffing levels and skill mix remain determined locally based on needs assessment, patient dependency etc., RCN guidance on staffing standards points to the benchmark proportion of 65% registered nurses (RN) as a percentage of total nursing staff in place on general wards, more with high acuity/dependency patients.

As one interviewee explained:

*“Because the hospitals serve small populations they only have small wards: on average these have 15 – 20 beds, with some having only 12. To staff that size of ward requires two registrants on every shift – one to provide a minimal level of cover and one to build in resilience (to cover for meal breaks, or in case one is off sick etc.)...typically there would be a health care support worker (level 2 or 3) employed on every shift as well, in line with RCN guidance on staffing standards – for instance, the guidance for wards for older people requires three staff for every 15 patients.”*

Directors of Nursing who were interviewed were understandably reluctant to take decisions that contravened such guidance. While *in principle* therefore the staff complement per shift could consist of one registrant and one Assistant Practitioner, *in practice* two registrants are required per shift to build in resilience and ensure coverage across meal breaks or in case of sickness. Therefore, as this interviewee noted, in such wards, typically two registered nurses would be on duty, assisted by one or more HCSWs at level 2 or 3.

With smaller workforces there is less scope for re-profiling on the basis of skillmix. This leaves managers and workforce planners only with the option of direct role substitution. In such settings, should a registrant be replaced by a level 4 role, this would mean that staffing levels would fall outside those recommended by the RCN.

Whilst the RCN recommendations do not constitute a statutory requirement, for obvious reasons Directors of Nursing were keen to ensure that their staffing levels complied with RCN guidance. The high profile failings of Mid Staffordshire NHS Trust in England and the intense media spotlight on nurse staffing levels are likely to cement this view and move employers away from making what they may view as ‘risky’ workforce re-profiling decisions. The alternative way of introducing Assistant Practitioners would be to replace an existing level 3 with a level 4 post. However, this would increase the wage bill without necessarily bringing any benefits in terms of increased skills or flexibility<sup>6</sup>.

### **Supervision**

Most supervision of level 4 personnel is at ‘arms length’, with regulated staff providing general oversight and appraisal of the work of Assistant Practitioners rather than providing close monitoring of the ongoing performance of individual tasks<sup>7</sup>.

<sup>6</sup> A Band 4 would be able to undertake a wider range of activities, it is true, but whether these would be required would depend on the individual circumstances within wards, units or departments.

<sup>7</sup> Note that All Wales guidance on delegation is available at <http://www.wales.nhs.uk/sitesplus/documents/829/All%20Wales%20Guidelines%20for%20Delegation.pdf>

However, in some work settings there is a requirement for each piece of work undertaken by Assistant Practitioners to be signed off by a regulated professional during the course of work: for example in a laboratory, where the Assistant Practitioner's analyses have to be approved before reporting the results, or in an imaging department, where the radiographs typically need to be approved by a radiographer before the patient can be allowed to leave the department.

Our interviews highlighted that several of the scientific disciplines were moving to shiftwork arrangements and the requirement for sign off by a registrant inhibits the deployment of Assistant Practitioners on shifts where lower case volumes are seen.

Furthermore, if only one person is required per shift then the supervisory requirements for Assistant Practitioners mean that the member of staff deployed can only be a registered professional. Managers also said that if two people are required on shift but one is an Assistant Practitioner, the sign-off requirement means that the registrant has to be available for the whole of the Assistant Practitioner's shift, causing problems with scheduling meal breaks (or alternatively, no cover at all for the period of the meal break).

Therefore the overall number of staff deployed at any one time, the number of sites (or areas) across which the service operates and the nature of supervisory arrangements all impact on managers' ability to deploy Assistant Practitioners in the workplace.


In addition, on several occasions interviewees referred to confusion over the precise nature of the supervisory arrangements required for Assistant Practitioners and in particular the legal position regarding activities delegated by regulated professions to non-regulated practitioners. This was clearly an area where the sharing of good practice across the sector would be of use.

### **Volume of work**

In addition to impacting on rostering decisions, the volume and nature of activity also affects the extent to which meaningful roles and job descriptions can be developed at level 4. Provided there is sufficient work of an appropriate level to support design of level 4 posts then departments can find such posts extremely useful.

Several of our interviewees referred to the value of Assistant Practitioners in terms of the volume of patients that could be responded to (or volume of tasks, in the science-based areas) and the ability of level 4s to respond quickly, something which regulated practitioners with heavy case loads and fully booked appointment lists may find difficult to do.





In laboratories, the advancement of technology and the large-scale mechanisation of tasks that previously required high level knowledge and skills have made it increasingly feasible for Assistant Practitioners to take on high volume analytical tasks with laboratories; this has resulted in small gains in wage costs but large gains in productivity.

Where there is only a small volume of work however this becomes less feasible: for example, one GP practice had considered introducing a Band 4 post to undertake vaccinations, as their Health Board did not allow responsibility for this activity to be devolved to level 3 HCSWs. However, on considering this further they realised that there was insufficient volume of work and therefore number of hours in connection with this single activity to make the level 4 role viable. It made better sense in this situation to maximise the use they made of the practice nurse.

One of the Health Board workforce development managers also noted a similar point, in that it was:

*“easier to introduce Assistant Practitioners in Boards where they have more acute provision and more secondary and tertiary services. In rural areas, though, they struggle because they cannot achieve the critical mass to provide sufficient work for these roles.”*

It is therefore clear that there is a complex inter-relationship between the volume and nature of work, workforce model, patterns of deployment and supervisory arrangements that together determine the feasibility of introducing Assistant Practitioner roles.

### **Occupational area**

The extent to which level 4 posts have been readily assimilated into working arrangements varies greatly across occupational areas. These posts appear to have been incorporated fairly readily into the scientific disciplines and, amongst the health care professions, in radiography, with few problems (apart from those relating to specific issues to do with deployment and supervision as outlined in earlier sections) and to have brought real value in supporting workflow and efficiencies in working arrangements.

In the scientific disciplines Modernising Scientific Careers has clearly had an impact on take-up of level 4 posts. In Radiography the early work by the College of Radiographers on the ‘four tier career development framework’ has been particularly helpful. Understanding of this level of work appears to be easier in the domains in which there is a history of technical posts/technician grades. In some of these areas, however, while the managers believed the post to be (in essence) an Assistant Practitioner role, there was no intention to rename the job or to formally recognise it as an Assistant Practitioner post within the organisational employment hierarchy.

In nursing and the less technically-focussed healthcare disciplines there was a more mixed picture. In Hywel Dda Health Board an interviewee reported they had eight Assistant Practitioners trained and in place with another 40 'ready to go'. In contrast however an interviewee in another Health Board said that "*the idea [of Assistant Practitioners] had 'withered on the vine'*". While some people remained keen on Assistant Practitioner roles they were in a minority:

*'Generally there is no real interest and nothing in the Workforce Development strategy regarding these roles.'*

This Board had initially sent HCSWs for training but the interviewee reported that

*'It is hard to get the roles to use these skills in. There is some real frustration for individuals and other people who wanted these roles in place.'*

Therefore the extent to which the roles had been successfully introduced varied not just with occupational area but varied significantly across Health Boards too.


### **Accessing appropriate education and training**

In those departments that were keen to introduce or retain Assistant Practitioners some interviewees commented on the challenges they had experienced in gaining appropriate learning provision for potential 'Trainee Assistant Practitioners'. They could not put people into Assistant Practitioner posts (or trainee positions) until they had sourced appropriate education and training, but providers were often unable to design and run new programmes unless they had a guaranteed cohort of students. Several interviewees referred to the 'chicken and egg' nature of this situation.

In some cases programmes had been designed in response to an initiative in a particular occupational area, and, while initial uptake had provided the numbers needed to make a course economically viable, subsequent small numbers had rendered the course unsustainable in the long term.

Shortfalls in numbers accessing training had arisen for various reasons. In some cases, where the initial trained cohort remained in post and/or there had been no further roll out of the posts the consequence had been a lack of any further demand from those initial sites for training places.

A secondary issue is gaining sufficient funding for education and training. In one case a manager had identified a course that was appropriate for their HCSWs to attend, but had been unable to gain funding for the trainees. The course had since closed. A provider of education and training said that since its initial establishment their course had managed to run only on alternate years due to little demand from employers. In 2012/13 it had run only because trainees had been sent from England.



In another case a manager had found appropriate provision, but the programme (a foundation degree) was in England. They were however concerned about the long term sustainability of that course, as a specialist programme they had used in the past at the same university (and the only such programme in the UK) had recently closed, despite having recruited 17 potential students for the next intake. The university had taken the decision not to support any courses with fewer than 20 students.

Several Welsh universities have developed courses for people employed in HCA and HCSW positions and most interviewees believed these courses provided a sound basis of underpinning knowledge and skills for individuals seeking to become Senior Healthcare Support Workers or Assistant Practitioners. However, there remained quite widespread concern at the lack of a standardised and accredited training/preparatory programme for those seeking to move into band 4 positions<sup>8</sup>.

The final tranche of interviews were conducted at the time the Cavendish Review was published in England. Respondents pointed to the findings of that review in relation to the standardisation of education and training. However, in contrast to this view, many interviewees felt that, rather than further standardisation, provision should instead be focussed more on specialised areas. Several expressed the view that current provision met the needs only of those in nursing-related roles whereas Assistant Practitioners worked in a far wider range of occupational areas than this.

It should also be noted that, for certain specialised areas in which Assistant Practitioners were longer-established, accredited programmes do already exist. For example, in radiography and in many of the scientific or engineering based disciplines there are specific accredited education and training programmes designed for level 4 staff in those specialised posts.

### **Locus of treatment**

There was speculation by several interviewees 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. Integrated roles that combined health and social care components were in development at the time the research was conducted (including the 'Single Point of Access Worker' project in Denbighshire<sup>9</sup>) and this was highlighted as a key area for future developments.

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<sup>8</sup> Although this was under consideration at the time of the research

<sup>9</sup> See <http://www.ssiacymru.org.uk/resource/Denbighshire-SPA-Project-Report-March-2013.pdf>

However, the extent to which Assistant Practitioners will be able to take on community-based roles may be influenced by the nature of the community and its geography and population. In rural and remote settings such initiatives need to be balanced against the need to ensure that the member of staff who is working in such settings can meet the needs of all the clients on the day's visiting list. As one interviewee noted, while savings might be made from sending an Assistant Practitioner out to patients in rural settings (especially taking into account the costs of the time spent in travel) if a second visit is required by a regulated practitioner to undertake a restricted and/or hands-on task then any savings could be lost - in fact this model could be more expensive and may not be viewed as providing the best patient experience.

However, the nature of the task clearly influences such decisions. For example, in Cardiff and Vale the rehabilitation engineering department provides a national service across Wales. They envisage using Assistant Practitioners in the community, with video conferencing facilities being used where 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.

Where the required activity does not require the physical presence of the registrant then the use of communication technologies for the provision of advice or for the approval and sign off activities appears to be a sensible way forward and one that could accelerate the uptake of Assistant Practitioner roles.

### **Understanding of the post**

The literature review revealed that the Welsh Government had worked to provide guidance and define the role of Assistant Practitioners. However the interviews conducted with employers highlighted that this guidance is not widely known about and there is anxiety within the sector regarding the Assistant Practitioner role.

The Flexible and Sustainable Workforce document concluded that:

Box 2: Extract from the Task and Finish Group report on Strategy for a Flexible and Sustainable Workforce

*'The introduction of roles at band 4 will require a redesign of both the registered practitioner and support workers function[s] and contribution to the care of patients and clients... The breadth and depth of competencies required for these roles will vary. They may work uni-professionally, multi-professionally or across sectors.'*

(NHS Wales, 2008, p. 15)

The report noted that there was no agreed 'all Wales' perspective on the role of band 4 workers and at that time. While it pointed people to the Standards and Guidelines for Role Redesign in the NHS in Wales (2007), published by NLIAH<sup>10</sup> it also noted that 'no published definitive guidance existed on the development of the role, its educational basis, implementation or evaluation'. It is therefore possible that people remain unaware of what has been drawn up since that time.

The research indicated that there remains confusion and anxiety over the nature of Assistant Practitioner posts. Many people, from Board level down to health care support workers, asked about the definition of 'Assistant Practitioner'<sup>11</sup>. In many cases, people were either unaware of the existing guidance and/or definitions or knew of them but felt that they were insufficiently clear. As well as expressing uncertainty regarding the overall nature of Assistant Practitioner roles people said that they felt particularly unsure of what differentiated a band 4 from a band 3 role, and a band 4 from a band 5 role and wanted clearer guidance. As one interviewee said:

*'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.'*

At the very least the current research findings suggest there is a need for better publicity regarding the guidance that is currently available.

In addition, there is some evidence that insurance cover can restrict the tasks that are devolved to Assistant Practitioners and that this differs between insurance companies. In one of the interviews with a GP practice manager it emerged that their insurance cover does not currently allow their HCSWs to undertake vaccinations. For this reason the administration of childhood and flu vaccinations was restricted to regulated practitioners, although the interviewee believed that HCSWs undertook this task elsewhere.

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<sup>10</sup> In addition the document points readers to the Skills for Health publications on higher education within the health sector (Skills for Health, 2006a) and developing an Awards Qualifications Framework (Skills for Health, 2006b)

<sup>11</sup> Note that a definition exists in England, where Skills for Health has defined Level 4 of the Career Framework as a worker who: competently delivers health and social care to and for people; has a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker; and is able to deliver elements of health and social care and undertake clinical work in domains that were previously the remit of registered professionals. In addition, SfH have published core standards for assistant practitioners, available at <http://www.skillsforhealth.org.uk/~media/Resource-Library/PDF/Core-Standards-for-APs.ashx>

## Registration and regulation

Registration and regulation mean different things however they 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 professional body that oversees the standards for the relevant profession (the Regulatory Body). The Regulatory Body has two main responsibilities: firstly assuring fitness to practice through specifying the standard to be achieved prior to registration; and secondly investigating allegations of impaired fitness to practise (and taking disciplinary action where this is proved). Impaired fitness to practise may be alleged on grounds that a practitioner has put a patient at risk of harm, brought the profession into disrepute, breached a fundamental tenet of the profession or acted (or is likely to act) dishonestly. Where impaired fitness to practise is proven, an individual can be struck off the register.

The issue of registration and regulation is complex; the interviews were conducted at a time when the Francis Review into the failings of Mid Staffordshire NHS Trust in England was very topical and fresh in respondents' minds. The review itself made recommendations in relation to registration of HCSW in particular but this would also cover the remit of Assistant Practitioners.

A source of anxiety for employers in considering the introduction of Assistant Practitioners through devolving tasks from registered practitioners is that they are taking a subset of activities from a regulated and registered professional and passing them to a worker who is not registered/regulated. The concern for several employers was therefore the question of how, in the absence of registration or regulation, they can ensure that they delegate tasks that are clinically appropriate in a safe way that maintains clinical quality.

There is no national registration scheme for Assistant Practitioners in Wales although in 2011 the Welsh Government introduced an all-Wales Code of Conduct for HCSWs (a Code of Conduct was introduced for HCAs in England in 2013). Interviewees divided into those who believed that registration and regulation of HCSWs should be introduced and those who thought that introduction of regulation would cause more problems than it would solve: for instance, one interviewee said that if HCSWs became regulated then they would be responsible for their own work and therefore '*would not be subject to supervision*'. Whilst this ignores the fact that most supervisory relationships within the health sector are between registered personnel, nonetheless it helps illustrate the depth and range of uncertainty that pertains in this area.

Others, though, believed that the lack of regulation was a major factor fuelling suspicion of the roles. In response to our question about the barriers to the introduction and use of Assistant Practitioners one Director of Workforce and Organisational Development said:

*'The main issue is the suspicion of how does it fit in with the wider nursing agenda and the issue of regulation / non-regulation and management? ... [People say] 'They're not safe' - well if they were not safe we would not use them.'*

Addressing such fears can go a long way towards helping to instil confidence. Hywel Dda, one of the case study Boards, had decided early on to confront the issue of delegating work in a safe and clinically appropriate way in order to prevent it becoming a barrier: as one interviewee put it:

*'The barrier that 'could have been' was delegation and safety but because we brought in EAGLE quickly they got the faith of all involved'.*

EAGLE stands for Excellence, Assurance and Governance in a Learning Environment and provides an organisational development strategy and governance framework for an employer-led regulation and registration system of health care support workers within Hywel Dda Health Board. In addition, they have introduced a generic Band 4 job description for an Assistant Practitioner (Nursing Support Worker), a KSF outline and an application form for introducing Assistant Practitioner posts, which is submitted to a Scrutiny Panel for approval<sup>12</sup>.

In taking steps to put in place the types of assurances that people require Hywel Dda has been particularly proactive. As far as could be ascertained in the course of the research no other Board had attempted to resolve this question to date. The EAGLE approach therefore provides an example of a way in which this challenge can be addressed by Boards in a way that provides the necessary safeguards whilst avoiding the need for statutory regulation.

### **Progression**

For many people, level 4 posts constitute a good quality, aspirational career goal in their own right. Many HCSWs have no desire to undertake the additional academic study that is required in order to move to a registered post. Assistant Practitioner posts should be recognised and acknowledged as a legitimate career goal.

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<sup>12</sup> Note that while all jobs that fall within AfC are required to have a generic description, a KSF outline and be approved by a job-matching (scrutiny) panel, this approach differs in providing a standard template for assistant practitioner roles.

However, the potential for career progression to a level 4 post varies a great deal depending on discipline/subject area. This is for two main reasons. First, in some areas level 4 posts are niche occupations and effectively constitute 'destination' posts – there are no or few higher band posts to move into within that specialism (for example, where there are only managerial posts above that, and only one or two of those across Wales, as was cited as being the case in one of the screening services in Wales).

Secondly, career progression to a regulated position depends on the availability of an appropriate education or training pathway to provide a bridge between level 4 and level 5. In many occupational areas these pathways either do not exist at the moment, or exist only as a full-time study option. For people who are already in work, and who may have family and/or financial responsibilities, such provision is simply out of reach.

It was of concern to one interviewee who had been involved in developments that some of the changes planned under Modernising Scientific Careers appeared to threaten the loss of the part-time route to further qualification. The emerging challenges regarding provision of higher education programmes in niche markets for small numbers of students (noted earlier in this chapter) constitutes an additional threat to progression.

### **Costs**


It should be noted that the research took place at a time when there were severe economic constraints in place. Several interviewees pointed to funding constraints as a barrier to the introduction of band 4 posts. They reported that there was no money to fund promotion of band 3s to band 4 and in some cases little money for training. In addition, several interviewees said that they felt that financial concerns alone should not drive skill developments.

However, in many cases there was recognition that cost considerations would drive practice and new ways of working. For example, one of the interviewees who managed nurses and HCSWs in a GP surgery said that

*“Costs more than anything will force us and the NHS as a whole to revisit what we’re asking of the nurses. We’ve moved the food chain down [i.e. devolved skill requirements] from GPs to nurses and from nurses to [health care support workers], even admin tasks are being shifted as we have to maximise what we ask each level to do.”*

Many managers recognised that the Assistant Practitioner posts (along with the changes to working practices they enabled) were enabling cost-efficiencies and helping to contain costs.





As one manager of a scientific department said:

*“We have been looking at skillmix, workforce planning...the finances of the NHS are quite restrictive and you have to get value for money as well. In these 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 different skill sets that are needed now.”*

## 4.4 Summary

In the interviews the health sector managers, directors and course leaders described the various settings in which Assistant Practitioners – or similar roles with different titles – have been introduced. They described the ways in which supervision was arranged, the challenges to supervision in some circumstances and the ways in which these could be overcome.

Challenges had been encountered in accessing education and training for Trainee Assistant Practitioners, both in terms of provision to equip them for the Assistant Practitioner role and to enable them to progress from it, should they wish to do so.

The interviewees also pointed to innovative ways in which fears had been allayed regarding the safe devolution of tasks to health care support workers and Assistant Practitioners and the way in which the introduction of Assistant Practitioners had helped them to contain costs whilst maintaining or increasing capacity and quality.

## 5. The HCSWs' experiences


### Key points

- Focus groups were held with health care support workers, mostly employed at band 3, but with a few at band 2 and 4 (or equivalent, where they were employed by GPs or charities). All participants were undertaking university courses that in principle would equip them with an appropriate level of knowledge to progress to an Assistant Practitioner post.
- There was generally a lack of knowledge regarding what constituted an Assistant Practitioner role, except amongst the radiography trainees. Mostly participants reported not having level 4 posts in their departments, apart from nursery nurse posts.
- Healthcare support workers viewed the Assistant Practitioner post as potentially providing an attractive progression option, if they were to be introduced into their department or ward. However, most believed the economic situation made their introduction unlikely in the short term.
- The discussion revealed that many of the HCSWs were undertaking complex activities with minimal or no supervision. Some were told they needed to work autonomously in order to be considered for an Assistant Practitioner post.
- Some raised concerns at the scope of work they were required to undertake along with the lack of supervision they received in the workplace or in their work experience departments. In part they believed this situation arose because higher band staff were unsure of what work could be delegated to HCSWs or Trainee Assistant Practitioners, but there was a suspicion too that this arose from a lack of interest in the development of HCSWs.

### 5.1 Introduction

Understanding the experiences and thoughts of HCSWs who are currently undertaking education and training that would equip them with the knowledge and skills for level 4 posts in the future is an important element of this research.

This activity was necessary in order to not only validate some of the earlier findings from managers and directors but to also explore issues that can only be voiced by the workforce themselves. These issues include; the realities of studying whilst working in a demanding HCSW role; their future motivations for studying and their future aspirations.



Four focus groups were held with HCSWs studying on courses that were designed to support development and progression to level 4 posts. The courses were run at three universities, with three of the focus groups comprising students taking qualifications in health care studies and one comprising students who were taking a certificate in radiographic practice.

This chapter provides an account of their perceptions and their descriptions of the situation within their departments or organisations. It should be emphasised that it is not possible to validate these accounts and that individuals' experiences may not be fully representative of the picture across Wales. Equally, however, it is important to point out that there was consistency in the accounts given by individuals across the four groups and the three geographical areas covered in these discussions.

## **5.2 About the participants**

The HCSWs worked in a wide range of organisations and settings, including renal units, special care baby units, the hospice at home service, GP surgeries, psychiatric units, stroke units, orthopaedics and gynaecology, with the Radiographic Assistants working in radiography departments and in Breast Test Wales, the national breast cancer screening programme for Wales. Most were employed on band 3 positions, some were on band 2 and those employed in private practice believed that they were employed at a level equivalent to band 3.

Where it is necessary to distinguish between broader HCSW group and those in radiographic imaging we refer to the HCSWs in imaging as 'Radiographic Assistants' and the remaining HCSWs are referred to as 'Healthcare HCSWs'. It is of course recognised that Radiographic Assistants are also healthcare workers and the term is adopted solely for the purposes of clarification between the two groups within this chapter.

## **5.3 Accessing education and training**

The majority of the Healthcare HCSWs reported that their current studies were being funded through the Welsh Government via their individual employers.

There were reported differences across the groups in relation to the ease with which they were able to gain agreement to attend the training and the willingness of their organisation to grant them time off to attend the course. Some participants reported inconsistencies in the decisions made about training.

One respondent described how within their workplace only one of the two HCSWs was allowed to attend the course as they could not release both HCSWs at the same time. It is clear therefore that the overall size of department and flexibility to cover planned absence have an impact on managerial decisions regarding when and who to train.

Two HCSWs reported that they felt they were overlooked when training was on offer. They believed that managers were reluctant to grant them training as they are worried that they would have to pay them more if they started using these new skills in the workplace:

*'If you practised they would have to pay you. They shouldn't stop you progressing'.*

These issues are of course not unique to the health sector, the experiences that the HCSWs shared are mirrored in many different organisations and sectors across the UK.

## **5.4 Awareness and availability of Assistant Practitioner and level 4 posts**

Amongst the Healthcare HCSWs only a minority reported the existence of level 4 posts in their departments. The great majority were uncertain of what constituted an Assistant Practitioner role (three of the four sessions started with participants asking the facilitator what an Assistant Practitioner post was). Only a very small minority were aware of such roles being in place within their employing organisations.

The Radiographic Assistants differed in that they were aware of the Assistant Practitioner role and all said that these roles were in place in the departments in which they worked.

Some of the participants believed that the only thing differentiating between a level 3 and level 4 post was the educational requirement. One HCSW who was employed on level 2 said:

*'The nursery nurses were all on band 4s, I was doing the same work as they were, the only difference was that they had the NNEB [L4] qualification. When one of the nursery nurses left, they took off the requirement for the NNEB [qualification] and advertised it as a Band 2 Health Care Support Worker'.*

At one site there had been a full time band 4 but that person had left and the organisation was considering replacing the existing post with two part time Band 3s.

In addition (and as was found in the interviews with managers and directors) the focus groups confirmed the issue regarding the lack of understanding of quite what is required to justify a level 4 post. One issue raised in the discussions was the question of autonomy. Although the great majority of level 4 posts are undertaken under supervision (albeit 'light touch' in some situations) several interviewees believed that autonomous working was a key requisite of a post being defined as an Assistant Practitioner.

Many participants were unsure whether they would in fact be able to move into a level 4 position when they graduated. Participants consistently reported that if level 4 positions were not available that they would remain in their substantive Band 2 or Band 3 posts. However, some were concerned that if they failed their final examinations they would not be able to go back to their current job as the posts were being frozen or terminated.

Many participants confirmed that they would like to move into a band 4 role – and indeed many believed they were already working beyond the requirements of their current band 3 role – but they were not optimistic about the likelihood of progression in the current economic climate. One HCSW said that her line manager had asked if she would be interested in progressing to a Band 4 and she had said that she would. However, it subsequently became clear that there had been no support for this suggestion further up the organisational hierarchy and so she expected to remain at Band 3 after completing her qualification.

## 5.5 Motivation and progression

Many of the Healthcare HCSWs said that they had taken the course for the developmental opportunity it provided. The majority felt that although they had grown in confidence as a result of taking their courses they had not yet been able to use the additional knowledge they had gained in the workplace and sadly they felt that they were unlikely to be able to do so in their current situation.

Many had hoped for a future in a higher band post, but now felt that the training '*guarantees us nothing*'. Several – across all the groups – said that they felt demoralised by the lack of any prospect of progression:

*"Well I knew it [the job/promotion] wasn't guaranteed but thought that a job might become available in a few months. If it doesn't come to pass... well I'll feel like packing it in. I'm just hanging in there to better myself and get more money and because I have a fantastic supervisor. If it wasn't for him I think I'd have packed it in by now."*

Most felt that they were already working above their level but had little chance of any further progression other than to move into nurse training.

*"I love my job but wouldn't stay if I wasn't going into nurse training - there are no Band 4 posts, nothing to progress into."*

Around a fifth to a quarter of all the healthcare studies students were planning on continuing into nurse training because it was the only option they could see for any further career and pay progression.

## 5.6 Supervision

Many of the Healthcare HCSWs and several of the Radiographic Assistants reported varying levels of supervision being provided in their current role.

One of the Radiographic Assistants had told the host department that she felt uncomfortable with the situation she found herself in: she had been left without formal supervision for about eight weeks and the situation had “*knocked my confidence*”. Another reported being left in the supervision of first year radiography students.

Participants felt that these situations arose mainly as a result of staff shortages, but also in part because ‘*some of the staff are not interested in APs*’. One of the groups of Healthcare HCSWs said that it was a grey area regarding what HCSWs can do, with one saying:

*“The higher bands don’t know what is or can be done by the other bands; they don’t know what they can delegate.”*

Many of the Healthcare HCSWs had several years’ experience – 8, 9 or 10 years was not unusual – and one had over 20 years’ experience. Many spoke of routinely undertaking activities that they believed should qualify them for a level 4 position: “*Bloods, ECGs, dressings, immunisations....we have our own list of patients, do annual reviews [of patients], recalls*”.

Some reported undertaking specialist activities, for instance, inserting feeding tubes into infants. A similar situation was reported by the Radiography Assistants. They reported that they were often asked to do things that were beyond the specified scope of practice: working with children under 12, working in A&E, with in-patients, “*It’s just how it is.*”

Given the lack of knowledge about the nature of the Assistant Practitioner/level 4 role it is unsurprising that there are misunderstandings about what is required. One healthcare HCSW said:

*“A lot of the difference is that someone else makes the decision. When you start giving advice to patients, I was told that’s the sort of [autonomous] thing you have to do to be a Band 4”*

## 5.7 Summary and discussion

The great majority of the HCSWs who participated in the focus groups said that they would value the opportunity to advance into level 4 positions; the main impediment to this was the lack of availability of such posts. There was a prevailing perception that there was unlikely to be increased availability of such posts in the short to medium term.

The participants' responses supported the earlier findings from the interviews with health sector managers and directors: that rollout of Assistant Practitioner roles was not widespread across Wales and that there was some confusion regarding what was required within a level 4 post in comparison to a level 3.

The discussion and debate around obtaining level 4 positions following the completion of their training potentially raises interesting, yet subtle, differences around the perceptions of workers in the health sector in comparison to other sectors.

It would appear that there is potentially an intrinsic psychological link between qualifications and pay for people in the health sector, and that there is a belief that once qualified to a certain level, posts at a level commensurate with those qualifications should be available.

In addition to this, tasks, roles and responsibilities, particularly amongst clinical staff are clearly defined within the sector. This means that individuals are generally aware of when they are undertaking 'higher level' work. They may however lack the understanding regarding the 'critical mass' or frequency of higher level activities that might be required before they would be considered to be fully working at that level.

The types of training that the participants of the focus group were undertaking are also quite clearly a useful progression into degree level training for nursing etc. This investment in training from employers in Wales could therefore provide a useful stepping stone to degree level training for some individuals which might otherwise have been out of reach.

## 6. Introducing Assistant Practitioners; the benefits and barriers

### Key points

- Several staff pointed to the improvements in capacity and cost-efficiencies that Assistant Practitioners had enabled them to achieve, at no loss of service quality.
- However, many interviewees pointed to the difficulties they had encountered when considering whether to introduce such posts.
- The lack of clarity regarding the role and supervisory requirements hindered progress in some departments and greater guidance was requested regarding the role of the level 4 HCSW
- How workforce planners go about planning and allocating duties across staffing levels can impact on how viable they see the posts as being, along with work volume, level and location. These issues are linked in turn to size of the staffing establishment, with managers encountering particular problems in ensuring supervision for Assistant Practitioners in small wards or departments in which only two staff are required on duty at a time.
- Managers had encountered difficulties in identifying appropriate education and training for their trainee Assistant Practitioners and in some cases had found that appropriate provision had been withdrawn because the student cohort could not be guaranteed every year or had been too small to support the course.
- Although concerns were raised about the lack of regulation of HCSWs examples were found of ways in which such fears had been allayed through actions taken either by the professional body or by the Health Board. These provide potential ways in which employers can address local concerns on this point.

### 6.1 Introduction

In this chapter we report on the benefits and barriers to introducing Assistant Practitioner roles. We examine how the pattern of uptake and use of Assistant Practitioners is affected by the nature of the work, the nature of the supervision required and the ways in which individuals are deployed.



## 6.2 Benefits of introducing new roles

There were several accounts of how the introduction of staff at level 4 had brought benefits to their departments, in particular through improving work flow and increasing capacity. In several of the scientific areas (for example Haematology, Pathology, Biomedical Sciences) and in imaging services managers outlined the positive impact that the introduction of these roles. They pointed to improved work flow and cost efficiencies arising from their implementation.

*"It has been a small saving in money terms but a huge increase in efficiency and productivity."*

Some managers saw a role for these posts in nursing-related roles and believed they would have more of a role in future, especially with the move to community/home-based provision. One nurse manager who was in charge of a community-based psychiatric service said:

*"There are lots of benefits; [Assistant Practitioners] bridge the gap between qualified and unqualified nurses. Because of their level of experience they are able to work with people in the community and report back to the qualified nurses and therapists and liaise with other agencies and GPs."*

In addition, and as the research found, in many cases band 4 posts are helping achieve more cost-effective work flow, but they are not necessarily called Assistant Practitioners. All Assistant Practitioners may be level 4s<sup>13</sup> but not all level 4 posts are Assistant Practitioners.

It may be that it is the title, not the role that is the barrier to introduction in some cases. If new level 4 posts have job titles that are based on the role, and the role describes a job that is required within the organisation, then it is more likely that posts will be introduced where they are useful and cost effective. Note, though, that such level 4 posts are unlikely to show up in surveys asking about numbers of 'Assistant Practitioners' however.

The above illustrates the potential benefits that can derive from introducing these roles. In the sections that follow we consider the factors that can constitute barriers to the introduction and deployment of Assistant Practitioners and the ways in which these barriers might be overcome.

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<sup>13</sup> In fact, earlier publications have pointed to the fact that even this is not a given: see Miller 2011.

## 6.3 Barriers to introducing new roles

### Lack of clarity regarding the role


The finding that people wanted to know the definition of/did not know there was a definition of the Assistant Practitioner role is a key finding. In the absence of an understanding of what comprises an Assistant Practitioner role or what people in such roles can do, a manager, director or board is unlikely to push for their introduction or use.

There is also the possibility that the term itself confuses people. While the term 'Assistant Practitioner' is used in the Career Progression Framework, it does not necessarily hold much meaning for people in general within the health sector nor for those making decisions about service and workforce configurations. Looking at posts at level 5 in the Career Framework, while these are labelled 'practitioners', nobody actually has the job title 'practitioner': they are called 'nurse', 'radiographer' 'haematologist' or 'occupational therapist'. Starting to consider the ways in which level 4 posts can usefully be deployed, and basing the titles on the activities of the role, is probably the single action that would help with increased uptake.

Linked to this is the fact that while a definition of the role does exist it is clear that many people find it difficult to grasp, even people in quite senior workforce roles. It is not simply that people are unaware of the definition but rather that they want more guidance on the boundaries of the level 4 role and in particular what differentiates such roles from those in level 3 and, crucially, 5. There is a particular need for clarification around the issues of autonomy and supervision. A range of different interpretations were given during the research.

Several people pointed to the difficulties experienced by those who are not well-versed in the language of competences, national occupational standards etc. Even those who are relatively high up within the Boards felt that some clearer, introductory guidance would be helpful in this area. Case studies of successful implementation were also thought to be useful and were seen as being a "*help to avoid reinventing the wheel.*"

In pointing to the need for greater clarity of roles, responsibilities and supervisory requirements we note that several of the professional bodies have dealt with this issue directly by issuing definitions of Scope of Practice that set out the activities that unregulated individuals are allowed to undertake, the situations in which they can work and the nature of any supervision required. The Society and College of Radiographers (SCoR) is one such body that has led in this area.



As ever there was no single viewpoint regarding this issue. While several pointed to the need for more guidance, a small number of interviewees felt either that they did not require such guidance or that guidance would be impractical as it would need frequent updating due to changes in practice. That said, the guidance issued by SCoR does appear to be valued by imaging managers and this suggests that the development of similar guidance by more of the professional bodies could help address some of the concerns around this issue. This is especially likely to be of use in the early days when organisations or departments are embarking on the use of Assistant Practitioners for the first time and people may be grappling with what an Assistant Practitioner/level 4 role can or cannot be expected to do.

### **Workforce model**

We found less use of these roles in the private and charitable sector, often linked to retention of a more traditional nursing model, although we should emphasise that this was not always the case. This serves to reinforce the fact that in many cases, decisions regarding whether it is appropriate to introduce Assistant Practitioners (or similar posts at level 4) are influenced by the workforce model held by the key person making workforce decisions.

Many of the decisions reported by interviewees had been influenced by a model of workforce planning that saw planners start by considering their requirement for regulated staff and then considering the extent to which tasks could be devolved downwards. However, in one GP practice the nurse manager had started her workforce planning by considering what and how much work could be assigned to the band 2 phlebotomist, after that what could be achieved by the band 3s. She had tried, but failed, to find any additional tasks that could be taken on by a band 4 person, recognising that above that level she required nurses for the remaining tasks.

However, in one of the private hospitals the director of nursing had similarly started *'with a clean slate'* in terms of workforce planning and had considered the full range of competences required, rather than taking a top down perspective and as a result that hospital now had HCSWs employed at an equivalent position to level/band 4 in the NHS. The hospices tended to have what may be described as more traditional staffing structures and in those organisations the tendency was to have nurses plus Health Care Assistants equivalent to levels 2 or 3, but currently not 4, although they recognised that they might need to consider this option in the future.

## **The need for sufficient work volume and level to justify role development**

Linked to the issue of the workforce model and planning, several interviewees pointed to the fact that volume of work determines the feasibility of introducing Assistant Practitioners. There needs to be *sufficient* work at an *appropriate* level to render these posts of value in either a full time or part time capacity.

In some settings either the patient or the task volume was viewed as not being sufficient to justify introduction of these posts. For example, one GP practice had considered using Assistant Practitioners to undertake vaccinations. Ultimately they decided that the volume of work was insufficient to justify the introduction of even a part-time post at level 4.


In contrast, another GP practice had sufficient volume of work to justify employing a phlebotomist at level 2 and two HCSWs at level 3. The nurse manager had adopted a bottom-up model, allocating tasks to higher band staff only when the lower band workers had reached their capacity or the work exceeded their capability. This was very cost-effective; the interviewee believed that this gave them the skill complement they required and therefore felt that there were no tasks that required employment of a person at level 4.

The main lesson here is the fact that in both cases managers had assessed the volume and nature of the tasks that needed allocation across the whole of their workforce and the level of staff required to undertake those activities. They had then considered the implications of this for the profile of staff required. This is the key issue underpinning successful implementation – or alternatively, underpinning the recognition that introduction of an Assistant Practitioner is unlikely to bring benefits.

## **Supervising Assistant Practitioners**

Several of the directors and departmental managers– including those who spoke positively about the use of Assistant Practitioners - reported challenges in extending use of these posts because of the supervisory requirements. While in many disciplines the work of Assistant Practitioners did not require continual oversight, nonetheless in the majority of cases their work usually needed to be 'signed off' by a regulated professional, which meant they could not be deployed in settings or on shifts where only two members of staff in total would be on duty, for the reasons set out in Chapter 3.

The issue of supervision was therefore seen as significantly impeding attempts to deploy more Assistant Practitioners and, as well as the challenges already identified, there is an additional factor: to employ more people at level 4 in most cases meant that managers would have to lose a regulated professional and in turn this would lead to a decrease in the number of people available to undertake supervisory duties.



Managers therefore described how they reached a self-limiting distribution in their departmental workforce profiles which prevented any further change. It should be noted that in earlier research, similar challenges to those seen in Wales were reported by managers of imaging departments in Scotland who had introduced Assistant Practitioners.

There are some ways in which managers may seek to overcome this barrier and ensure best use is made of Assistant Practitioners. The first is to ensure that they analyse work flow and ensure that all of the tasks that can be undertaken by non-regulated practitioners are, in the words of one interviewee, 'passed down the food chain'. Most of those who were utilising Assistant Practitioners had done this. Second, efficiencies can be attained through batching the approval process: for example, in imaging services, 'justification' of imaging requests can be undertaken in a batch in readiness for the Assistant Practitioner to undertake their work.

Furthermore, one of the interviewees reported that where their Assistant Practitioners were working remotely and a query arose, video conferencing was used to contact and seek guidance from the regulated practitioner. In Breast Test Wales images taken by Assistant Practitioners are signed off remotely by a centrally-based mammographer.

It is possible that greater use of technology could facilitate the increased take up of Assistant Practitioners in future. This is likely to be of particular use as more care is devolved out into the community and individuals' homes.

### **Challenges accessing education and training**

Sourcing, sustaining and funding training is a particular challenge and respondents felt that this was an issue that may worsen. It is important to note that the Welsh Government has taken steps to support education and training for Assistant Practitioners, for example agreeing funding for a specified numbers of places on programmes for Radiography Assistants each year. However, even here there are problems: in one university the radiography programme had run only on alternate years because of lack of demand while in another there was some uncertainty over whether the next year's quota of places would be filled.

There is a group of issues to do with identifying, funding and sustaining education and training. Boards and employers want clearer signposting to the education that is available, while colleges need sustainable student numbers to ensure course survival. To resolve these problems Boards need to link workforce planning and education commissioning intentions, but as two interviewees said:

*'We can't see the figures for Assistant Practitioners in the overarching workforce plan because only the divisional plans have details.'*

*'The commissioning people are frustrated because they want to make the most of the education and training they are commissioning, but for that to happen they need the people in workforce planning to do their bit'.*

In addition (and as is the case throughout the health sector), training decisions remain largely the province of individual managers and their training decisions differ widely. Individuals at level 4 (or below that and hoping to gain access to training to enable them to progress) are not helped by the view of some managers that training budgets should be focussed on their regulated staff.

It has to be recognised that there is a particular problem in finding and sustaining education and training for small and specialist groups of learners such as rehabilitation engineers. Universities and colleges have to make difficult commercial decisions on whether they can continue to support courses that attract small or variable numbers of students. The small numbers of learners in some areas (both in terms of specialism and geography) may mean that universities decide to close specialist courses even though training is needed in the immediate short term and likely to grow in future.

This had been found to be a problem even in Cardiff, home to the national services and therefore with comparatively larger numbers of learners than many of the Boards serving smaller populations.


Where courses exist, funding often remains an issue and very different experiences were reported. Some people said they had 'found' funding (typically, they reported, unspent nurse funding) from NLIAH but were uncertain where they would go next for funding or would go for information about funding, as NLIAH had closed on 31st March 2013. Although the NLIAH website was still available as an archive it was not being updated<sup>14</sup> and the successor website was not fully operational at the time the research was undertaken<sup>15</sup>.

Taken together, this problem of uncertainty over the filling of existing places, and ensuring the sustainability of small volume, niche training causes ongoing problems for employers. With the emergence of increasing numbers of specialist roles (and with this only likely to increase with movement of services out into the community and individuals' homes) a way has to be found to make such training feasible and ensure its availability.

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<sup>14</sup> Message at: <http://www.wales.nhs.uk/sitesplus/829/page/65227>

<sup>15</sup> NLIAH and its successor body did and do in fact have specific funding available for level 4 education, but it is evident that many interviewees were unaware of this. In addition, in the previous year this funding had been opened up to employees seeking training to move up to level 4.



Note that while this emerged during the research within Wales this is not an issue that is restricted to Wales. Indeed, one of the interviewees referred to a course at a university in England that had been used by the interviewee and colleagues – the only one of its type and in a specialism that is likely to grow in future – and which had been closed despite recruiting 17 students for the next intake year. It is clear that this is an issue that has ramifications for NHS England/HEE as well as for the Welsh Government.

It is difficult to envisage a way to resolve this issue short of action at a strategic level. Co-ordinated action is required to ensure that education and training provision that is both central to maintaining service quality but likely to be taken up by relatively small numbers of people is able to remain viable. While it is fully understandable that colleges and universities at present only have the option of running courses that are financially viable, there is nonetheless a need to ensure that niche provision remains available.

This appears to be an issue that can only be resolved through either the Welsh Health Boards (individually or together) or (ideally) the Welsh Government entering into discussions with the universities and colleges. Given the fact that some interviewees had been utilising courses in England which had then closed those discussions ideally should, where relevant, also involve the English universities and Health Education England too.

### **Concerns about the lack of registration and regulation**

Related to scope of practice is the issue of registration and regulation. The interviews revealed there remain concerns regarding posts below level/band 5 remaining non-registered and unregulated. Again, it is important to emphasise that there were mixed views on this and it is questionable the extent to which registration would change what individuals actually did or the supervisory arrangements. However, several interviewees pointed to the need to allay fears on this point and it is perhaps the concerns about this point, rather than the issue of non-registration in itself, that is the main issue.

It is also worth re-iterating the point that the HCPC has flagged up the UK Government's intention only to introduce any further statutory regulation requirements in 'exceptional circumstances' and where there is a 'compelling case'. There is no Government intention (in Wales or the UK more widely) to introduce statutory regulation for staff below level 5. We also note that Skills for Health has no policy position regarding regulation of HCSWs.

Nonetheless the interviews revealed that the issue of non-regulation remains a concern for some managers and while those concerns remain unallayed this is likely to impede progress, with many interviewees believing that registration and regulation was a necessary step towards overcoming barriers to wider implementation.

In the absence of any prospect of action at national level to address such fears it is worth noting that the research identified several examples of alternative ways in which this issue had been confronted. These provide potential models that other Boards, employers and professional groups seeking to address this issue may wish to contemplate. These were as follows:

**Voluntary accreditation:** The Society and College of Radiographers (SCoR) has gone some way towards addressing the lack of regulation by introducing a voluntary accreditation scheme for Assistant Practitioners. This sets out criteria that enable individuals to gain accreditation as an Assistant Practitioner and also sets out the Scope of Practice for Assistant Practitioners, identifying the activities they are allowed to undertake, the settings they can work in and the types of patients they can work with.

Note that despite the SCoR scheme being voluntary, by early 2013 they already had some 726 Assistant Practitioner members. An RCN survey suggested that around three quarters of Assistant Practitioners in nursing-related areas believed that they should be registered.

**Pharmacy Technician Registration Scheme:** One of the interviewees pointed to the compulsory registration scheme that has existed for Pharmacy Technicians since 2011. Pharmacy Technician posts sit at band 4<sup>16</sup> within the AfC framework, and are undertaken by individuals qualified to QCF level 3. Originally a voluntary scheme, registration for Pharmacy Technicians became mandatory following the review of their role in the White Paper on the allied health professions, *Trust, Assurance and Safety: The Regulation of Health Professionals (2007)*. The White Paper recognised that while Pharmacy Technicians were working more closely with patients than in previous years, nonetheless they could be utilised even more efficiently. However, this would require technicians to become regulated in a similar way to other allied healthcare professions. Employers too were keen to see Pharmacy Technicians become a regulated profession; they could then be used more flexibly, including allowing technicians to work more independently of pharmacists. From the 1st July 2011 it became mandatory for Pharmacy Technicians to be registered with the General Pharmaceutical Council.


Note that in this last case both the government and employers recognised the value that registration could bring with the ability to distribute prescription medication, a task restricted to regulated practitioners, being a critical factor driving the decision to introduce regulation Tamkin et al<sup>17</sup>.

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<sup>16</sup> Note there are also Pharmacy Technician posts at Band 5 filled by individuals who hold degrees.

<sup>17</sup> Tamkin, P, Miller, L, Williams, J, and Casey, P (2013) *Understanding Occupational Regulation*. Evidence Report no. 67.





**EAGLE:** Since 2009 Hywel Dda Health Board has had an organisational development strategy and governance framework for an employer-led regulation and registration system of health care support workers<sup>18</sup>; this is the Excellence, Assurance and Governance in a Learning Environment or EAGLE system. This was introduced in recognition that staff at band 4 and below would be increasingly involved in service delivery in future and that statutory regulation was likely to be some years away. The Scope of Practice is set out in each job description with the roles being designed using the Role Redesign Principles as outlined in 'Standards and Guidance for Role Redesign'<sup>19</sup>.

## 6.4 Summary

In this chapter we have provided an overview of the benefits and barriers to implementation of Assistant Practitioner roles. Regarding benefits, prime amongst these is the increase to capacity and cost-efficiencies. However, even those that held very positive views regarding the impact of Assistant Practitioner roles in their departments pointed to challenges in making rostering arrangements and providing supervision. Other barriers include difficulties in ensuring appropriate (and sustainable) education and training provision and concerns about the fact that Assistant Practitioners would take on some of the responsibilities of regulated practitioners without themselves being regulated. Ways in which some Boards and other health care bodies had dealt with these challenges were described.

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<http://www.ukces.org.uk/assets/ukces/docs/publications/evidence-report-67-understanding-occupational-regulation.pdf>

<sup>18</sup> The document can be viewed at:

<http://www.wales.nhs.uk/sitesplus/documents/862/342EAGLEStrategyEmployerLedRegulationHCSW.pdf>

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[http://www.wales.nhs.uk/sitesplus/documents/829/Standards%20and%20Guidance%20for%20Role%20Redesign%20in%20the%20NHS%20in%20Wales%20\(English\).PDF](http://www.wales.nhs.uk/sitesplus/documents/829/Standards%20and%20Guidance%20for%20Role%20Redesign%20in%20the%20NHS%20in%20Wales%20(English).PDF)

## 7. Summary and conclusions


In this final chapter we reflect on the findings and set out our conclusions. It is worth noting that many of the points reported above effectively reflect those found in the wider literature on Assistant Practitioner developments across the UK (see, for example Miller, 2011 and Miller, forthcoming). The picture in Wales therefore reflects that seen across the UK, but there are particular challenges that arise from the dispersed nature of the populations in some parts of Wales, rural geographies and the relatively small populations in some Boards.

First, the research showed there is a role for level 4 posts. Where they are in use they are typically well-regarded. In some high volume areas, level 4 posts had been successfully introduced and were helping to achieve significant cost-efficiencies. In some Boards Assistant Practitioners in nursing-related roles are in place and more are being developed; there are significant developments in the scientific (laboratory-based) disciplines; and radiography remains the area in which the roles are most well-established.

The research also revealed that these level 4 roles are often called by other titles. Those titles are often more meaningful within the department, ward or unit, often referring to the functions undertaken by individuals in those roles rather than simply referring to their title in the Career Development Framework. The use of more meaningful job titles may be one of the easier, and more effective, ways to support and encourage greater utilisation of these roles.

Many see the move to increasing community-based care as leading inexorably to a demand for more level 4 practitioners, with some of these roles straddling health and social care. If such moves are to be supported it will be necessary to ensure that appropriate education and training is in place to develop people for these posts. This currently presents a major challenge.

Beyond this, three key factors influence developments: the nature of the work and its requirements for supervision, the workforce model in place and the current economic climate. Small workforces provide only limited room for changes to skillmix. Where people are working on their own with patients in rural settings supervision can prove challenging and a registered practitioner may be the most cost-effective and flexible option for an employer. The case for further expansion of the Assistant Practitioner role was viewed as not being helped by the widespread financial constraints within the health sector at the time the research was conducted. There were many accounts of posts being down-graded from their current banding, either when the post was vacated and re-advertised or, in some cases, while the current job incumbent was in post (albeit with salary protection). This included support worker roles.



Regarding finance, there appear to be two broad factors in play: one is the potential for cost-efficiencies to be gained by devolving some activities from regulated staff to lower level/band workers, with - potentially - a cost saving as well, if the Assistant Practitioner post is introduced following reduction in the establishment of regulated staff. However, where any change involved upgrading of current staff – i.e. from HCSW to Assistant Practitioner – without loss of other staff, then it can be challenging at present to gain approval for such workforce planning decisions, as the main focus is on the potential increase in staffing costs, irrespective of any potential cost-efficiencies that might follow on from this.

The research also confirmed that differences remain between the occupational groups in terms of the recruitment routes into and career progression available beyond level 4 roles. In radiography the great majority of Assistant Practitioners and trainees have been recruited from amongst the current support workers and in just a few cases had the trainees been recruited externally. The same was true of nursing-related posts. However, in other occupational areas, people with good general – or specialist - education had mainly been directly recruited to Trainee Assistant Practitioner positions and then trained. This pattern is likely to change as the pool of potential trainees within the existing HCSWs is gradually exhausted.

The reasons for variation in progression options from such posts varied. One reason was because some of these posts are viewed as destination posts in their own right – they are demanding and relatively well-rewarded roles, and fill specific niches in the health landscape that do not have a natural progression route. In other cases, however, where they were viewed as a (potential) route to a registered post often – in probably the majority of cases there was no part time study route to the requisite degree and therefore, the only option was for the individual to leave their job and study full time.

Lastly, the difficulties that managers encounter in ensuring appropriate niche training provision for potential Assistant Practitioners is likely to continue and, if anything, exacerbate, if universities are required to ensure that all courses are economically viable. Valued courses had already been lost. As healthcare grows ever more specialised the Governments of all the UK nations will need to consider how to ensure that essential education programmes are supported.

## **7.1 Limitations of the work**

We recognise that the research is qualitative and may be criticised for being based on the views and perceptions of individuals. However, it should be recognised that these are the individuals who shape the service, create policies and drive initiatives. The work was not a review of policy nor of whether the policy had succeeded or failed but an examination of how and why Assistant Practitioner posts had been introduced – or not. As such, interviewees were selected for their place within the human systems that take the decisions on whether to introduce new roles and were instrumental in appointing, managing or educating these individuals.

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## 7.2 Summary

The work has provided an overview of the extent of implementation of Assistant Practitioner posts across the healthcare sector in Wales. It has identified barriers to implementation and ways in which these might be overcome. The research confirmed that there is a place for these roles in the healthcare sector in Wales and this could be better supported through enabling better access to education and training, both for initial preparation (entry) and for progression into registered roles. In addition, many Managers and Directors would appreciate more guidance on the development and implementation of the roles.

## 8. The case studies



### Cardiff and Vale Health Board

Cardiff and Vale has a unique position amongst the health boards as it provides a range of national and regional services as well as services for the geographical area covered by the Board. While some of the areas covered are rural, Cardiff itself is a dense urban area, surrounded by other, smaller towns. Transport connections are good and there are several universities within easy reach, as well as Cardiff University within the town. Many of the University's departments are co-located on the Heath Hospital campus.

There is a high population density and a high work turnover. The Board employs people in a wide range of Band 4 positions and in many of these work areas managers believe that they fulfil the definition of an Assistant or Associate Practitioner. In some cases, though, while they fulfil that definition, the history of the particular profession often means that they may work under a different title.

#### Assistant Practitioners, Associate Practitioners and other band 4s

There are several specialist posts at Band 4. Examples include Clinical Videographer, Retinal Photographer and Retinal Grader. There are also band 4 posts within clinical teams but who fulfil a non-clinical role: Employment and Housing Advisors in recovery and in mental health outreach services. In Speech and Language Therapy there are band 4 posts which in Cardiff and Vale are called Technical Instructors, while the Professional Body refers to the posts as 'Assistant Practitioners'. In Pharmacy a standard band 4 job description has been used in drawing up the specification for their two band 4 posts, but the job title used for this position is Pharmacy Technician, in line with custom emanating from the General Pharmaceutical Council. In one department the term 'Associate Practitioner' was reserved for use in a specific and quite different circumstance, which is when a person has forgotten to renew their professional registration; they are called an Associate Practitioner until they renew.

Therefore it can be seen that even though this is one of the Boards in which the greatest use is made of Assistant/Associate Practitioners and/or band 4 posts, the title is not used or applied consistently. One of the interviewees reported that the Board had made a start on developing new posts and new titles and there was a view that there was a need for more continuity '*across the patch*'. As part of this the Training and Development department had carried out a scoping exercise to try to reduce the number of KSF outlines. This work was ongoing at the time of the research.

### **A high volume Health Board**

Given the nature of Cardiff and Vale Health Board there is a dense population and a high volume of work and consequently many of the managers we spoke to had considered ways to increase capacity. Perhaps the largest scale developments are being seen as a result of the changes made under Modernising Scientific Careers. The scientific disciplines in particular face very high volumes of work and many were introducing shift work and round-the-clock cover. Introducing the Assistant Practitioner roles has brought real cost-efficiencies; as the manager of one scientific department in which these roles had been introduced said:

*"It has been a small saving in money terms but a huge increase in efficiency and productivity."*

In that department the band 4 Healthcare Associate Practitioner posts were being used both as a 'destination post' and as a 'stepping stone' (i.e. as part of a progression route). The manager saw both as being valuable but also noted an additional benefit for those who progress to registered posts from the Associate Practitioner roles: he has found that they are able to work autonomously more quickly than are individuals recruited directly to Band 5 posts.

In several cases the changes in the science departments had been enabled by developments in analytical technology reducing the need for highly skilled input. This had led managers to re-consider the optimal ways in which to organise work:

*"In these two 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 skill sets, the different skillsets that are needed now."*

Indeed a recent strategy document drawn up by the Artificial Limb and Appliance Service (ALAS) Directorate noted the value of these roles in achieving service improvement and cost reduction whilst also recognising the real value these roles can present for further development of unregistered staff:

*'There is a need to develop the knowledge, skills and experience of the healthcare science workforce within ALAS whilst maintaining sufficient flexibility to adapt to the changing circumstances likely to be encountered over the next few years. By adopting a strategic approach to this, opportunities for cost reduction, service improvement and service development will emerge. For example, the use of Healthcare Science Associates/Assistants based in one service to provide cover and support to other services as and when the need arises will go a long way to addressing recruitment, retention and sickness issues across all the ALAS services. It may also present personal and professional development opportunities to staff which would not otherwise be available. Furthermore, roles previously undertaken by registered professionals may in future be undertaken by appropriately educated and trained Healthcare Science Associates (HCSAs) under the supervision of a registered professional.'*

There are other specialist areas for which Assistant/Associate Practitioner roles do not currently exist but the service leads believe they could play a role. One interviewee had been a member of the national group developing an Associate Practitioner role in Cardiac Physiology. The interviewee saw a place for this role in her own department and believed that other managers too would see the value of these posts, although she noted that even so *'the numbers will not be very great'*. Potentially the roles would provide a good career progression option for support workers. The main barrier to introduction of the posts, though, is training:

*"The problem is the 'chicken and egg' situation with regard to training – you need to have the education arrangements in place before you can train Associate Practitioners – but there are difficulties in arranging education before you have the potential trainees."*

### **Constraints in introducing Assistant Practitioner roles**

Many of the developments in Cardiff and Vale are happening because of the high volume of work in this Health Board. However, even in the high turnover departments constraints similar to those seen in the rural Boards have been reported. Several departments were in the process of moving to shiftwork, and while the daytime staff numbers can support the supervisory requirements, it is not possible to deploy Assistant Practitioners on night time shifts:

*"I would employ more APs but there is issue of supervision – APs have to have their work signed off by a registered person and cannot work alone; if only one registered person was on shift then they could not have a break. Band 5 and 6s can practice in their own right. The AP can't do that. That's why there are so many Band 6s – if you oversubscribe to the idea, [i.e. have too many APs] then you could get a situation where there is no Band 6 on duty. The Band 6 can do the Band 4's work but not vice versa."*

However in some areas of work managers were finding innovative ways to enable supervision. The Rehabilitation Engineering Unit (REU) is a department within the ALAS Directorate had taken part in a Skills for Care project to look at the role of Rehabilitation Engineering in Telecare. Cardiff REU is one of three such Units providing Rehabilitation Engineering services across Wales whose staff may need to visit clients in remote areas. Sending Associate Practitioners to visit patients, where appropriate, could save these departments significant amounts of money. The Associates are able to work remotely and if they have any queries or they need to check anything with their supervisor this is resolved remotely:

*“The associate can go and, if necessary, make contact via videolink if they have any queries. There’s a lot of work in North Wales developing this type of approach.”*

### **Training and progression**

At the time the interviews were undertaken the possibility of gaining accreditation for an in-Board generic training pathway for Clinical HCSWs at Level 4 was being explored. What training was available or in development at Level 4 tended to be either specific to the various disciplines or did not cover the areas of practice set out by Skills for Health for Assistant Practitioners. Therefore the Board was in discussion with an accrediting body regarding the potential for accrediting existing in-Board modules to provide a qualification that could be made available for senior support workers across all the Health Boards in Wales.

While some of these posts allow for potential progression to band 5 posts, this is not always the case. In some cases the relatively specialised nature of these posts means there is no real option for progression as they are destination jobs in their own right. In such cases progression may not be an issue. In other areas, though, managers said that they were *‘struggling with how to offer or design a progression route’*. In addition, for some of these roles there is currently no education or training route to a higher band post other than a return to full-time study.

Cardiff is well placed for educational provision and the majority of managers were keen to see their Band 4 staff train and progress. Nonetheless several managers in specialist services had encountered difficulties in accessing training for their staff. Two managers pointed to university programmes that had been withdrawn (one in Wales, one in England); in the case of the English course this meant that there was now no appropriate training in that specialism across the UK.

The difficulties experienced by managers in this large, high volume Health Board are not just specific to the development of Assistant Practitioners but rather point to an issue that will need to be resolved at national level to ensure training remains available for smaller, specialist groups of staff.





## Hywel Dda Health Board

Hywel Dda is one of the Health Boards that has made much progress in implementing Assistant Practitioners. There are eight already working within Hywel Dda Health Board and more than 40 trained and ready to go into these posts as and when they become available.

The 'Flexible and Sustainable Workforce' report<sup>20</sup> published by NHS Wales had highlighted the staffing challenges that would confront the health sector in Wales, including a background of financial constraints, an ageing workforce and an awareness that the current number of nurses in the healthcare system would not be enough to cover all the demands placed upon it.

Hywel Dda recognised the value of the ideas proposed in the NHS Wales report and this led them to take action and explore whether they could produce a different, more cost-effective model. The Flexible and Sustainable Workforce report had pointed to the need to make more use of level 4 staff and Hywel Dda decided to introduce Assistant Practitioner posts. Using the definitions from NHS Wales' 'Flexible and Sustainable Workforce Strategy', Hywel Dda developed Band 4 Assistant Practitioner roles for staff who would: "through appropriate accredited education and training, deliver protocol based care as delegated by a registered practitioner. They make decisions and instigate treatment in accordance with the agreed protocols and usually work within the skills and competencies framework of an Agenda for Change band 4 post (as detailed within the KSF outline)"

However, the Board saw that potentially there might be concerns around the issues of lack of regulation and delegation of these posts. Therefore they decided to introduce a regulation system at Board level in order to avoid this potential barrier. This is known as the 'Eagle' framework.

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<sup>20</sup> Available at:  
<http://www.wales.nhs.uk/sitesplus/documents/829/a%20strategy%20for%20a%20flexible%20and%20sustainable%20workforce.pdf>

## The 'EAGLE' framework

In the absence of professional registration of Health Care Support Workers (HCSW), Hywel Dda Health Board introduced the 'EAGLE' (Excellence, Assurance & Governance in a Learning Environment) Framework. This is an employer-led regulation and registration system to support the development of Assistant Practitioner roles at Agenda for Change Band 4, and allow Assistant Practitioners to undertake duties previously only carried out by registered nurses and therapists.

While still in its infancy, the EAGLE framework -

- establishes the way in which clinical support worker roles are developed, implemented, monitored and assessed and sets out the education requirements for the roles.
- provides a mechanism by which the support worker, the registered healthcare professional, the organisation and above all the patient / service user are protected through appropriate delegation and accountability arrangements, and
- sets out the employer-led arrangements for the development of Assistant Practitioner at Agenda for Change Band 4, in the absence of a central approach or statutory regulation.

The framework is built on three interlinked pillars:

**Responsible delegation:** provides a description of Scope of Practice, core job and role descriptions, broad KSF outlines, supervision, schemes of delegation, delegation skills, and clear lines of accountability and communication.

**Assured competence:** codes of conduct, accredited learning, formal assessment records, career opportunities, talent management, continuing development, transferable learning

Together, these result in:

**Right people, right time, right place, first time, every time:** service driven, appropriate care, skills, knowledge and understanding.

Assistant Practitioner Core Job Descriptions and Broad KSF outlines were developed. A distinct scope of practice is developed for each role, which is then considered by a scrutiny panel to ensure the required education/training and scope of practice adheres to the EAGLE framework before the role is approved and registered.

### **Level 4 Education**

Specific education programmes have been developed in partnership with Swansea University School of Human and Health Studies. HCSWs at Bands 2 and 3 are able to study two modules of the Level 4 Certificate in Healthcare at Swansea University, which together carry 60 credits, which allows them to apply for a Trainee Assistant Practitioner role. Once in post, they undertake a further two modules of the Level 4 Certificate in Healthcare, to gain a further 60 credits. Once they hold these full 120 credits they carry the title of Assistant Practitioner.

### **Protection of Title**

As part of the governance arrangements, appropriate delegation is assured. A Scrutiny Panel ensures that each role developed adheres to the EAGLE framework. The titles of Assistant Practitioner and trainee Assistant Practitioner are protected within the Health Board, and staff holding these titles are registered on the Electronic Staff Record (ESR).

### **Added Value**

The education programme has been designed to give an additional pathway opportunity to staff, as qualified Assistant Practitioners then hold the requisite qualification level for eligibility to apply for registered nurse degree training. Assistant Practitioners who opt for this route enter the programme at year 2, subject to places being available.

### **The benefits**

The Board has found that

“Being able to give assurance in this way has been a big enabler”

To date, the Assistant Practitioners working within Hywel Dda have been a great success. They are working in surgery, dermatology and in medicine and there are plans to extend into the community and into the therapies in the near future.

Note: The EAGLE document is available from the Hywel Dda website, at: <http://www.wales.nhs.uk/sitesplus/documents/862/342EAGLEStrategyEmployerLedRegulationHCSW.pdf>



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

## Powys Teaching Health Board

Powys occupies 25% of the landmass of Wales but has a population of just 130,000. It has a rural geography and is very agriculturally-based; there is a low population density which is thinly spread out. There are 15 community nursing teams which are grouped into locality nursing teams, and there are five broad health economies.

There are nine small community hospitals in Powys, which are well-equipped and have both in- and out-patient facilities, two have day theatres and endoscopy clinics. However, because they serve small populations they only have small wards: on average these have 15 – 20 beds, with some having only 12. To staff that size of ward requires two registrants on every shift – one to provide a minimal level of cover and one to build in resilience (to cover for meal breaks, or in case one is off sick etc). As there are 12 – 15 patients then typically there would be a health care support worker (level 2 or 3) employed on every shift as well in line with RCN guidance on staffing standards – for instance, the guidance for wards for older people requires three staff for every 15 patients.

There are several factors that influence staffing decisions. With an older client group there is a level of dependency but not a high level of acuity: while such patients may need a lot of care they typically do not require a lot of intervention. In such circumstances the staffing level would be the two registrants plus one HCSW. In order to introduce a level 4 they would have to replace either one of the registrants or the level 2 or 3 HCSW. If one of the registered nurses was replaced that might result in a situation that was not safe: the registrant would be working at 100% capacity and there would be a problem if they were off sick. The alternative is to decide what it is that the HCSW lacks and give that person additional tasks [and make the job up to level 4]. However, this would involve an increase in the overall pay envelope for each shift. So it makes more sense for registrants to do those tasks as part of their role, rather than to train and promote the HCSW.

Looking at community based provision the district nursing teams currently consist of a District Nurse, staff District Nurses and HCSWs at level 3. The HCSWs are working relatively unsupervised. They are deployed in geographical clusters. In planning deployment it is important to ensure that a member of staff is deployed who can meet the needs of everyone on that 'round'.

*"If you deploy a District Nurse they may be able to do a compression bandage, which a Healthcare Support Worker can't do. Next door there might be someone who needs a catheter change – the Healthcare Support Worker could do this but it would not make sense if the District Nurse was a*

*few doors away doing the compression bandage. It's a job that only takes a few minutes and the time lost in travel would be significant."*

As a result of these constraints Powys currently has a fairly 'flat' skill mix and the staff are mainly registrants.

*"There are not many HCSWs in the community teams because the geography means you cannot deploy them in an efficient way."*

In one area in which the service is being re-designed they are currently considering whether or not to introduce Assistant Practitioners. Some in-patient beds are about to be transferred to a new residential home that is currently being built. This will provide facilities for elderly and frail people and in patient provision will be within this facility and it is possible there will be a role for Assistant Practitioners there.

Staff skills are being increased to ensure that they can respond adequately to the needs of the elderly and frail population and offer secondary care. Community staff and some from one of the local hospitals are on a programme to increase their skills and increasing their understanding and awareness of working out in the community. The training is taking place across all bands and uses the '*Designing for Competency*' approach and working with national occupational standards to map the skills needed within the team as a whole and then build those requirements up into roles.

However, while there's a keenness in the nursing and therapy teams to develop an Assistant Practitioner role nonetheless they have encountered some problems. First, there is the issue of the relatively small staff numbers against a rural setting. Second there is the deployment issue:

*"One Band 4 role has gone into the costings but there are questions about how this can be deployed, they are now questioning if it is feasible. People want it but we're struggling with how that is going to be implemented. In combination with the geographical issues, sometimes you think perhaps it would be better with a band 5 as you get much more value."*

There might be more of a rationale for introducing Band 4s in treatment rooms and in reviews, but because of the small patient numbers there may be insufficient work of an appropriate nature to justify a number of Band 4s; again, if just one was introduced there is the question of arranging cover when they are on leave. It is unclear whether it will be possible to introduce these posts within rural areas:

*"It is easier to introduce Assistant Practitioners in Boards where they have more secondary and tertiary services, more department-based services, with a skill mix within the department to not only meet need but volume also, and where high volume, low acuity roles and tasks can be delegated and supervised appropriately. In rural areas, though, we would struggle because we cannot achieve the critical mass to provide sufficient work for these roles."*

## 9. Appendix

**Figure 2: Extract from Appendix to RCN report: Numbers of Assistant Practitioners across the UK – NHS**

Wales		Responses received			
Area/Board	Total numbers of APs trained	Annual numbers of APs in training	2010/11 cohort	Workforce plans for APs	Comments
Health Board 1	143				Offer a level 4 certificate that forms the basis for any AP development
Health Board 2					No specific nursing AP posts and no educational programmes to support their development
Health Board 3	162				The term 'Assistant Practitioner' is not used within the organisation. These Band 4s cover all hospital, mental health and community services within the health board
Health Board 4	17		20		2011 will see a greater number

Source: Based on Appendix 1, RCN Assistant Practitioner Scoping Report, 2010

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