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# Assistant Practitioners in the NHS: drivers, deployment, development

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## Executive Summary

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In early 2011 Skills for Health published '*The role of Assistant Practitioners in the NHS: factors affecting evolution and development of the role*'. The paper reported the background to the introduction of these posts and the qualification requirements that were being established at that time. It discussed the factors that had contributed to the introduction of these roles, and the challenges and debates that were underway at that time. It concluded by identifying the main current issues that would need to be addressed and resolved.

This Working Paper is a follow-up to that earlier publication. Assistant Practitioner posts have been widely introduced in the intervening period as part of the Workforce Modernisation Strategy. The paper therefore reviews the current situation, examines the types of education and training being offered to individuals prior to taking on these roles and the progression pathways available and considers the extent to which the issues identified in the earlier report have been addressed and/or resolved.

The main findings of this review are that:

**Assistant Practitioner posts are likely to continue expanding.** They cover a range of jobs that provide opportunities for progression for existing Health Care Assistants and (in some cases) non-clinical workers. The great majority of Assistant Practitioners enjoy their jobs and in some cases have used the posts as stepping stones into training for professional posts.

**There remains a need for further research to clarify developments in these roles.** Current data collection arrangements do not allow for estimates of numbers in Assistant Practitioner posts. Better data are needed to allow the growth and development of these positions to be more accurately tracked.

**There remains a wide range of approaches to defining the posts.** While some Trusts have produced guidance and toolkits to guide developments, a significant proportion of Trusts have introduced these posts in the absence of any code of

practice, training standard or guidance on delegation of roles and this is a matter of some concern.

**There is wide variation in the levels of qualification provided for these roles.**

While it is important that roles and the training for those roles are linked to local needs, the lack of any national specification for training or qualification means that a very wide range of qualifications has been used over the past few years, varying from level 2 to level 5. Some Assistant Practitioners appear to hold no qualification at all. Ideally there should be a nationwide drive to ensure all Assistant Practitioners hold a relevant minimum level of qualification; given the scope of these roles it is difficult to see why this should not be set at level 3.

**There remains inter-professional friction across occupational boundaries.** While the majority of organisations see the value of these roles, a significant minority of staff continue to resent the introduction of Assistant Practitioners. Perceptions of fairness, loss and overburdening exacerbate any minor frictions. Some of the problems can be laid at the door of the recession and the shrinkage of funding for training and development. Nonetheless managers will need to consider how best to deploy the skills of their team as a whole and how to ensure that registered staff do not feel penalised by introduction of these roles or overburdened by supervisory requirements introduced because of the roles.

**Issues around accountability, registration and regulation have not been resolved.** England has dragged its heels on the issue of registration of Assistant Practitioners compared to Scotland, which has a compulsory scheme. In Wales, there is an All Wales Code of Conduct for healthcare support workers and one of the Health Boards has introduced an employer-led regulation scheme for health care support workers. While Skills for Health and Skills for Care were consulting on a draft Code of Conduct and minimum training standards at the time this report was written, if these are accepted there is currently no plan to incorporate the Code and standards within a national registration scheme. Although the Francis report recommended registration this recommendation was not subsequently accepted by the Coalition Government.

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## Assistant Practitioners in the NHS

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In early 2011 Skills for Health (SfH) published '*The role of Assistant Practitioners in the NHS: factors affecting evolution and development of the role*'<sup>1</sup>. The paper reported the background to introduction of these posts and the qualification requirements that were being established at that time. It discussed the factors that had contributed to introduction of these roles, and the challenges and debates that were underway at that time. It concluded by identifying the main current issues that would need to be addressed and resolved.

This paper is a follow-up to that earlier report. Assistant Practitioner posts have been widely introduced in the intervening period as part of the continuing Workforce Modernisation Strategy. This paper therefore reviews the current situation, examines the types of education and training being offered to individuals prior to taking on these roles and the progression pathways available and considers the extent to which the issues identified in the earlier report have been addressed and/or resolved.

### Assistant Practitioners - role and rationale

The majority of Assistant Practitioners are employed in Band 4 positions: this is just below the level of professionally qualified staff (Band 5) and above Health Care Assistants (Band 3). Across regions these roles have been developed to meet changing service demands, increase capacity or – in part – as a response to a shortage of professional staff, that is, staff at Band 5 and above (see for example Leach and Wilton, 2008). Increasingly Assistant Practitioners have been required to take on responsibility for the delivery of protocol-based clinical care (under the direction and supervision of a registered practitioner) which previously would have been the responsibility of registered professionals (Swift, 2010).

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<sup>1</sup> Available at: [http://www.skillsforhealth.org.uk/component/docman/doc\\_view/1761-skills-for-health-assistant-practitioners-expert-paper.html](http://www.skillsforhealth.org.uk/component/docman/doc_view/1761-skills-for-health-assistant-practitioners-expert-paper.html)

Delegation of these tasks to lower-band workers is usually viewed as enabling higher-band, professionally-qualified staff to attend training, extend their scope of practice and move into more advanced roles. Consequently, it was an expectation of such schemes that they would free up the time of registered staff so that they could spend proportionally more of their time in development and on higher added-value activities. It is of interest to examine the extent to which this model is borne out in practice.

Development of Assistant Practitioner posts was in line with the philosophy which drove development of Agenda for Change and the Skills Escalator, with the posts being viewed as providing potential progression pathways for staff in healthcare support roles or other types of support role (eg clerical and administrative) at Band 3. There was a strong expectation that these roles would help ameliorate service delivery pressures whilst providing better care for patients. A survey conducted in 2007 by Spilsbury et al. (2009) had revealed that some 46 per cent of Acute Trusts had already introduced Assistant Practitioners and a further 22 per cent had been planning to implement the role before 2009. By the time of the previous SfH report, development of Assistant Practitioner roles was underway within six of the health regions: East and West Midlands, North West, London, South West and South Central. London and the West Midlands had identified certain clinical areas (mainly in the long-term conditions pathway) as priorities for development of these roles. When the SfH report on Assistant Practitioners was published in early 2011, the number of roles was continuing to multiply and the number of personnel in these positions was expected to increase.

Early on, the occupational area that saw the most developments in Assistant Practitioners was nursing, but the development of further types of Assistant Practitioner role was assisted by establishment of a series of demonstration sites. Derbyshire was one of these early demonstration sites and the mixture of roles and requirements found is illustrated by developments there. Work at the demonstration site identified a range of areas in which Assistant Practitioners could be introduced, and Box 1 lists these areas, along with the numbers of Assistant Practitioners being employed in each clinical area; in total they amounted to 35 individuals<sup>2</sup>:

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<sup>2</sup> [http://www.workforce.derbys.nhs.uk/Portals/0/Workforce\\_Plan\\_08/Webpage\\_App\\_10\\_Assistant\\_Practitioner\\_Development.doc](http://www.workforce.derbys.nhs.uk/Portals/0/Workforce_Plan_08/Webpage_App_10_Assistant_Practitioner_Development.doc)

### Box 1 Assistant Practitioner roles in Derbyshire

Psychology (1)  
 Imaging - Diagnostic (5)  
 Imaging - Breast Screening (2)  
 Clinical Oncology Radiography (1)  
 A & E (2)  
 Paediatrics (5)  
 Intensive Care (1)

Histopathology (1)  
 Cancer Support (1)  
 Surgery (4)  
 General Medicine (5)  
 Obstetrics & Gynaecology (3)  
 Clinical Radiology trainees (3)  
 Clinical Oncology Radiography trainees (1)

*Source: Derbyshire SHA*

Looking at the rationale provided by Derbyshire for introducing the roles it can be seen that different issues influenced the decision to introduce Assistant Practitioners in the different clinical areas (Box 2). While difficulties in recruiting professional staff underpinned decisions in some departments, in others the introduction of these posts was driven by the need for new skills or workers in new areas of activity. The Derbyshire example shows that in the early days these roles were as likely to be developed to assist with service improvement in specific pathways as they were to be introduced in response to staff shortages:

### Box 2 Rationale for introducing Assistant Practitioners

- **Mental Health** - Issues relating to skill mix, recruitment, succession planning and an ageing workforce may be addressed, in part, by the development of Bands 1-4 and specifically APs.
- **Planned Care** - Unable to develop rehabilitation staff internally and therefore need to develop Bands 3 and 4 for generic health interventions.
- **Surgical Directorate** - Needs to recruit for new skills, develop new skills internally and review skill mix and banding. Retention of Band 4's and HCAs has been difficult due to comparable salaries and working conditions in local employment sectors. The gap analysis indicated a lack of AP posts.
- **Children's Services** - Identified need to develop family support workers, Chlamydia screening and smoking cessation skills. Highlighting a current difficulty in recruiting dental staff, they recommend the need to develop the role of dental therapists. In addition, the need to train 'other' staff in preparation for planned retirement over the next two years i.e. development of AP roles.
- **Learning Disabilities** - There is a shortage of adequately skilled staff and fewer pre-reg nurses or Allied Health Professional's choosing Learning Difficulties branch. Skill mix review and extending roles of HCAs to Assistant Practitioners is required; including training programmes, additional resources to address capacity increase, planned retirement and flexibility in community nursing teams.
- **Long Term Conditions** - Care Closer to Home will impact demand on community teams. Areas for concern include - the ageing workforce, planned retirement and

fewer experienced younger nurses recruited. There is a need to develop Assistant Practitioner roles in order to provide a seamless transition to end of life care service.

- **End of Life Care** - Key workers are required. An ageing population is leading to an increased demand for care in the community. Concerns include - the need to recruit to and redefine District Nurse role, demand and supply imbalance, overall commitment and investment in development and training. There is a clear indication to develop AP roles in order to improve patient pathway and ensure patient choice is met regarding preferred place of care and end of life needs.

- **Medical Directorate** - Need to further develop HCA skills to Assistant Practitioner level, particularly in speciality areas e.g. nutrition, stroke, renal and acute medicine. Fewer newly-qualified nursing staff recruited. Demand for nurse and AP-led clinics means increased demand for staff to support them. Staff morale is low. In addition, projected, and planned, retirement figures indicate a clear need for skill re-design and skill mix.

*Source: Derbyshire SHA*

By the time of the last SfH report, a total of 467 Assistant Practitioner roles had been developed or were in development across the six demonstration regions in England. It was noted that there was a significant amount of overlap between what were specified as 'functions' in some cases and as job titles or roles elsewhere. In addition, the roles might be specified as relating to a professional area (eg nursing, diagnostic radiography), sometimes they related to an organisational location or function (eg Main Theatres, Microbiology) and sometimes they were linked to specific conditions (stroke, diabetes, cancer).

This continues to be the case today. For example, looking at imaging services, while some sites may have a Screening Technician, others may have an Assistant Practitioner in Breast Screening, or alternatively an Assistant Practitioner in Clinical Imaging. There are reports in the research and practitioner literature of the development of further specialised Assistant Practitioner roles: for example the Spilsbury et al. survey (2010) suggests that six per cent of Assistant Practitioners were already involved in the administration of medicines while the consultancy Firefly has recently reported that across the North West some 31 per cent of Assistant Practitioners were involved in this activity as part of a scoping study to support the development of an Assistant Practitioner role in Administration of Medicines in the region (Firefly, 2012).

While reports of the development of new Assistant Practitioner roles are seen from time to time in the literature it remains difficult to gain an estimate of the overall number of these roles which now exist or indeed a clear idea of the numbers in post. In a scoping report on Assistant Practitioners for the RCN, Hands (2010) reported that:



*'There is currently no pooled data available that enables a comprehensive examination of the numbers of [Assistant Practitioners] working in the UK. England, Wales and Northern Ireland do not currently collect information on numbers of band four nursing staff.'*<sup>3</sup>

An enquiry to Skills for Health in October 2012 confirmed that Skills for Health do not have data for the numbers currently in these posts.

Some idea of the growth in numbers can be gained from the fact that the North West Allied Health Professions network reports that there are now more than 1,200 qualified Assistant Practitioners in the North West and a further 750 in training<sup>4</sup>. Hands (ibid) notes that the Nursing and Midwifery Codes available within the NHS Occupation code manual were being updated to reflect the structure of the modern nursing workforce and to help fulfil the needs of local, regional and national workforce planning. She also commented that, while:

*'... there have been codes available for APs working in the health care scientist area for some time, the addition of APs into the nursing area in 2011 will complete the roll out of this coding and allow consistent recording and monitoring of this important and growing staff group across the NHS.'*

(Hands, 2010, p. 4)

While this will undoubtedly improve the data for Assistant Practitioners falling within the nursing footprint nonetheless a gap will remain in information relating to Assistant Practitioners outside of nursing and health care scientist. Clearly, improved data is desirable.

## **Recruitment, training and qualification**

In the early trials the initial trend was for the majority of Assistant Practitioner posts to be filled through recruitment from (and training of) individuals already occupying posts as Health Care Assistants or other lower-band posts. Now there is more of a focus on recruitment to Assistant Practitioner posts per se as a positive career choice (Hicking-Woodison, 2012); note that this has also been supported by careers information materials provided by the NHS.<sup>5</sup>

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<sup>3</sup> Although Hands did note that NHS Scotland Workforce Information does distinguish between bands for nursing staff.

<sup>4</sup> <http://www.ahpnw.nhs.uk/?page=103>

<sup>5</sup> <http://www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/clinical-support-staff/assistant-practitioner/>

The earlier SfH paper pointed to a range of approaches to training, with some Assistant Practitioners receiving no training or training only to fill identified skill or knowledge gaps. The 2008 Derbyshire report on development of the Assistant Practitioner role noted the range of options potentially available:

*'The training options available include NVQ, Foundation Degree, BTEC, Open University Programmes, Modern Apprenticeships, Diploma in Higher Education and in-house training programmes.'*

This variation continues today and is a source of some concern. The survey by Spilsbury et al (2010) revealed that a small proportion of Assistant Practitioners held no qualification. While around nine in ten Assistant Practitioners (91.5 per cent) did hold a qualification, these varied in nature and level. While 39 per cent held a foundation degree (level 5 in the NQF), 33 per cent held an NVQ level 3 and – of more concern – just over 10 per cent held only an NVQ level 2. A small number held other types of qualification. Note that in Scotland, Assistant Practitioners are more likely to undertake HND or HNC programmes or, less often, Cert HE programmes (Foundation degrees do not exist in Scotland).

It can be seen therefore that there is considerable variation in the levels of qualification required of and held by Assistant Practitioners: while some hold a qualification that sits within level 5 in the National Qualification Framework (NQF) others hold qualifications that are variously level 4, 3 or 2 in the NQF. On the basis of the Spilsbury et al. survey it would appear that just under ten per cent of Assistant Practitioners hold no qualification at all<sup>6</sup>. It is unsurprising then that concerns about such variations in training and care standards has led the RCN to campaign for statutory regulation. Spilsbury has concluded that at national level there needs to be clarification of the broad aims of AP roles, guidance on regulation and registration, and standardisation of training and preparation (Spilsbury et al., 2011; see also McGowan and Campbell, 2010).

### Mentoring

Whichever qualification is pursued there is a need for the trainee to receive support in applying their new skills and knowledge in the workplace and for this reason there is a requirement for Assistant Practitioners to be mentored in work for the duration of their training. However, Leach and Wilton (2008) reported that it can be difficult for trainee Assistant Practitioners to find mentors able to give them appropriate levels of support during their training. They also found that

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<sup>6</sup> Given the lack of overall data on Assistant Practitioner posts it is not possible to estimate the extent to which Spilsbury's sample is representative of staff across England.

nurses assigned to mentoring roles said that they were not always sure of the level of skills and competencies required of an Assistant Practitioner.

A recent report by Griggs (2012) suggests that this remains the case, at least in some situations. Her study of nurse mentoring of Assistant Practitioners in a large community NHS trust found that mentors found the work-based paperwork (practice competencies) confusing and their lack of preparation for the role meant they were not able to reassure trainees. The findings indicated that more information was needed regarding the expectations of trainee Assistant Practitioners, their mentors and (in this case) the university. In order to improve the support for mentors, the university had created a new role called the work-based learning facilitator. Research by Miller, Price, Hicks and Higgs (2011) in imaging departments in Scotland found that training for the mentor role was viewed as desirable but was not always provided. In addition, there could be issues around the release of time to undertake their mentoring duties and release of Assistant Practitioners to allow them to meet with their mentor.

As the Assistant Practitioner role is introduced into a wider range of contexts the questions of who is best placed to mentor trainees, how they are prepared for the mentoring role and how such arrangements are managed will need to be addressed.

## **Inter-professional boundaries**

The two processes that underpin the process of developing new Assistant Practitioner roles 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 (role or vertical substitution), accompanied by the freeing up of professional staff to take on or spend a greater proportion of their time engaged in more complex, higher-added-value activities.

While this was often the initial expectation, in recent years the impact of the recession has sometimes foiled such plans. Reduction in staff numbers can mean that there is no overall increase in staff numbers. Furthermore, there have been some challenges in implementing the requirement for Assistant Practitioners to be supervised. Consequently some registered staff saw few personal benefits from introduction of the new roles, which has contributed to conflict in some departments. For example, in an evaluation of the impact of introduction of Assistant Practitioners in imaging services in Scotland Miller et al. (2011) found wide variation in the experiences of radiographers following introduction of the roles. In some cases, introduction had coincided with funding cuts and decisions not to refill vacant posts, meaning that Assistant Practitioners had effectively replaced registered staff. Taking on responsibility for supervising Assistant

Practitioners had led to additional pressures on staff, especially where there had been staff cuts. Only a fifth of radiographers reported that introduction of Assistant Practitioner posts had led to them having any additional time for training and development, and fewer than a fifth felt it had led to any opportunity for them to move into advanced practice.

The 2011 SfH paper noted that there had been a considerable amount of writing on the issue of professional roles and boundaries, and conflicts arising from this. There were accounts of conflict and of staff treating Assistant Practitioners as subordinates and failing to give them support, and this is often related to the fact that registered staff fail to see any benefits arising from such changes. Reports of such issues continue today in the online forums on the Assistant Practitioner Network. Comments posted indicate that some staff continue to resent perceived role encroachment by Assistant Practitioners while Assistant Practitioners report a lack of support from their colleagues, including healthcare support workers.

However, without doubt the issue of registration and regulation remains the particular point of contention for registered staff. We consider this issue next.

### Regulation

The issue of accountability and responsibility generates particular concerns. While registered staff are professionally accountable to their respective regulatory bodies (for example the Nursing and Midwifery Council) and to the Health Professions Council and can be struck from the register held by their professional body if they make an error<sup>7</sup>, Assistant Practitioners are not similarly accountable.

Registration has become a particular issue given the absence of any national standards for education and training in England. In Scotland, since 2011 all new HCAs have been required to meet induction standards and comply with a code of conduct, while employers are required to sign up to a code of practice. In Wales there is an All Wales Code of Conduct for healthcare support workers. In addition the Hywel Dda Health Board introduced a code of conduct for health care support workers, along with an employers' code of practice<sup>8</sup> *'to provide an assurance framework for public protection'* (Horner, 2012). A voluntary register, but no mandatory regulatory system, exists in Northern Ireland.

England has not implemented a policy in this respect. In 2011 a report in Nursing Standard suggested that the Department of Health intended to set up a voluntary

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<sup>7</sup> Members of the regulated professions can be struck off for other reasons, too, including professional misconduct, failure to respect professional boundaries or unethical conduct.

<sup>8</sup> <http://www.wales.nhs.uk/sitesplus/862/document/215729>

register of HCAs in England but this has not subsequently been implemented. The then Secretary of State for Health Andrew Lansley gave the reason for not regulating Assistant Practitioners as being the fact that:

*'Good local supervision offers support every day; distant national regulation can often only react after the event. Employers must be accountable for the staff they employ. We recognise that employers can be supported better and a code of conduct and minimum training standards will provide clarity in this area.'*

(Lansley, speech to the NHS Employers conference, November, 2011)

The subsequent Francis Report<sup>9</sup> recommended introduction of registration for health care support workers, but the Coalition Government decided against adopting this policy<sup>10</sup>.

It is unsurprising then that the question of regulation of Assistant Practitioners has remained an ongoing concern and subject for discussion. Amid concerns about variations in training and care standards the RCN has continued to campaign for statutory regulation and for all health care assistants<sup>11</sup> to be professionally regulated through the Nursing and Midwifery Council. They have called for quality-assured training and for regular assessment of competence. A report of research undertaken by the National Nursing Research Unit at the Nursing and Midwifery Council (Griffiths and Robinson, 2010) concluded that there was a particularly urgent need for regulation of Assistant Practitioners because, they claimed, in many cases Assistant Practitioners were being used as substitutes for nurses. The RCN has emphasised that Assistant Practitioners must not be expected to perform tasks *'for which they have not been trained or deemed competent to perform'*.

The Nursing Standard cited a survey of 94 NHS trusts in England which found that more than 60 per cent had no code of conduct for HCAs<sup>12</sup>. In addition, over a third had no guidelines for delegating tasks to HCAs, even though the registered professional responsible for supervising the Assistant Practitioner remains accountable for the work being done and, hence, any errors made. NHS Norfolk

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<sup>9</sup> <http://www.midstaffpublicinquiry.com/report>

<sup>10</sup> <https://www.gov.uk/government/news/putting-patients-first-government-publishes-response-to-francis-report>

<sup>11</sup> Note that the RCN sees Assistant Practitioners as 'senior healthcare assistants' and therefore in referring to regulation of healthcare assistants is referring to Assistant Practitioners.

<sup>12</sup> For an example of an NHS Trust code of conduct from Wirral University Teaching Hospital NHS Trust can be seen at:  
[http://www.whnt.nhs.uk/document\\_uploads/Clinical\\_skills/CodeOfConductForAssistantPractitioners@WUTH\\_%20PRINTVERSION2012.pdf](http://www.whnt.nhs.uk/document_uploads/Clinical_skills/CodeOfConductForAssistantPractitioners@WUTH_%20PRINTVERSION2012.pdf)

and Waveney has drawn up a toolkit to assist in the implementation of Assistant Practitioners across the Norfolk and Waveney Health Economy<sup>13</sup> and this included development of a code of conduct and statement of contemporary competence and a code of practice. The statement of contemporary competence requires the Assistant Practitioner to sign the following declaration annually:

### Box 3

In the previous 12 months I, the undersigned, have:

- A. Worked for at least 100 hours in my field of practice
- B. Had my practice observed by a Registrant employed by my organisation, who has signed my competence statement below
- C. Updated my portfolio of practice competence, which I am willing to submit for review as required.

*Source: NHS Norfolk and Waveney Toolkit, Appendix 6*

Appendix 7 of the Toolkit sets out the Code of Practice and this is based on the standards and codes of practice drawn up by the Scottish Government and the Welsh Assembly Government. It specifies the standards of conduct and practice expected of the Assistant Practitioner<sup>14</sup>.

In the absence of a national code of conduct there has been activity in the private sector as well as in the NHS. The Nursing Standard recently featured a private hospital that had introduced a code of conduct and minimum training standards (Horner, 2012). They report that BMI Healthcare, a private sector group of 78 hospitals, has adopted a policy that requires newly-recruited HCAs to undertake an initial five-day induction course with vocational competencies based on the Skills for Health career framework<sup>15</sup> and then to be deemed competent before working in any area of patient care.

In April 2012 Skills for Health and Skills for Care were commissioned by the Department of Health (DH) to develop a code of conduct and minimum training standards for healthcare support workers. They are currently consulting on these

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<sup>13</sup> <http://www.norfolk.nhs.uk/sites/default/files/Assistant%20Practitioner%20Report%20with%20Mental%20Health%20Appendix.pdf>

<sup>14</sup> The full report and appendices can be found at: <http://www.norfolk.nhs.uk/sites/default/files/Assistant%20Practitioner%20Report%20with%20Mental%20Health%20Appendix.pdf>

<sup>15</sup> See <http://www.skillsforhealth.org.uk/workforce-transformation/customised-career-frameworks-services/>

and a decision is expected in January 2013. The suggestion is that when agreed, these statements might form the basis for a 'voluntary register' (or registers) of support workers<sup>16</sup>.

In the meantime, some of the professional bodies have taken action in the absence of a national lead. As an example, the Society and College of Radiographers (SCoR) has gone some way towards addressing this problem by introducing an accreditation scheme for Assistant Practitioners<sup>17</sup>. They note that the introduction of large-scale screening programmes such as the Abdominal Aorta Aneurysm (AAA) screening programme in England had driven the development of new Assistant Practitioner roles in imaging services, such as the screening technician role. The increasing numbers of such roles has led SCoR to establish a set of criteria that enable individuals to gain accreditation as Assistant Practitioners. These are shown in box 4 below:

#### **Box 4 SCoR criteria for accreditation of Assistant Practitioners**

In order for individuals to receive accreditation it is necessary for them to demonstrate knowledge, skills and achievement at the relevant level as identified in the Society & College of Radiographers Curriculum Framework.

Demonstration of the necessary competences is most readily achieved by attaining relevant qualifications and awards approved by the College of Radiographers as fit for purpose and practice. However, the College also recognises that individuals develop through portfolios of activities and informal or work-based learning. It is the College's intention to recognise development of this nature for accreditation purposes where appropriate.

*Source: SCoR Assistant Practitioner Guidance*

It should be emphasised that the SCoR scheme is currently voluntary; despite this, they already have 726 Assistant Practitioner members. Given that the RCN survey suggested that around three quarters of Assistant Practitioners believe they should be registered, if a similar scheme were adopted more widely it is likely that that too would be widely taken up.

### **Substitutes or supernumeraries?**

It was noted at the time of the previous SfH report that there appeared to be an element of stock-taking in many of the developments: a feeling that it was time to re-assess what the various occupational groups across the NHS do, revisit how

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<sup>16</sup> See <http://www.skillsforhealth.org.uk/about-us/news/consultation-continues-for-the-code-of-conduct-and-minimum-training-standards/>

<sup>17</sup> <http://www.sor.org/career-progression/assistant-practitioners/aap-register>

services are organised and consider who is best placed to undertake tasks and activities. Much of this is prompted by the drive for 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. It was also recognised that there were challenges in assessing the value and impact of these roles. One of the reasons it is difficult to assess value and impact is because it is unclear to what extent Assistant Practitioners are being used to *replace* registered personnel or being used as *supplements* to the departmental establishment: in other words, added to overall staff numbers.

The East Midlands Assistant Practitioner Toolkit<sup>18</sup> recommends that the business plan for an associate practitioner sets out the estimated costs involved in development of the role and the costs of training once the roles are instituted. However, after implementation, while the guidance on evaluation does suggest reviewing whether care delivery has improved, there is no suggestion that comparison of ongoing costs be made once the posts are in place and the individuals trained, either in the form of the total staffing costs envelope or in the form of a cost-efficiency or cost-effectiveness calculation (eg, cost per procedure, overall patient throughput for the given staff cost or increase in Quality Adjusted Life Years (QALYs) for the given staff cost). While the guidance does suggest the use of data such as 'ease of access to the service' and 'quality of service', there is no suggestion that these data be combined with salary cost data or other overheads to give an estimate of cost-efficiency.

This is an important point if the business case for Assistant Practitioners is to be made and especially so where they are introduced as supernumeraries (ie they extend the staffing complement of the department rather than substitute for a higher band member of staff). In general there has been no consistent approach to deployment models and therefore there is no clear answer regarding the impact of Assistant Practitioners on departmental costs. In their evaluation of the impact of Assistant Practitioners in imaging services in Scotland, Miller et al. (2011) found that where Assistant Practitioners had been employed as supernumeraries they had added to costs overall but contributed to a lowering of unit costs for X-rays. Where Assistant Practitioners had been substituted for a radiographer then this led to savings at a departmental as well as at unit cost level.

It is recognised that many of those commenting within the literature and on discussion boards reject the idea that Assistant Practitioners should replace

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<sup>18</sup> Wilson, M (2010) *East Midlands Assistant Practitioner Project Assistant Practitioner Toolkit*. NHS East Midlands available at: <http://www.nhsemployers.org/SiteCollectionDocuments/Assistant%20Practitioner%20Toolkit.pdf>



registered personnel. In addition, the limits to the expected competence level of Band 4 personnel, together with the requirement that they are supervised by registered staff should restrict any significant level of substitution of registered personnel. Nonetheless there is a moral imperative – especially in economically troubled times – to deliver services in the most cost-effective way possible. Without cost and performance data for departments it is impossible to gain any hard evidence for whether the introduction of Assistant Practitioners constitutes a cost benefit or not. Clearly further information on this point would be valuable.

## Progression

The earlier SfH paper noted that there were few progression options available at that time to Assistant Practitioners. The issue of progression routes has yet to be resolved. As a significant number of Assistant Practitioners have been in post for several years it is unsurprising that many are now considering their career options. This is currently an active topic for debate on the Assistant Practitioner Network<sup>19</sup>. While some are happy to remain as Assistant Practitioners, many are seeking either further role extension or some form of career advancement.

While some part-time study options exist that would allow progression from a Foundation Degree (or from an HNC, HND or Cert Ed) to a Bachelors' degree, these do not exist in all subjects. For those who hold an NVQ the options for progression may be even more restricted<sup>20</sup>. Many of those currently in Assistant Practitioner roles are older workers, having been in work for some time prior to becoming an Assistant Practitioner; often they were employed previously in support worker roles. They therefore tend to be more likely than other recruits to have families and/or other financial responsibilities and therefore often are not in a position to give up employment to take on full time study on a bursary.

Aside from career progression, at present there are limited opportunities for continuing professional development (CPD) too: just half of the Assistant Practitioners who responded to the survey by Spilsbury et al. (2010) reported receiving CPD. At the same time, issues around scope of practice limit the range of activities in which Assistant Practitioners can undertake or the areas in which they work. In some cases preparatory courses have contained input on activities which the Assistant Practitioners have found they are unable to work.

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<sup>19</sup> <http://www.ukaps.info/>

<sup>20</sup> Although the current focus on developing apprenticeships (and hence, by implication, NVQs) at levels 4 and 5 may address this in the longer term.

Clearly this situation is also less than ideal and needs to be resolved. While working with employers on the development of new training programmes can help ensure training is focused on specific local needs,<sup>21</sup> the professional bodies play a large part in determining scope of practice. This is essentially an issue of occupational boundaries and many of the professional bodies are reluctant to see Assistant Practitioners take on further areas of work that are more typically the remit of their members. However, many employers as well as Assistant Practitioners find the restrictions on the ways in which they can deploy Assistant Practitioners irksome. Yet at the same time, some managers are aware that it may be unwise to extend scope of practice for Assistant Practitioners while economic conditions and staff shortages restrict the development and progression opportunities they can offer their professional staff (Miller et al., 2011).

In summary then, while the numbers of Assistant Practitioner roles continue to grow, the options for progression remain virtually as limited as reported previously. More part-time study options need to be designed to enable progression, in line with what was initially intended by the Skills Escalator. It is, however, important that there is equity in development and progression options offered to all staff bands and while funding for backfill is restricted it would be unwise to prioritise one group over another for CPD and/or progression.

## Joined up change

Transferring simpler activities to lower-band staff can open up the opportunity to make more appropriate use of professionals' skills and/or enable registered staff to spend a greater proportion of their working time engaged in higher-skill, higher-value activities. In introducing Assistant Practitioner roles, the opportunity to take on more extended role activities is usually offered as a 'carrot' to encourage staff to agree to introduction of the role. Often this works well (see Price and Miller, 2010, for an example of this amongst radiographers). However, more recently freezes on staff recruitment following the downturn in the economy have led to restrictions of staff release for training and lack of availability of money for backfill for staff in training or indeed to pay for the training itself. This has led to resentment amongst some staff (Miller et al., 2011).

While shortages of funding are primarily coincidental to the introduction of Assistant Practitioners (although they may be introduced as a subsequent response to staffing budgets being cut), the impact of such issues and the way in

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<sup>21</sup> See for example the West Yorkshire Lifelong Learning Network report on Building a Framework for Learning and Development of Assistant Practitioners in Yorkshire and the Humber available at: [http://www.heacademy.ac.uk/assets/documents/LLN/WYLLN\\_Building\\_a\\_Framework\\_for\\_Learning\\_and\\_Development\\_of\\_Assistant\\_Practitioners.pdf](http://www.heacademy.ac.uk/assets/documents/LLN/WYLLN_Building_a_Framework_for_Learning_and_Development_of_Assistant_Practitioners.pdf)

which they are managed in departments can serve to either fuel or ameliorate resentment. For example, in the Miller et al. (2011) case studies one manager had delegated quality assurance and audit roles throughout his department as a way of providing additional learning opportunities and further responsibility for staff. The Assistant Practitioners had been accepted in that department, in contrast to other departments where all development had been withdrawn when the funding was reduced.

The various toolkits to help organisations in developing and introducing Assistant Practitioner roles usually point to the need to consider the business case for Assistant Practitioners, the type of skillmix needed and the way in which such skills map against service delivery pathways. In undertaking these initial analyses managers need to consider the ways in which the differently-skilled groups will work together. In the Scottish imaging departments several managers had not fully considered the implications that the supervisory requirements had for staff rostering. This had meant that introduction of these roles had not always brought the increased flexibility that had been hoped for.

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

There is a great and growing variation in the tasks and activities in which Assistant Practitioners are engaged and the fact that little was settled in respect of the content of these posts was noted in the earlier report. A review of tasks by Lizarondo et al. (2010) summarised the two broad groupings of activities as being clinical and non-clinical, with the key terms used in describing the various duties being: assisting, supporting, administrating, monitoring and maintaining.

If anything the picture is becoming more complex. It is clear that some sites are moving the role of the Assistant Practitioner beyond this assistive role and expecting higher levels of responsibility than would seem to be appropriate given the career descriptors drawn up by Skills for Health. There are concerns that individuals are being asked to work in areas outside their realms of competence. This is demonstrated, for example, by reports of Assistant Practitioner involvement in medicines administration (in the survey conducted by Spilsbury et al.) and plans to introduce this role more widely in the North West (Firefly, 2012).

It is to be expected that the roles themselves will continue to evolve for the foreseeable future. In part role change is driven by changes to the nature of the service itself and by changes in the ways in which the service is delivered. Further changes are likely to require more new roles but developments need to ensure that the expectations of the various Agenda for Change bandings are not exceeded. The development guides and Assistant Practitioner toolkits will go some way

towards bringing more consistency in developments but need to be more widely promoted.

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## Summary

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Assistant Practitioner posts are likely to continue to expand. They cover a range of jobs that provide opportunities for progression for existing Health Care Assistants and (in some cases) non-clinical workers. The great majority of Assistant Practitioners enjoy their jobs and in some cases have used the posts as stepping stones into training for professional posts.

This review of developments over the two years since the first SfH paper on Assistant Practitioners was written has found that many of the issues identified two years ago remain to be resolved. There also remains a need for further research to clarify developments in these roles. Improved data are needed in order to accurately track growth of these positions.

A wide range of approaches to defining the posts also still exists. Guidance and toolkits have been produced which outline development approaches and the issues that should be considered when designing these jobs. Specifications for codes of practice and minimum training have been drawn up by some organisations and these are undoubtedly helpful. However, a significant proportion of Trusts have introduced these posts in the absence of any code of practice, training standard or guidance on delegation of roles and this is a matter of some concern.

While it is important that roles and the training for those roles are linked to local needs, the lack of any national specification for training or qualification means that a very wide range of qualifications have been used over the past few years. Current job incumbents' qualification levels range from level 2 to level 5, with some having no qualification at all. While competent performance is perhaps more important than a qualification, in the absence of a qualification there are problems in terms of proving competence in the event of an accusation of negligence; career progression for individuals without qualifications is likely to prove problematic also. Ideally there should be a nationwide drive to ensure all Assistant

Practitioners hold a relevant minimum level of qualification; given the scope of these roles it is difficult to see why this should not be set at level 3.

While the majority of organisations see the value of these roles a significant minority of registered staff continue to consider Assistant Practitioners to be usurpers to their role and as having no place within the health service. Perceptions of fairness, loss and overburdening exacerbate any minor frictions. Some of the problems can be laid at the door of the recession and the shrinkage of funding for training and development. Nonetheless, managers need to consider how best to deploy the skills of their team as a whole and how to ensure that registered staff do not feel penalised by introduction of these roles or overburdened by supervisory requirements introduced because of the roles. Training for supervision and mentoring is advisable, but again may be difficult to arrange in recessionary times.

Without doubt the issue of registration, regulation and accountability continues to be a key issue underpinning the debate around these roles. On the issue of registration for Assistant Practitioners, England has lagged behind Scotland, which has had a compulsory scheme since 2011. In Wales, one of the Health Boards (Hywel Dda) has had an employer-led registration and regulation scheme since 2009. While Skills for Health and Skills for Care were consulting on a draft Code of Conduct and minimum training standards at the time this report was written, if these are accepted there is currently no plan in place to incorporate them within a national registration scheme; furthermore any registration scheme(s) established are likely to remain voluntary.

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