As a consequence, the provision of services is also changing with:

At the same time workforce changes are focused on:

The role of Assistant Practitioners in the NHS: factors affecting evolution and development of the role

Skills for Health Expert Paper
Skills for Health - Skills and Labour Market Intelligence

Skills for Health, is the Sector Skills Council for the health sector across the UK. Its aim is to help employers in the sector improve the quality of health and healthcare through the development and utilisation of skills of all those who work within it. One means of achieving this is to provide Skills and Labour Market Intelligence that helps employers make decisions and to inform the development of training and development activities.

To this aim Skills for Health conducts a wide range of skills research and labour market intelligence gathering exercises. It publishes each year an annual Sector Skills Assessment of the UK’s health sector, and assessments for England, Scotland, Wales and Northern Ireland. It conducts research into a range of specific themes, recent examples include research on the voluntary sector as well as productivity. It also has an ongoing programme of future oriented research designed to assist employers in thinking about future of the sector and its skills and employment needs.

Skills for Health Expert Papers

From time to time, Skills for Health invites commentators and academics to develop expert papers on a theme of importance to the sector. The aim of the papers is to present well evidenced insight into a key theme affecting the skills and employment needs of the sector. We hope therefore that they serve to stimulate debate on the shape of employment and skills in the UK’s health sector.

Skills for Health invited Dr Linda Millar from the Institute of Employment Studies (IES), to review the evidence around the development of the assistant practitioner role throughout the UK. Linda has extensive experience in working with the field of health care and with the emergence of the assistant practitioner type role throughout England, Scotland, Wales and Northern Ireland.

Should you have any queries around the content of this report please feel free to contact Ian Wheeler Head of research and LMI at Skills for Health ian.wheeler@skillsforhealth.org.uk

Institute for Employment Studies

IES is an independent, apolitical, international centre of research and consultancy in HR issues. It works closely with employers in all sectors, government departments, agencies, professional bodies and associations. IES is a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and HR planning and development. IES is a not-for-profit organisation.
The Role of the Assistant Practitioner

This paper provides an overview of the current position regarding Assistant Practitioners within the NHS. Assistant Practitioners occupy an intermediate position just below the level of professionally qualified staff but usually above Health Care Assistants. The paper starts by outlining the background to introduction of these posts and their current qualification requirements, and then goes on to consider the factors that have contributed to introduction of these roles, and the challenges and debates regarding their introduction. It concludes by identifying the main current issues that will need to be addressed and resolved.

Background

The NHS Career Framework, reinforced through the NHS pay system, Agenda for Change, introduced a nine-tier framework for career progression within the NHS. This set out a formal progression route that would allow people to enter at any point within the framework (depending on their level of qualification and/or experience) and then to progress and expand their role with further experience and training.

The purpose of the career framework was to enable skills escalation and aid the development of new roles to meet patient need. Its other aims were to assist with the development of competence based workforce planning, give opportunities for individual career planning, enable easier recruitment and retention and improve transferability of roles and skills across healthcare organisations regardless of location. The career framework, therefore, is viewed as supporting earlier developments in workforce redesign introduced to facilitate the design and delivery of care arrangements that would help ameliorate pressures for efficient service delivery whilst meeting patient expectations and preferences. Table 1, below, shows the progression framework.
Table 1: Nine level career progression framework

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

Source: Department of Health

Introduction of the framework allowed those individuals who were taking on additional responsibilities - usually referred to within the health sector as ‘extended roles’ - to have these extra efforts formally recognised and rewarded through recognition as senior or specialist practitioners, advanced practitioners or consultants. Advanced Practitioner and Consultant roles are characterised by requirements to operate across an increased breadth of function or alternatively, with increased specialist skills and knowledge; in addition they typically require management of own case loads and high levels of decision-making and diagnostic reasoning.
At the lower end of the progression framework there has been a raft of activity to develop new posts at Bands 3 and 4 (mostly 4), with these posts usually being labelled as Health Care Assistants (HCA; these posts are normally at Band 3) or (more often) Assistant Practitioners (AP; Band 4). In 2009, Skills for Health defined the Assistant Practitioner role in the following way:

"The Assistant Practitioner role developed is at Level 4 of the Career Framework. An Assistant Practitioner is defined as a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer and, more importantly, the people they serve."

Assistant Practitioners occupy an intermediate position just below the level of professionally qualified staff; therefore in principle these posts may provide a platform for entry into professional education. Perhaps most importantly though, in terms of both defining the roles and understanding their importance for future workforce planning, is that they provide opportunities for task delegation downwards from professionally qualified staff.

In principle the tasks that are delegated down to Assistant Practitioners are mostly those that are more simple and/or routine and can be performed safely with training and under protocol and supervision. Delegation of these tasks to lower band workers in turn (and again in principle) is seen as enabling higher band, professionally qualified staff to extend their scope of practice and move into more advanced roles. In addition, task delegation also potentially frees these staff to spend proportionally more of their time on such higher added-value activities.

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1 Although it should be noted that England and Wales have until recently been more advanced in these developments than Scotland (Federation for Healthcare Science 2007).
2 In the USA, this is sometimes referred to as ‘task shifting’.
The two processes that underpin this process then are: the downwards delegation of a raft of lower-risk, relatively routinised activities to individuals in lower bands than the professionals who previously would have undertaken these activities. This is usually referred to as role substitution (or alternatively, vertical substitution). At the other end of the scale, the freeing up of professional staff to take on, or to spend a greater proportion of their time engaged in more complex, higher-added-value activities is usually referred to as role extension or extended scope of practice or (more rarely), role enhancement (Lizarondo, Kumar, Hyde and Skidmore, 2010). This too can involve one staff group taking on activities previously deemed to be the province of other, such as nurses or radiographers taking on roles conventionally undertaken by doctors, although this is not always the case. In radiography for example the emergence of many new imaging technologies (starting some twenty years ago with sonography) has led to a direct demand for radiographers (rather than doctors) with additional skills in alternative modalities. At present, attainment of these skills remains largely acquired through post-registration development. Where Assistant Practitioners have been introduced this has often freed up the time of these higher band staff to undertake training to acquire skills in additional modalities (Miller, Price, Higgs and Hicks, work in progress).
This upward and downwards movement of tasks and responsibilities, which allows lower level tasks to be undertaken by less-qualified and lower-paid staff while freeing up the time of professional staff to spend on higher-value tasks, is seen as a key strategy in making the working arrangements within the health sector increasingly cost-effective (Taché and Hill-Sakurai, 2010).

While much of the emphasis has been on role extension in the higher bands, it should be noted that development of Assistant Practitioner roles through the downward delegation of roles previously undertaken by higher band staff constitutes a form of role extension for Band 3 and 4 staff. While the tasks delegated downwards are relatively routine, they are nonetheless (and by the standards of work undertaken elsewhere within the lower bands of the Career Progression Framework) demanding and rewarding activities in and of their own right. It is only by comparison with the more complex activities of professionally-qualified staff that they may be considered ‘routine’ or ‘simple’. These roles therefore provide an opportunity to offer career development to lower band staff, with the potential to progress into higher bands where the individual is capable of further development and where further training routes and employment opportunities exist.
Patterns of development/introduction of these roles

The Career Progression Framework applies across all areas of the NHS, so that in principle it is possible for Assistant Practitioner roles to be introduced at Bands 3 or 4 below any of the existing professional areas (nursing, occupational therapy, physiotherapy and the like). However, as these roles are often introduced to meet local service needs, often the roles do not necessarily fit within an existing profession. Typically, they are developed to assist with service improvement in specific pathways.

Table 2 shows the posts that had been developed or were currently in development as of 2010 and the pathways with which they had been developed to assist. These developments were underway within six of the health regions: East and West Midlands, North West, London, South West and South Central. Where the main functions have been assigned these are set out in the third column alongside that role/job title; for Acute Care, in which the greatest number of new roles is found, where the functions have not been specified the roles are shown in one cell of the table for conciseness of presentation.

It should be noted that at present, there is a significant amount of overlap between what are specified as ‘functions’ in some cases and job titles or roles elsewhere. 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), sometimes they are linked to specific conditions (stroke, diabetes, cancer). Full descriptions of a selection of these Assistant Practitioner roles (stroke, nuclear medicine, district nursing, podiatry and radiography) can be found at the web site http://www.nhscareers.nhs.uk/details/Default.aspx?id=2030

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3 By ‘within’ is meant that the role is formed from a subset of lower level tasks and activities derived broadly from the job description for that professional group.
<table>
<thead>
<tr>
<th>Pathway/area</th>
<th>Assistant Practitioner role</th>
<th>Main functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Conditions</td>
<td>Assistant Practitioner Rehabilitation</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assistive Technology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrated Health &amp; Social Care</td>
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<tr>
<td></td>
<td></td>
<td>Diabetes Outpatients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke Rehabilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist</td>
</tr>
<tr>
<td></td>
<td>Care Navigator ; Assistant/Associate Practitioner, LTC; Stroke Care Assistant</td>
<td>Occupational therapy, physiotherapy, speech and language, podiatry, nursing</td>
</tr>
<tr>
<td></td>
<td>Assistant Practitioner Community Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy; Night Duty; Community Nursing</td>
<td></td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>AP Smoking Cessation</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td></td>
<td>Sexual Health</td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
<td>No title at present</td>
<td>Communication, assessment, planning care - symptom management, comfort and dignity</td>
</tr>
<tr>
<td></td>
<td>Assistant/Associate Practitioner, EoL Care; Macmillian palliative care</td>
<td></td>
</tr>
<tr>
<td>Maternity &amp; Newborn</td>
<td>Obstetric Theatre Support Worker; Maternity Support Worker; Assistant Practitioner, Maternity</td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td>Assistant Nurse Practitioner</td>
<td>Role within Minor Injuries Clinic</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Assistant Practitioner</td>
<td>Fractured neck of femur care pathway and stroke pathway</td>
</tr>
<tr>
<td></td>
<td>Assistant Practitioner</td>
<td>Role within range of acute care wards</td>
</tr>
<tr>
<td>Pathway/area</td>
<td>Assistant Practitioner role</td>
<td>Main functions</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Assistant/Associate Practitioner; Assistant Practitioner, urgent care; Assistant Practitioner, Rapid Assessment Unit; Assistant Practitioner, Stroke; Assistant Practitioner, Cardiac; Assistant Practitioner, operating theatre; Assistant Practitioner, Spinal; Assistant Practitioner, Trauma; Assistant Practitioner, Neurology Assistant Practitioner, Rehabilitation; Assistant Practitioner, Gynae; Assistant Practitioner, (Acute, Elderly &amp; General); Blood Sciences; Critical Care; Microbiology; Blood Transfusion; Cell Pathology; Rehab Assistants; Ambulance Services; Emergency Care Assistants; Emergency Medical Unit; ITU; Recovery; Endoscopy; Renal; Care of the Elderly; Pharmacy; Clinical Imaging; Nursing; Therapies; Minor Injuries Unit; Breast screening; Cytology; Elderly care; High care; Allied Health professionals; Main Theatres; Surgical Pre-assessment Unit; Orthopaedic technical instructor; Palliative Care therapy assistant; Diagnostic Imaging; Ultrasound; Respiratory Service; Audiology; Hearing Services; Women’s Health; Acute and General Medicine; Generic AP; Oncology; Amputee Service; Microbiology; Health Psychology; Radiotherapy; Pathology; Medical Photography; ED; Endoscopy; Cardiac Cath Prep Ward; Walk in centre; Rapid response; Physio; ITU; Neuroscience HDU; Resus training dept; Medicine; Medical Admissions; Respiratory; Diabetes; Discharge liaison; Radiology; Nursing assistants; Outpatients; Urology; Fracture clinic; A &amp; E; PRE-OP Assessment; Recovery; Day case surgery; Musculoskeletal; Renal; Transplant team; Pain clinic; Burns unit; General surgery; Endoscopy; Oncology; A&amp;E; Cardiac HDU; Radiotherapy; Care of the elderly; Occupational Therapy; Clinical Assistant Practitioners.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Assistant Practitioner</td>
<td>Elective Orthopaedics</td>
</tr>
<tr>
<td></td>
<td>Assistant Practitioners, Radiography</td>
<td>Orthoptists / Ophthalmology</td>
</tr>
<tr>
<td></td>
<td>Assistant Practitioner, Radiotherapy</td>
<td>Diagnostic Radiography</td>
</tr>
<tr>
<td>Pathway/area</td>
<td>Assistant Practitioner role</td>
<td>Main functions</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Assistant Practitioner, Cancer; Assistant Practitioner, health care science; Assistant Practitioners Radiography (Diagnostic); Other Scientific, Therapeutic &amp; technical; Dental; CT / MRI; Assistant Practitioner Plain film &amp; procedures; Breast Imaging; Radiology (Appendicular Skeleton &amp; Chest); Radiology (Breast Screening); Podiatry; Radiology; Audiology; Heart Failure; Podiatry; Speech and Language Therapy; Community Rehab - therapies; Therapies - Physio, O.T’s and stroke; Speech &amp; language therapies; Community Nursing; District Nursing; Leg ulcer services; Podiatry; Intermediate Care; OT; Physiotherapy; Community Nursing; Clerical and admin; Associate Practitioner; Perioperative; Assistant Practitioner; Assistant Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Assistant Practitioner, Mental Health; Assistant Practitioner; Clinical Psychology; Support, Time and Recovery Worker; Assertive Outreach; Active Therapies; Adult Mental Health; Adult and Older People’s Community Mental Health; Addictions; Senior Support time and recovery workers; Assertive Outreach and Recovery; Intermediate Care Mental Health</td>
<td>CAMH</td>
</tr>
<tr>
<td>Children &amp; Families</td>
<td>Assistant/Associate Practitioner; Assistant Practitioner Paediatrics; Assistant Practitioner Learning Disabilities; Assistant Practitioner Paediatrics; Occupational Therapy; Physiotherapy; Speech &amp; Language Therapy; Assistant Practitioner School Nursing; Learning Disabilities; School Nursing; Health Visiting; Breastfeeding; Nursery Nurses; Learning Disabilities; Health Visiting; Learning Disabilities; Learning Disabilities; Paediatrics</td>
<td>Theatre A&amp;E Child and Adolescent mental health</td>
</tr>
</tbody>
</table>

Source: Skills for Health, 2010
In total, the number of Assistant Practitioner roles in these six SHAs in England amounted to 467. A large number of Trusts had not recruited to these proposed posts yet. Typically, where Assistant Practitioners are employed, there are just one or two within a pathway within one Trust; often, though, the Trust would have established Assistant Practitioner roles within more than one pathway. At present, though, the numbers of Assistant Practitioners remain relatively low in comparison with numbers of Health Care Assistants: Bach, Kessler and Heron (2009) have reported that in England the employment of this staff group more than doubled between 1998-2008 from 21,849 to 45,678. The Wanless review (Wanless, 2002) suggested that an additional 74 000 healthcare assistants (HCAs) would be needed over the following 20 years (that is, by 2022). A survey conducted in 2007 by Spilsbury, Stuttard, Adamson, Atkin, Borglin, McCaughan, Wakefield and Carr-Hill (2009) of Directors of Nursing across the ten English Strategic Health Authorities revealed that some 46 per cent of Acute Trusts had already introduced Assistant Practitioners and a further 22 per cent were planning to implement the role before 2009.

Therefore, while at present Assistant Practitioner posts are not very numerous (either in comparison with the numbers employed within a hospital or in comparison with numbers of HCAs), nonetheless these numbers are increasing at a relatively rapid pace. London and the West Midlands had identified some of these areas (mainly in the long term conditions pathway) as priorities for development. While in the early days the occupational area in which most developments were seen was nursing, these posts are now being developed across almost the full range of activities within the NHS.

At present the majority of Assistant Practitioner posts appear to be filled by recruitment from/training and promotion of individuals already occupying posts as Health Care Assistants or other lower band posts. An exception to this was the report by Bosley and Dale (2007) that the majority of Assistant Practitioners in GP practices had been recruited from existing reception, administrative, or clerical staff rather than staff in clinical support roles.
Routes to qualification

Recent data on Assistant Practitioner developments gathered by Skills for Health provides an indication of the types of training and qualifications that are typically required by these roles. The main qualification routes are:

- NVQ level 3
- BTEC Higher National Diploma or Higher Education Diploma
- Foundation degree

Of the 68 descriptions of the training being offered or considered in England for these new roles, some 60 were foundation degrees. Four referred to NVQs or a qualification 'based on competences' and two were using BTEC awards and one an HE Diploma. In Scotland, the great majority of Assistant Practitioners in imaging services are being trained towards Higher National Diplomas (Colthart McBride and Murray, 2010).

In August 2008 the Government announced its intention to introduce the Qualifications and Credit Framework (QCF). All accredited qualifications in future will sit within this framework. In line with this, a range of diplomas and level 3 NVQs has been developed for individuals in Assistant Practitioner posts. Appendix 1 shows where diplomas fit within the Qualifications and Credit Framework. The range of diplomas and level 3 NVQs currently available within the QCF includes:

- Diploma in Allied Health Profession Support
- Diploma in Blood Donor Support
- Diploma in Clinical Healthcare Support
- Diploma in Dental Nursing (Dec 2010)
- Diploma in Healthcare Support Services
- Diploma in Maternity and Paediatric Support
- Diploma in Optical Retailing
- Diploma in Pathology Support
- Diploma in Perioperative Support
- NVQ Diploma in Pharmacy Service Skills

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4 Note that in Scotland the Scottish Qualification and Credit Framework is in use. Within the SQCF the educational requirements for the future HCSW workforce are: HCSW - SCQF level 6; Senior HCSW - SCQF level 7; Assistant Practitioner - SCQF level 8; (Source: NHS Education for Scotland, 2010)

5 Appendix 2 shows the Scottish CQF.
In addition, the following diplomas are replacing the current Health and Social Care NVQs from January 2011:

- Diploma in Health and Social Care (Adults) for England
- Diploma in Health and Social Care (Adults) for Wales and Northern Ireland
- Diploma in Health and Social Care (Children and Young People) for Wales and Northern Ireland
While these posts have been developed to support service developments, they have not been without some controversy. This section focuses on the factors that tend to encourage the implementation of these roles. In the rest of the paper the current challenges and debates will be considered.

Some SHAs have identified these posts as priority areas for development. It is appropriate therefore to ask what factors are contributing towards introduction of these roles. Harrison has considered the factors within gastrointestinal nursing that have accelerated the need for Assistant Practitioners. Her account (see Table 3) focuses primarily on changes to health policies and education issues but also notes the increase in public demand and changes to workforce skill mix.

Table 3: Reasons for development of the Assistant Practitioner role

<table>
<thead>
<tr>
<th>Changes to workforce skill mix</th>
<th>Numbers of qualified nurses available to fill posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to nurse education</td>
<td>Graduate training nationally from 2012</td>
</tr>
<tr>
<td>Lack of availability of school leavers</td>
<td>Fewer school leavers seeking to join health profession</td>
</tr>
<tr>
<td></td>
<td>Need alternative sources of employees and trainees</td>
</tr>
<tr>
<td>NHS targets</td>
<td>18-week waiting targets</td>
</tr>
<tr>
<td></td>
<td>2-week cancer referral</td>
</tr>
<tr>
<td></td>
<td>National bowel screening programme</td>
</tr>
<tr>
<td>Agendas</td>
<td>The Quality, Lean and Productive agendas</td>
</tr>
<tr>
<td>Public demands</td>
<td>Demands from the public for a more flexible and accessible service</td>
</tr>
</tbody>
</table>

Source: Harrison (2010) based on Dean (2010); Scott (2010); Department of Health (2010)

Elsewhere Bosley and Dale (2007) have also identified the range of factors driving the development of Assistant Practitioner posts in GP surgeries, including: extended longevity and the consequential demographic shift to an ageing population; increased patient expectations; technological and pharmaceutical developments; spiralling costs; and shortages of skilled healthcare professionals. Extended longevity and increasing patient expectations are (in part at least) consequences of the technological, pharmaceutical and other advances within the National Health Service and perversely, serve to compound the increasing demands on the service.
As patient populations expand in both number and complexity of needs, the demand on registered practitioners increases. Therefore it can be seen that the origins of change and the need for more staff is driven initially by this increasing (and increasingly elderly) population with in turn increasingly higher expectations. However, once the need for more capacity within the NHS is established, the focus needs to turn to what might be viewed as the secondary set of drivers, that is, the factors within the health sector itself that drive the necessity for workforce changes and introduction of these roles. This is the focus of this paper.

Task delegation and/or role substitution has often been adopted as a means of addressing the shortfall of registered staff at higher levels (Bowman et al., 2003; Warr, 2002; Chang, 1995). This is not a new idea: Nancarrow and Mackey (2005) have noted that although professional titles such as medical practitioner (doctor) or nurse have been historically protected, nonetheless a proportion of the tasks traditionally undertaken by these individuals frequently have been delegated to other care-givers or providers, to free up the time of qualified staff to respond to more complex needs requiring specialist skills (see Buchan and Dal Poz, 2003; Cooper, 1998; 2001; Richardson, Maynard, Cullum, and Kindig, 1998; Nancarrow and Borthwick, 2005; Richardson, 1999).

In part related to this, economics and cost-efficiency often play a large part in such decisions. Assistant Practitioner roles require lower levels of training (usually they are trained to an NVQ level 3, Diploma or Foundation Degree level; see previous section) and the posts sit below the professional bands of the Career Progression Framework; consequently the individuals in these roles are paid rather less than the professional staff who might otherwise carry out these tasks. It should be noted that similar calculations of the costs and benefits of these roles has led to their introduction in the USA, Canada, Finland, Hong Kong and Australia (see Bosley and Dale 2008; Nancarrow and Mackey, 2002).

An increasing range of technologies has led in some areas to a surge in demand for professionals with additional specialist skills. Radiography is probably the foremost example of this. Firstly, increasing sophistication in the use of conventional X-Ray techniques - for example, the use of injected contrast media to facilitate imaging - has led to an increased demand for radiographers with additional skills in tasks such as administering intravenous injections, not previously within their remit (Price, Miller and Mellor, 2002). Second, over the past twenty years a wide range of new imaging technologies have been introduced: computed tomography (CT), magnetic resonance imaging (MRI) and ultrasound being just a few of these.

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6 A protected title is one which is protected by law and which an individual may not use unless appropriately qualified and registered.
Typically these newer imaging modalities are not substituted for conventional X-rays but rather are supplementary. This has led to a vastly increased demand for imaging services and consequently radiographers have taken on many of the activities previously the preserve of radiologists (Miller, Price and Vosper, 2009). The demand for increasingly specialised radiographers has in turn required a way of coping with the demand for plain film radiography, and to meet this need Assistant Practitioners in radiographic services have been introduced in many imaging departments. These individuals most often work under direct supervision of radiographers, mostly with straightforward plain film imaging (ie, where no modified technique is required), with radiographers ‘signing off’ each imaging request and image produced.

Issues of capacity and flexibility underpin arguments about staffing levels and demand for services. Having an extra person to undertake the simpler tasks can be used to allow an increase in the number of patients who can be seen, or to decrease the length of wait before being seen. Therefore, these posts have often been introduced as a cost-effective way of increasing capacity or meeting targets for waiting times. Where service demand or waiting lists are the primary driver, the Assistant Practitioner may be used to provide additional capacity but (in contrast to the accounts of role extension given earlier) with no real change being seen in the work profile for the higher band staff. One such example is reported by Petrova, Vail, Bosley and Dale, (2010) who found that in primary care teams HCAs were viewed as valuable additions to the primary care team who accelerated, rather than extended, services.

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7 That is, medically qualified staff.
What issues need to be resolved?

Judging from the amount of development effort at present going into designing these roles it appears that this is a group of occupations whose day has come. While much of this is about cost containment and achieving cost-efficiency in the NHS (as well as in health care systems elsewhere in the world) there appears also to be an element of stock-taking in these developments: a feeling that it is time to re-assess what the various occupational groups across the NHS do and are paid to do. Much of this has probably been prompted by notions of workforce modernisation and the introduction of Agenda for Change and its explicit promotion of the idea that individuals should be able to step onto the ‘skills escalator’ at any point, progress as far as their skills and abilities allow them and be graded according to and paid for their skill level.

Nonetheless there remain challenges to be resolved before the Assistant Practitioner role becomes fully embedded within organisational structures. Simply trying to add a new role or job to an existing organisational structure is unlikely to be sufficient. There needs to be some recognition of the fact that working arrangements as a whole will need to change in order to accommodate the new post (Miller, Cox and Williams, 2009). These issues are considered in the following sections.

Substitutes or supernumeraries?

The 2007 survey of Directors of Nursing in Acute Trusts conducted by Spilsbury, Stuttard, Adamson, Atkin, Borgin, Mccaughan, Wakefield and Carr-Hill (2009), revealed that resistance to the Assistant Practitioner role in nursing existed in 32 per cent of Trusts at that time. The reasons given for not introducing the role included there being no perceived need for the role, a lack of evidence of effectiveness, financial constraints and professional and patient safety concerns. Concerns about financial constraints may appear puzzling given that a need to constrain costs is often identified as a driver for introducing these posts. However, it appears only rarely to be the case that organisations explicitly appoint Assistant Practitioners instead of (that is as substitutes for) staff at Bands 5 and above. Often the Assistant Practitioner posts appear to be introduced as supernumeraries to the current establishment, and on occasions these posts have been funded by hospitals as an explicit attempt to reduce waiting lists and meet the targets set under the No Delays initiative. Sometimes their introduction has been specifically prompted by the availability of development funding. It should be noted that where Assistant Practitioners

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8 However there is evidence that Advanced Practitioners or Consultants are more likely to be appointed instead of a more expensive medically-trained person; sometimes this is in response to recruitment difficulties rather than explicitly to save money.
are supernumerary to the previous staff establishment then this will tend to drive costs up rather than down. It may only be through considering performance issues such as departmental capacity or patient throughput alongside staff costs that cost-efficiencies can be seen. Often, though, there is no attempt to demonstrate the cost-effectiveness of such initiatives.

**Uncertainty regarding the nature of the role**

Given the recent attention paid to development of Assistant Practitioner roles it is unsurprising that one area of research attention has been the work expected of the Assistant Practitioner role. Often the nature of the job description relates to the rationale involved in its introduction at each specific site or setting; in turn this has implications for sustainability and issues such as professional boundary disputes.

Wakefield, Spilsbury, Atkin, McKenna, Borglin and Stuttard (2009) have explored the fit between the ideas for Assistant Practitioner roles set out in national policies and the realities of local practice set out in Assistant Practitioner job descriptions. Wakefield and her colleagues concluded that:

‘The AP was identified as a practitioner with a remit to deliver protocol based clinical care, previously associated with the work of registered practitioners [13,43]. The main focus of this protocol based care was that it should be ‘undertaken under the direction and supervision of a State registered practitioner’ [43,44]. Likewise, the House of Commons Health Committee on Workforce Planning Document 2007 ([45]: 117) states that APs: ‘are non-professional personnel trained in a particular set of skills (such as taking blood) used to support (see footnote 1) professional staff and generally graded at level 4 under the Agenda for Change Framework’. The Royal College of Radiologists and the Society and College of Radiographers (RCR and SCR) [46] further reinforced these assumptions and stated ‘there is no delegation or transference of care to AP’s. These are supervised roles’ (4.8 p. 11).’

Wakefield et al. 2009, p. 288

Given the fact that these are expected to be supervised roles, and ‘assistive’ in nature, Wakefield and her colleagues analysed sixteen job descriptions for these posts representing all the clinical divisions within one acute NHS Hospital Trust. They found that few of the posts were fully assistive and commented that in many cases the Assistant Practitioner was also expected to take on roles more in keeping with the work of the registered practitioner. Wakefield et al. found five different types of Assistant Practitioner role, which are shown in Box A:
The authors note that even though the role is categorised as assistive, there were times when the Assistant Practitioner was expected to be more autonomous. The researchers found just one of the job descriptions to be fully assistive in nature: seven of the sixteen job descriptions were categorised as supportive/assistive; four were deemed to be supportive/substitutive, three required the Assistant Practitioner to undertake a substitutive/autonomous role and one was judged to be fully autonomous. They conclude that while the AP role provides non-registered employees with an opportunity to develop their career and the current ‘fluidity’ of the role ‘allows employers to cover more areas of practice by generating generic healthcare workers… potentially this may contribute to further role overlap, confusion and tension’ (Wakefield et al. ibid. p. 293).

**Box A: Categories for AP job descriptions**

**Fully assistive**
Postholder who worked in assistive roles and did not take on tasks that fell outside this remit. In reality this postholder was expected to do little more than an HCA

**Supportive assistive**
Postholder who undertook tasks which were largely supportive of the work of the registered practitioner and predominantly assistive in their orientation

**Blended supportive assistive/substitutive**
Postholder that took on largely supportive assistive tasks but who on occasions was expected to take the place of or substitute for the registered practitioner so as to act more independently

**Substitutive/autonomous**
Postholder who predominantly substituted for the registered practitioner. However, there were occasions when the postholder was expected to act more independently and not require any form of supervision

**Fully autonomous/independent practitioner**
Postholder that functioned as a fully independent practitioner

*Source: Wakefield et al. (2009)*
In similar work, but looking instead at the introduction of Health Care Assistants in nursing environments, Kessler, Heron, Dopson, Magee, Swain and Askham (2010) examined the assumptions made in policy documents regarding these posts. They suggest that they are variously viewed as a ‘strategic resource’, a ‘relief’ for other staff, a ‘substitute’ for other staff, an apprentice or as a co-producer. They found little evidence that HCAs were being used in a strategic manner, finding instead that:

‘In general, Trusts were driven by pressing targets linked to patient access, finance and other outcome measures, which senior managers were unable in any considered way to relate to workforce reform or planning, and certainly not to the support worker role’

Kessler, et al., ibid., p 135

The work did suggest however that HCAs were being used as a relief for nurses by taking responsibility for some of the more routine tasks from them. Perhaps unsurprisingly this had led in some cases to some discontent amongst HCAs, although Kessler et al., ibid., also point to the job satisfaction that most of them nonetheless gain from the work. There was less evidence that the HCAs were substituting for nurses, although it should be noted that several were employed on Band 2 rather than 3 or 4, which may have had an impact. Kessler et al. also reported high levels of enthusiasm for progression into training to become a nurse and therefore see strong evidence to support the idea that these posts may in future constitute a potential source for future registered nurses. However, set against this they observed that the ‘uneven approach to training within Trusts, the patchiness of completion of Personal Development Reviews (PDRs) and the general absence of workplace planning at any level raised some doubt about the [efficiency] and effectiveness with which Trusts were addressing these enthusiastic HCAs keen to develop within the role.’ (Kessler et al., ibid., p. 137).

Regarding the ‘co-producer/co-provider role they noted the distinctive qualities that HCAs brought to their roles and contributed to the patient experience. Overall Kessler et al., ibid., identified five types of HCA role, which varied in the diversity and complexity of tasks performed:

- the Bedside Technician (medium complexity/medium diversity)
- the Ancillary (low complexity/low diversity)
- the Citizen (medium complexity/high diversity)
- the All-rounder (high complexity/high diversity)
- the Expert (high complexity/low diversity)

9 ‘Co-provider’ might be a better term: he means by this a member of staff who brings their own distinctive strengths and background to the health care team
Wakefield et al. (2010) in a follow-up to their 2009 report examining the types of job descriptions in place for the Assistant Practitioner role considered the implications of these differences in conceptualising the Assistant Practitioner role for organisational expectations of the role. They noted that ‘a major consequence of vertical substitution is the potential for role conflict, role confusion and, perhaps more alarmingly, professional disputes’. This issue is considered in the next section.

**Conflict across professional roles and boundaries**

There has been a considerable amount of writing on the issue of professional roles and boundaries, and conflicts arising from this (see for example Bach, Kessler and Heron, 2005; Nancarrow and Borthwick, 2005). Nancarrow and Borthwick (ibid.) note that often, role substitution/vertical substitution is controlled by the higher groups (that is, the professions). While introduction of lower level roles in principle gives these professional groups the opportunity to delegate more basic tasks, thereby allowing them more time to work on more complex activities or indeed to develop further skills, in practice some have been reluctant to lose these activities.

Where professionals do hand over responsibility for basic tasks this can have a surprisingly disproportionate impact on their job satisfaction. Bach, Kessler and Heron (2005) and Workman (1995) report that nurses can experience ‘role deprivation’ at the loss of relationships with patients and hands-on care. Similarly, an evaluation of the introduction of Assistant Practitioners into a community occupational therapy service by Mackey and Nancarrow (2004) showed that the qualified therapists were reluctant to delegate some tasks to the Assistant Practitioners because the tasks that were delegated were the reason for which the therapists entered the profession in the first place (Mackey and Nancarrow 2004), while Farndon and Nancarrow (2003) and Mackey and Nancarrow (2004) have provided examples within podiatry and occupational therapy in which rather than being seen as an opportunity to ‘delegate the dirty work’ the introduction of support workers was viewed as devaluing these respective professions because the changes implied that less qualified workers could undertake parts of the work. Many professionals fear a loss of professional identity from loss of some aspects of their role (see, for example, Petrova et al. 2010) and sometimes the issue is around concern that lower band staff will not be able to perform a task as well as a professional.
Some professionals seek to defend their identity by treating Health Care Assistants and Assistant Practitioners as subordinates (Bosley and Dale, 2007). There are accounts in the literature of assistants being undermined by other professionals. One example is given by Rowles, (2009):

‘As a HCSW, I am constantly undermined at times by other healthcare professionals who I feel do not value and understand the role that the HCSW makes within today’s healthcare. For example, on one occasion while I was with a patient’s family discussing their relative’s care and gaining their trust, the district nurse walked into the house and said ‘You must discuss all your relative’s care with me because I am the ‘qualified’ nurse and she is just the carer’. I believe that the wider healthcare community, registered nurses, doctors and even families need more educating on the role of the HCSW in order for us to be accepted as part of the nursing family. We should not have to justify our role all the time, I may not be qualified in the terms of registration, however, I am qualified, i.e. have had the training, been deemed competent to provide an effective quality and safe care to patients - and we do a very good job.’

Rowles, 2009, The role of the HCSW in continuing NHS Healthcare

There are also issues around the use of protected titles within the NHS and this sometimes feeds into discussions around the duties of Assistant Practitioners. It should be noted that protected titles exist to protect the public, not just the professional groups, but professional sensitivities are sometimes aroused by plans to use the protected title within an assistant’s job title. An example of this is the prohibition in place at many imaging service sites on use of the term ‘Assistant Radiographer’.

Problems can arise when there is ambiguity and confusion over roles and responsibilities. Such confusion is more likely to arise where roles are allowed to evolve based solely on individuals’ skills rather than through individuals being assigned to a role designed by the organisation or health service to meet service needs (Brown, Mason and McAleavy, 2006; Bowman et al., 2003, Warr, 2002; Workman, 1996).
There can be particular concerns regarding accountability, responsibility and impact on standards of care (Hind et al, 2000; Roberts and Cleary, 2000; Chang, 1995). Brown et al. (2006), writing about the development of training for Assistant Practitioners in theatre and critical care noted that (at that time) the existing training and development of support staff was inadequate. They noted that there could be ‘possible risks for all staff as people may step over boundaries or, at the other extreme, work in a very restrictive way. Establishing a new role with defined parameters protects all individuals, especially patients’ (Brown et al., 2006, p 32).

Having a clear statement of the boundaries of responsibility can help all involved in implementation of the role. Petrova et al. (2010) have reported that nurses and GPs in practices that employed Assistant Practitioners felt there was a high level of uncertainty about the remit of HCAs in general practice and consequently a need for more information, guidance and policies, both at national level and practice-specific\(^{10}\). Although none of Petrova et al.’s interviewees were willing to see the Assistant Practitioner role circumscribed in a ‘specific task-by-task way’, nonetheless some did give examples of tasks that they would be unwilling to allow HCAs to perform; these included flu vaccinations, applying dressings, warfarin monitoring, diabetic checks and spirometry. In a study of the introduction of the Assistant Practitioner role in a small GP practice, Brant and Leydon (2009) found that agreeing the role boundaries between roles ahead of introducing Assistant Practitioners was key to gaining agreement from the existing staff members of the practice. In other reports professional staff indicated that the main challenge was to define the boundaries of the HCA role such that there are no fears regarding compromising patient safety.

One other issue can underlay these boundary disputes. Professionals are professionally accountable to their respective regulator (for example the Nursing and Midwifery Council) and to the Health Professions Council and can be struck from the professional register held by their professional body if they make an error\(^{11}\), whereas Assistant Practitioners are not similarly accountable as they work under supervision. Petrova at al. (2010) have pointed to a series of linked issues on this point: nurses expressed anxieties arising from this about patient safety and the associated issue of protection against litigation in addition to experiencing difficulties in giving the time commitment required for training and supervising the Assistant Practitioners.

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\(^{10}\) Note that the research was conducted in 2007 and it is likely that this situation has since changed

\(^{11}\) Members of the regulated professions can be struck off for other reasons, too, including professional misconduct, failure to respect professional boundaries or unethical conduct
The issue of professional accountability for the supervising professional is potentially controversial. Nancarrow and Mackey (2005), looking at the introduction of Assistant Practitioners in occupational therapy, reported that the supervising occupational therapists felt responsible for the outcomes of the Assistant Practitioners’ work, although in the situation reported by Nancarrow and Mackey the Assistant Practitioners were managing their case-loads autonomously. The authors reported that the team leaders said that ultimately, they carried the responsibility for the outcomes of the service, although each staff member was responsible for their own clinical outcomes. The report highlighted inconsistencies in professional accountability which meant that while an occupational therapist without signed ‘professional accountability’ (Health Professions Council) cannot treat patients, while Assistant Practitioners who are unregulated and do not have a professional qualification can deliver the same intervention without professional accountability (Nancarrow and Mackey, 2005). More recently Harrison (2010), drawing on earlier commentaries by Dean, (2010) and Scott, (2010) has suggested that Assistant Practitioners in nursing will not be registered with a professional regulator and their accountability will be to their line manager and employer. Speaking on developing regulations and roles for HCAs and Assistant Practitioners, Paul Vaughan, Health Care Assistant Adviser at the Royal College of Nursing has said:

“With or without regulation to beat employers over the head with or the promise of additional money for improved standards to entice them, it is time to say enough is enough. We cannot wait to improve care on the back of regulation that may or may not happen in the next 5 years. We need to begin to address this now. It is time for lead stakeholders in the development of the HCA and AP roles to come together and set some standards so that we all speak a common language and agree what is an accepted standard in relation to the development of these roles. HCAs and APs need to be a part of these discussions”


In Scotland, the Scottish Government has addressed the need to set standards by producing a code of conduct for healthcare support workers (The Scottish Government, 2009). The code of conduct sets out 13 areas of performance; these are: Accountability, Awareness, Integrity, Advocacy, Sensitivity, Objectivity, Consideration and respect, Consent, Confidentiality, Co-operation, Protection, Development and Alertness. The code also explains to healthcare workers how they can decide if their performance is meeting the prescribed standards.
Brown, Mason and McAleavy (2006) have suggested that in order to overcome potential difficulties arising around role boundaries and responsibilities any further role developments or new roles must be clear, unambiguous and standardised. There is a need to set boundaries and parameters. They suggest the use of process mapping as one way to identify the tasks and activities to be undertaken by Assistant Practitioners and the other staff groups with whom they work: ‘Process mapping is a useful way to break down the components of a role to obtain information on who does what during the patient’s journey. Process maps prompt new thinking and are one of the most effective ways to gain an understanding of existing processes’ (Brown et al., 2006, p 33).

Process-mapping events were held as part of the development process for Assistant Practitioners in critical care and theatre, in part to help avoid this problem. Involvement of the team members helped to ensure that the new role did not encroach on established professional roles and that the accountability within teams was defined.

Note that in Scotland NHS Education for Scotland (NES) has issued guidance both on developing new roles and on education and supervision for health care support workers (NES, 2010). In addition, a Healthcare Support Worker Toolkit has been made available that provides the information and resources needed to assist employers in applying the design principles set out in the NES guidance.

**Change cannot be undertaken in isolation**

By transferring simpler activities to lower band staff potentially this may allow more appropriate use of professionals’ skills and/or a greater proportion of the working time of higher band staff to be spent in higher skill, higher value activities. Therefore, in introducing Assistant Practitioner roles, the opportunity to expand the professional role is usually offered as a ‘carrot’ to encourage staff to agree to introduction of the role. Often this works well (see for example Price and Miller 2010 for an example of this amongst radiographers). Current ongoing work has found that the rationale for introduction of Assistant Practitioner posts was to free up staff time to engage in professional development and training, often aimed at moving them into more specialist areas of work and/or increase flexibility (Miller, Price, Higgs and Hicks, work in progress).
However, there can be problems with this process. An evaluation of the introduction of Assistant Practitioners into a community occupational therapy service by Mackey and Nancarrow (2004) showed that the qualified therapists had nowhere to expand to. Nancarrow and Mackey (2005) have subsequently noted the need to consider the whole range of posts, suggesting that one of the limitations of recent initiatives has been that while a potential career hierarchy has been introduced for the unqualified staff, there has been no corresponding examination of the potential for the development of qualified staff member roles. They conclude, rightly, that some of the challenges around the introduction of the new roles may have been prevented if the extended roles were examined simultaneously for both groups of practitioners.

However, a further problem here is that where this is taken to extremes this can lead to the workload of the higher band staff becoming too intense. Professionally-qualified staff can find their jobs now comprise solely the more complex and difficult jobs, rather than a more balanced workload (Petrova et al., ibid.). Therefore in considering role redistribution attention needs to be paid to general principles of job design across the career hierarchy.

The types of task/activity in which Assistant Practitioners are involved

The tasks in which Assistant Practitioners are engaged obviously differ according to clinical area. However, in addition to differences between clinical areas, several practitioners have pointed to differences in the job descriptions for Assistant Practitioners. In particular they have noted the fact that many of these roles go beyond merely assisting. Such differences are seen within single trusts as well as between different trusts.

The first point to make then is that there is little that is currently settled in respect of the content of these posts. The information collated by Skills for Health regarding Assistant Practitioner developments indicated that, across many trusts in England at present, the content of these jobs is still under discussion. While activities will be largely dictated by clinical area, the precise nature of the patient pathway will also have some bearing on the matter. What follows in this section is just a sample of the reports that have started to outline the work that is undertaken by Assistant Practitioners and Health Care Assistants.
Lizarondo and her colleagues (Lizarondo et al. 2010) undertook a systematic review of the tasks undertaken by allied health assistants internationally. They analysed the jobs of and found that these grouped into two main categories of activities: clinical and non-clinical. Details are shown in Table 4, below:

**Table 4: Clinical and nonclinical duties and responsibilities of AHAs as reported in the literature**

<table>
<thead>
<tr>
<th>Clinical duties</th>
<th>Nonclinical duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist allied health professional</td>
<td>• Administration</td>
</tr>
<tr>
<td>• Physical and social support to patient</td>
<td>• Stock ordering/requisition</td>
</tr>
<tr>
<td>• Administer clinical services and modalities</td>
<td>• Prepare/maintain environment</td>
</tr>
<tr>
<td>• Transfer patients</td>
<td>• Equipment maintenance</td>
</tr>
<tr>
<td>• Communication of patient progress/communication with other staff</td>
<td>• Health promotion</td>
</tr>
<tr>
<td>• Assist with mobility and gait</td>
<td>• Monitor and update health care-specific database</td>
</tr>
<tr>
<td>• Provision of equipment</td>
<td>• Recording/statistics/database</td>
</tr>
<tr>
<td>• Patient education</td>
<td>• Housekeeping</td>
</tr>
<tr>
<td>• Provision of health care to patients</td>
<td>• Cleaning</td>
</tr>
<tr>
<td>• Supervise/conduct exercise classes</td>
<td></td>
</tr>
<tr>
<td>• Prepare patients for treatment</td>
<td></td>
</tr>
<tr>
<td>• Individual or group therapy</td>
<td></td>
</tr>
<tr>
<td>• Coordinate and assist in the operation of services</td>
<td></td>
</tr>
<tr>
<td>• Assist and coordinate health service</td>
<td></td>
</tr>
</tbody>
</table>

Lizarondo et al. summarised their findings in the following way: ‘Key terms used in describing AHA duties were assisting, supporting, administrating, monitoring, and maintaining’ (Lizarondo et al., 2010, p.151. In contrast though with the findings of Wakefield et al., however, they conclude that:

‘This was in stark contrast with the key terms used by allied health professional staff such as evaluating, assessing, diagnosing, planning, and implementing. Key terms used to denote AHAs’ duties in direct patient care are reflective of their scope of practice. Duties such as diagnosing and planning of treatments are beyond the scope of AHAs and are hence exclusive to allied health professionals.’

The difference of course is that Lizarondo and her colleagues were reviewing reports appearing in journal articles, whereas Wakefield and her colleagues (and, for Health Care Assistants, Kessler et al. ibid.) were examining in-house hospital documentation to look at actual job descriptions.

The scoping document recently drawn up by Skills for Health based on trusts and SHA’s responses following a request for information on any Assistant / Associate Practitioner roles which are being developed requested information on the Pathway for which the Assistant Practitioner post was being developed and the functions that the post would involve. The functions identified for Assistant Practitioners in long-term condition pathways included: rehabilitation, assistive technology, integrated health and social care, diabetes outpatients, stroke rehabilitation, therapist, rehabilitation, occupational therapy, physiotherapy, speech and language, podiatry, nursing. In end of life pathways the functions included: communication, assessment, planning care, symptom management, comfort and dignity. In the acute care pathway Assistant Practitioners were envisaged as having a role within Minor Injuries Clinic and in the fractured neck of femur care pathway and stroke pathway. In the planned care pathway the ‘functions’ reported would include elective orthopaedics, orthoptists / ophthalmology and diagnostic radiography, while in Children and families the functions reported included theatre work, accident and emergency and child and adolescent mental health.

Thus it can be seen that these descriptions constitute a mixture of locations (eg outpatients, minor injuries clinic), clinical areas (nursing, podiatry) and actual activities (therapy, symptom management). In addition, in line with Wakefield et al.’s observations, some of these posts appear to go some way beyond the ‘assistive’ role.
Looking at the tasks performed by Health Care Assistants, Bosley and Dale (2007) report that in general practice, HCAs are commonly trained to undertake specific clinical procedures, such as blood pressure and new patient checks, health promotion, urinalysis, weight and height recording, ordering supplies, equipment sterilisation, and phlebotomy, although this varies from practice to practice are largely determined by the delegating GPs or practice nurses. More recently Petrova et al. (2010) have reported that the tasks that were most frequently performed by HCAs in GP practices were blood pressure checks, new patient medicals, height and weight measurements and body mass index (BMI) calculations, electrocardiogram (ECG) readings, spirometry, phlebotomy, removal of sutures, applying simple dressings, stock ordering and general administrative duties.

Clearly there is further research to be undertaken before the roles and duties of Assistant Practitioners (and of Health Care Assistants) are clarified. Set against that though is the likelihood that the roles themselves will continue to evolve for the foreseeable future.

**Supervision, training and mentoring**

While having one or two Assistant Practitioners can give a department far more flexibility, particularly with small teams, there are factors that can restrict the extent to which Assistant Practitioners can be used to improve departmental functioning. Prime amongst these is supervision. Much of the work in which Assistant Practitioners are engaged requires them to be supervised - even if indirectly, as in the example of radiography, where Assistant Practitioners need to have their X-rays counter-signed or approved by higher band staff. Some departments struggle with resourcing this, and in turn this can restrict the deployment of Assistant Practitioners: the supervision requirements mean that Assistant Practitioners can only be deployed in locations where a higher band member of staff is also working.

Considering the introduction of Health Care Assistants in GP's surgeries Petrova et al. 2010 have similarly found that, on a day to day level, employing an HCA ‘placed demands on staff time and practice’s resources for ongoing training, supervision and mentoring and also on the processes of planning and organization of the work within the practice’. Often such problems arise because the staff placed in these supervisory positions have no previous experience of supervision and are not trained for this role. Nancarrow and Mackey (2005) found that not all of the qualified occupational therapists within their study had experience working with Assistant Practitioners and in some
cases, the supervision of the Assistant Practitioners proved to be a challenge for the qualified staff, leading them to over-supervise or under-supervise the Assistant Practitioners. However, it should be noted that individuals’ attitudes towards such responsibilities differ and some staff welcome the opportunity to gain supervisory experience that working with an Assistant Practitioner brings (Colthart et al. 2010; Miller, Price, Higgs and Hicks, in progress).

At present there is often little alternative to involving professional staff in such mentoring schemes. However, as more Assistant Practitioners become qualified it may be possible for them to take on at least part of this role. A clinical educator has suggested this could be the case for Health Care Assistants:

‘Perhaps HCAs could act as associate assessors to new HCAs in their area, in an effort to reduce role conflict with registered colleagues. The purpose of any mentorship program is to determine competence in the HCAs role, the assessor or mentor may not carry out the role of the HCA and therefore may not have the time or knowledge to teach all the elements of the role. The assessor could facilitate the development of the softer skills, e.g. ethical, moral, accountable and responsible decision making (which they make every day perhaps without thinking, e.g. the best way to take a patient to the toilet, or whether to give a patient the drugs left on the locker). In addition, reflection and lifelong learning are elements that are difficult to teach in one session and perhaps require a longer investment by an experienced skilled mentor’

Iain Rennie, ‘Mentorship for HCA’ December 2007

If this is accepted for Health Care Assistants then such an arrangement is likely to be introduced for Assistant Practitioners too.
The development of qualifications and further development routes for Assistant Practitioners

The main routes to qualification that currently exist for Assistant Practitioners were outlined earlier. It should be noted that training for Assistant Practitioners is still in development at many sites. Unlike the professions, there are no regulatory requirements that set a required qualification. However, all qualifications will need to fit with the principles of the Qualifications and Credit Framework (Appendix 1). The core standards developed by Skills for Health (see Appendix 3) also provide a platform for developments.

Details of how a programme was designed to allow Band 3 staff to train through day release to move into Band 4 Assistant Practitioners working in a chemotherapy unit is given by McGowan and Campbell (2010). The centre worked with the education providers and agreed a core set of modules at level 7 in the Scottish Credit and Qualifications Framework plus one further module completed at university. Students attend the further/higher education colleges on a day release basis for the following modules:

- Pre HNC course
- Physiology for healthcare professionals (SCQF level 7)
- Positive healthcare for individuals (SCQF level 7)
- Principles of healthcare practice (SCQF level 7).
- In addition, they worked with Edinburgh Napier University to produce a new module at level 8 specifically for these workers.

It should be noted that at present such accounts of work to develop (or to evaluate) programmes for Assistant Practitioners are relatively rare in the literature (although the programmes themselves abound). There is more information regarding the development and evaluation of training for Health Care Assistants, reflecting the longer history of this role. Evaluations of the extent to which training for Assistant Practitioners is comparable across qualifications in terms of coverage and depth would be useful, but this is unlikely to be seen as a priority for staff deemed not to be professionals and therefore not bound by registration requirements, which guide the validation of courses for nurses, radiographers and the like.

12 Note that the NES guide to development of Healthcare Support Worker roles and education has been published since this article appeared.
The following example of an approach to designing training for Health Care Assistants described by Workman (2004) may be useful in designing future training for Assistant Practitioners, especially given the accounts of how many of these employees are required to be increasingly autonomous. Workman describes the development of a work-based training programme for Health Care Assistants in General Practice. This training portfolio provided to trainees gave an outline of the skills, knowledge and attitudes that the role required; this was devised using Stephenson's (1998) concept of dependent and independent capability framework which considers how individuals frame their work problems within a work context, gradually adding to their experiential learning over a period of time as ability to solve problems increases (see Figure 2). This could well present a way of identifying training needs and developing programmes for Assistant Practitioners as more roles emerge in future.

**Figure 2: Stephenson’s Dependent and Independent Capability Framework**

The proposed model for supervision of healthcare support workers set out in the recent guidance from NES is very similar to the Stephenson model. The NES model has four quadrants describing the nature of the care activities undertaken and derived from crossing the two dimensions of complexity (non complex to complex) and familiarity (familiar to unfamiliar). The NES model indicates that each quadrant should be considered separately, and that employers will need to recognise that the elements of delegation allowed, or direction, guidance and support required within each quadrant will vary dependent on the precise nature of the situation.

What needs to be borne in mind in designing training is the support that is usually required in the workplace for these individuals (both Assistant Practitioners and Health Care Assistants). It is normal for Assistant Practitioners to have mentors while in training and they are usually under direct supervision following qualification. However, as noted in the previous section, Petrova et al. (2010) have noted that the ongoing training, supervision and mentoring, together with the processes of planning and organization of the work within the practice can place a strain on staff. While the in-house training of a new HCA was generally viewed as a challenge for the nurses involved, these demands were felt to be greater where the supervising nurse had limited experience as a trainer, was not given adequate practice support and/or if the HCA had not worked in a health setting before. Similarly, Nancarrow and Mackie 2005 found that qualified occupational therapists working with Assistant Practitioners tended to either oversupervise or undersupervise their trainees because of the lack of guidance given to them on supervision.

There is therefore a general issue to do with equipping nurses and other professionals to be capable of supervising and/or mentoring. In focussing on the training required by the Assistant Practitioners (or Health Care Assistants) the need for the professional groups to be trained for their mentoring or coaching role is often overlooked. McGowan and Campbell (2010) report on this in their account of training Assistant Practitioners to work in clinical care in a chemotherapy day unit. The evaluation highlighted that the registered nurses were not clear about the Assistant Practitioner role and its responsibilities. Neither were they clear where their own accountability lay.

Without training therefore qualified staff may find the supervision experience challenging. While introduction of the posts can provide professional staff with the opportunity to develop supervisory and/or developmental skills, it can also lead to some need for development amongst the supervisors-to-be. This needs to be borne in mind when planning to introduce any staff who will need mentoring or supervision.
In the case reported by McGowan and Campbell the decision was taken to appoint a dedicated registered nurse to oversee the Assistant Practitioners’ training and ensure they met the required competencies. This full-time mentor produced a weekly report on each trainee AP’s progress, which helped to clarify their role and RNs’ accountability. A further point noted by McGowan and Campbell was that the external training (described above, and delivered by a FE and HE partnership) was considered useful because it reduced the dependence on in-house training. This helped guard against any potential omissions and also served to give the in-house training that was provided structure and impetus, and prevented it from ‘going on the back burner’. An important point, which perhaps cannot be overstated, is that having been seen to provide external training, especially where it led to an accredited qualification, was seen as offering protection in cases of litigation.

In England a report into patient deterioration in critical care settings led one acute trust to an advisory group to develop a two-day training workshop for registered nurses (Smith, Roberts and Fahey, 2006). In running the programme it emerged that although nurses now recognised the importance of monitoring and responding to clinical trends on the wards, much of this work was now devolved to HCAs. As a result the trust recognised that HCAs also needed to understand the importance of communicating clinical changes in the patient’s observations. However, neither the existing mandatory training nor the National Vocational Qualification covered this issue.

As a result, an ‘Empowering Clinical Practice’ workshop was devised by the advisory group to address gaps identified in the clinical training of HCAs. The workshop was well-received by the Health Care Assistants. In discussions following the workshop the HCAs indicated that following completion of the NVQ they had received no further development opportunities to maintain their skills and knowledge. The authors point out that in delegating care delivery from professional staff to HCAs steps need to be taken to ensure that these staff too are able to keep their skills and knowledge up to date.
The content of qualifications will of course vary by clinical or subject area and the specifics of the different programmes. However, publication of the core standards for Assistant Practitioner roles by Skills for Health in November 2009 should help ensure consistency\textsuperscript{13}. At present though, there is no specified, agreed level of training or training route. There is actually no national agreement making training mandatory. Potentially this can lead to inequities of treatment even within the same hospital. As hospitals are asked to make greater savings, a worry is that less training, rather than more consistent training, will be provided for these individuals.

**Progression opportunities**

Leach (2009) has reported that progression into the Assistant Practitioner role was viewed by many as a ‘second chance’ at education. Qualified Assistant Practitioners reported a desire to continue their professional development, whether this is achieved through progression into registered, fully-qualified positions, or by growing within their current job. A study by Warr in 2002 revealed that while support staff had untapped potential they were often offered few (or no) options for progression. Brown et al. (2006) also pointed to many studies that had revealed that support staff can feel frustrated by their roles and the difficulties that they faced in progressing in the health service without making quite radical life changes in order to undertake further training. While bursaries may be available to those who wish to pursue a degree programme, this is likely to amount to considerably less than if the individual remained in employment. At present there are few part-time routes to degrees in the health arena.

There is also surprisingly little information on college web sites regarding the amount of remission an individual would gain for already holding a foundation degree, diploma or an NVQ. At present Assistant Practitioners tend to be recruited from amongst existing support staff, many of whom are older, and therefore more likely to have family commitments. Full-time study may therefore not be a feasible option for these individuals.

There have been some attempts to address the barriers presented by full-time study for individuals in this situation. Some organisations have condensed their training programmes so that they can be completed in two years rather than 3. These developments have most notably been in nursing: Tees Esk and Wear Valleys is one NHS Trust that has worked on this approach\textsuperscript{14}.

\textsuperscript{13} The standards are available at http://www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/Core-Standards-for-APs.ashx
\textsuperscript{14} For further details see http://www.skillsforhealth.org.uk/developing-your-organisations-talent/careers-information-and-advice/~/media/Resource-Library/PDF/CiAG/IAG-Tees-Esk-Wear-supports-upskilling.ashx
Those who have attained a prior qualification (such as an NVQ or foundation degree) may be eligible for direct entry into the second year of a degree programme. For example, Newcastle Upon Tyne Hospitals NHS Trust has designed a two-year work-based NVQ programme that would allow the learner to progress straight into the second year of the 3-year diploma in nursing studies/registered nurse programme run by Northumbria university.

Lastly, there are some part-time nursing degree programmes and top up programmes in areas likely to be of use to Assistant Practitioners wishing to progress. As examples of such options, the Open University offers a distance learning route to a nursing degree while the University of Bedfordshire offers a one-year full time (or two year part time) top-up degree in Nutritional Sciences that enables learners with foundation degrees to attain a full BSc.

However, at present these more flexible qualification pathways do not appear to be widespread and it is extremely difficult to find the relevant information on university websites. It should be noted also that for some professions at present there is no part-time route to professional qualification (radiography is one of these). It is likely that more flexible qualification routes will need to become a focus for developments in the future.

15 For further details see http://www3.open.ac.uk/study/undergraduate/health-and-social-care/nursing/index.htm
Speaking primarily in the context of Health Care Assistants Williams has recently called for more attention to be paid to professional development for this staff group, but the same point applied equally - perhaps more so - to Assistant Practitioners:

‘With healthcare in the UK currently facing a potentially revolutionary era, the roles of HCAs could not be more pertinent… the successful delivery of healthcare in a ‘modernized’ NHS will rely on policy makers developing a comprehensive understanding of the roles that HCAs fulfil as well as their relationship with nurses and other members of their teams. Based on this understanding, local and national authorities must put the professional development of HCAs in the context of patient care at the front of their thinking. In hospitals and healthcare more broadly, roles matter more than anywhere, particularly when faced with the challenges that the ideology of a new government—and substantial economic pressures—will bring.’

Joe Williams, ‘The roles we play’ July 2010

Given the fact that many of these staff would be interested in progressing further a major focus for providers (and the professional bodies who validate professional qualifications) in the coming years should be the development of more flexible pathways. Part of these developments may involve encouraging Assistant Practitioners to start to drive the agenda themselves. As Paul Vaughan, Health Care Assistant Adviser at the Royal College of Nursing has said:

‘I think it is time for HCAs and APs to become masters of their own destiny and develop champions within their workforce to take their case forward for better opportunities for education and training and role development. Therefore my challenge would be to support HCAs and APs to gain the confidence to speak at conferences, develop their influencing skills so that they can make change happen for themselves and ensure that HCAs and APs begin to speak with one voice through nationally recognized bodies such as the RCN.’

Paul Vaughan, ‘You are the champions’ June 2008
Summary

This is a group of posts that is likely to continue expanding for some time. They provide a range of jobs that provide scope for progression for existing Health Care Assistants and (in some cases) non-clinical workers. This overview of the developing situation has identified a range of issues that will need to be resolved, and for which further research may be required in the future:

**How are Assistant Practitioner posts defined?** At present the functions of Assistant Practitioners are sometimes specified as relating to a professional area (eg nursing, diagnostic radiography), sometimes they relate to organisational location or function (eg Main Theatres, Microbiology), sometimes they are linked to specific conditions (stroke, diabetes, cancer). Ideally there needs to be some more consistency in agreeing job descriptions. Linked to this is the need for agreement on the level of activity implied by and required in these roles. There is emerging evidence of wide differences in job descriptions. Unless this is addressed it will lead to inequitable treatment of staff.

**Change needs to consider the career framework as a whole.** Nancarrow and Borthwick (2005) have used the terms ‘occupational fission’ ‘fusion’ and ‘capture’ to describe the processes by which occupations develop, and it is clear that all of these processes are currently being widely observed within the NHS. The rationale for introducing Assistant Practitioners may influence the way in which they are deployed, with consequent implications for the ability of higher band staff to benefit. Where some of the tasks of professional staff are delegated down to Assistant Practitioners this should be accompanied by an examination of the work profiles remaining for the professional staff. There is a need to avoid over-pressurising higher band staff through job intensification and ideally their development needs should be considered at the same time. These issues are particularly acute where the professional staff are required to supervise the Assistant Practitioner.

**Inconsistencies in professional accountability.** Supervision and regulatory responsibilities need to be resolved. While some professional bodies have set stringent limits on the work that may be delegated to Assistant Practitioners and specified the supervisory arrangements, elsewhere Assistant Practitioners are considered to be responsible for their own work. Some studies have suggested an increasing level of autonomy for these posts. Agreement needs to be reached regarding the levels of autonomy and direct or indirect supervision allowed. Without this there is potential for litigation.
Many routes to competence - are they all equal? A wide range of education and training routes are in development. These include NVQs, diploma and foundation degrees. Some programmes have been designed to meet the needs of a specific organisation or setting. As there is no regulatory body for Assistant Practitioners there are no consistent external validation requirements. Where qualification routes differ it can be difficult for recruiting organisations to be sure of the level of competence developed by an award (Miller, Price and Vosper, in press). Some way of ensuring consistent core content for all Assistant Practitioners within a delineated clinical area needs to be agreed. This in turn relates to the need to agree a formula for specifying the functions and activities of these roles discussed above.

No planning for development. Linked to this are the issues of development and progression. At present few development opportunities exist, either laterally or vertically. At the very least this can result in frustration for the staff in these posts. However one article has also pointed to the problems that can arise where tasks formerly the province of professional staff are delegated downwards, but not the training and updating associated with those tasks. Attention needs to be paid to ensuring that professional development is provided for all those tasked with a particular activity, not just the profession with whom that activity originally resided. Regarding upward progression, it is apparent that a significant proportion of these individuals would be keen to continue learning. At present progression routes that would allow them to remain in employment largely do not exist. Given the current economic climate it would be wise for providers and the professional bodies to consider more part-time routes to professional competence for people already employed within the NHS.

Train the trainers. It is clear that many people in Band 5 positions and above are increasingly being called upon to act as mentors, supervisors and trainers of Assistant Practitioners and Health Care Assistants. While some receive training, many do not. The lack of training adds to the strain that many of these individuals feel when required to take on these duties and such stresses do little to facilitate smooth team-working. More training needs to be designed to meet the needs of professional staff placed in these roles.
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Appendix 1: What does the QCF look like?
Appendix 2: The Scottish Credit and Qualifications Framework

THE SCOTTISH CREDIT AND QUALIFICATIONS FRAMEWORK

<table>
<thead>
<tr>
<th>SCQF Levels</th>
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Appendix 3: Core Standards for Assistant Practitioners

**Standard 1**

The role of the Assistant Practitioner should be recognised and valued in its own right.

1.1 Assistant Practitioners should be recognised by employers as valued workers who support the work of registered practitioners.

1.2 Assistant Practitioners may work under distant guidance and work as lone workers where appropriate.

1.3 Assistant Practitioners can be appropriately used in most service settings and across professional boundaries.

1.4 Assistant Practitioners should have job descriptions that reflect the scope and responsibility expected of them and the job description should be regularly reviewed.

**Standard 2**

Candidates who have the capability to undertake the job should be recruited to an appropriate post of employment and training programme.

2.1 There should be a formal selection process.

2.2 Employers must be involved in the recruitment and selection process.

2.3 Education and training organisations should accept a wide diversity of entry qualifications and/or equivalent experience.

2.4 Literacy, language and numeracy skills should be in line with the functional skills identified in the Skills for Health employability matrix for Career Framework Level 4 by the time their training is completed.

2.5 Trainee Assistant Practitioners should have relevant experiences that allow them to understand the challenges of the health and/or social care in the environment in which they are to work.
Standard 3

The education and training of Assistant Practitioners should support the development of a practice focused, competent individual.

3.1 The education of the Assistant Practitioner should be work based and employer led.

3.2 The education and training of Assistant Practitioners should be at level 5 of the Qualification and Credit Framework (QCF) which is equivalent to Intermediate Level Higher Education such as Foundation Degrees or Higher National Diplomas.

3.3 The duration of the training of Assistant Practitioners should normally be 2 years in duration.

3.4 Programme providers should consider each applicant as an individual and where possible AP(E)L should be applied.

3.5 Whilst in training, the trainees should be recognised as learners and be supported to develop their newly acquired skills as part of the care team.
Standard 4

The Assistant Practitioner should be acting at the appropriate level on the career framework.

4.1 The job description of the Assistant Practitioner should equate to Level 4 of the Career Framework.

4.2 The following career framework indicators should be applied to Assistant Practitioners:

» Manages their role under guidance
» Makes suggestion for improvement to outcomes of their job
» Demonstrates self-directed development and practice
» Makes judgements requiring a comparison of options
» Plans straightforward tasks and work guided by standard operating procedures and protocols.

And where appropriate:

» Undertakes the ongoing supervision of the routine work of others
» Takes some responsibility for the training of others and may deliver training.

Standard 5

The Assistant Practitioner should be competent in the following areas:

CfA 105 Store and Retrieve Information
CfA 106 Use IT to exchange information
CHS 36 Provide basic life support
GEN 12 Reflect on and evaluate your own values, priorities, interests and effectiveness
GEN 13 Synthesise new knowledge into the development of your own practice
GEN 22 Communicate effectively with individuals
GEN 23 Audit your own work practice
GEN 63 Act within the limits of your competence and authority
HSC D5 Comply with legal requirements for confidentiality
HSC 22  Support the health and safety of self and others
HSC 23  Develop your knowledge and practice
HSC 24  Ensure your actions support the care, protection and well-being of individuals
HSC 234  Ensure your actions support equality, diversity and responsibilities of others
HCS 241  Contribute to the effectiveness of teams

And where appropriate:
M&LD 5  Allocate and check work in your team

Where Assistant Practitioners have a clinical role:
AG 2  Contribute to care planning and review
CHS 118  Form a professional judgement of an individual’s health condition
ENTO WRV1  Make sure your actions contribute to a positive and safe working culture
GEN 4  Prepare individuals for clinical/therapeutic activities
GEN 5  Support individuals during and after clinical/therapeutic activities
GEN 6  Prepare the environment for clinical/therapeutic activities
GEN 7  Monitor and manage the environment and resources during and after clinical/therapeutic activities
GEN 8  Assist the practitioner to implement clinical/therapeutic activities
HSC 21  Communicate and complete records for individuals
IPC 2  Perform hand hygiene to prevent the spread of infection
Standard 6

The Assistant Practitioner should be enabled to develop within their role and progression routes should be available.

6.1 Continuing Professional Development should be available for Assistant Practitioners to develop within their role.

6.2 Employers should recognise transferable skills and competences.

6.3 Wherever possible, education providers and employers should work together to ensure smooth access onto practitioner level programmes.

6.4 Employers should ensure that available promotion opportunities, where appropriate, are open to Assistant Practitioners within their organisations.
The Assistant Practitioner role is growing in importance within the NHS. They are viewed as key personnel to help deliver health care more cost-effectively in the UK. A recent survey indicated that 46 per cent of Acute Trusts had already introduced Assistant Practitioners and a further 22 per cent were planning to implement the role before 2009. A survey by Skills for Health found that many trusts see these posts as priorities for development.

The Assistant Practitioner role sits at Level 4 of the Career Framework and Skills for Health has defined this 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.

Training

The training for Assistant Practitioner posts is usually through one of the following routes:

• an NVQ or QCF qualification gained through work-based training
• a BTEC Higher National Diploma or Higher Education Diploma, gained through part-time study, or
• a foundation degree, gained through part-time study.

In addition, a trainee Assistant Practitioner would be assigned a mentor during their training, to support their learning.

Areas of work

Assistant Practitioners work in a very wide variety of roles, clinical areas and environments. These include (but are not restricted to): Trauma; Neurology, Rehabilitation; Blood Sciences; Critical Care; Microbiology; Blood Transfusion; Cell Pathology; Rehabilitation; Emergency Care; ITU; Recovery; Endoscopy; Renal; Pharmacy; Clinical Imaging; Nursing; Therapies; Minor Injuries; Breast screening; Cytology; and Elderly care.

This list is just a small proportion of the areas of work in which Assistant Practitioners are working. It is probably more accurate to say that they exist in the majority of areas of clinical practice.
Recruitment

Although at present the majority of Assistant Practitioners tend to be recruited through internal promotion of Health Care Assistants (employees on Band 3 in the Career Framework) some are recruited externally. This is likely to increase as the numbers of these jobs increases.

Progression

There is increasing attention to the need to provide continuing professional development for Assistant Practitioners. However, at present this is very much at the discretion of the department in which the Assistant Practitioner works. Also, the regulations for the professional area in which the Assistant Practitioner is working may restrict the extent to which they can extend their area of practice. This very much differs by professional area.

Assistant Practitioners who want to progress may find themselves well-placed to enter degree programmes. They have a wealth of clinical experience on which to draw and are likely to be well-placed to gain employment at the end of training. British subjects who wish to undertake a degree programme in a health discipline that leads to a professional qualification (such as a nursing degree) will have their fees paid and will be eligible for a bursary to contribute towards their cost of living. The bursary will be means-tested if they still live with their parents.

In some cases secondments may be available, but this is dependent on organisational need and financial priorities.
Appendix 5: Further information

Additional information on advanced practitioner and healthcare assistant roles, training and progression opportunities may be obtained from:

http://www.hpc-uk.org/education/

http://www.rcn.org.uk/development/hca_toolkit

http://www.rcn.org.uk/search?q=Assistant+practitioner

http://www.sor.org/public/app.htm