

**What are the key factors in the successful  
implementation of assistant practitioner roles  
in a health care setting?- A service evaluation**

**A Report on Phases 1 & 2**

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## **Executive Summary**

### **Introduction**

This study explores the implementation of the assistant practitioner (AP) role in Cambridgeshire and Essex. A central theme of recent government policy has been the move towards a more flexible workforce and a key element of this has been the introduction of a new role the 'assistant practitioner'. Assistant practitioners are not registered professionals and operate below the level of a registered practitioner but are expected to take on more complex tasks than health care assistants. The implementation of the role has been patchy throughout country and in this report the possible reasons for this are explored. There is some variation in different areas regarding whether the title should be assistant or associate practitioner, for the purposes of this project both terms are used interchangeably.

### **Aims and Objectives**

The aim of the project was to assess the key factors necessary to ensure the successful implementation of the assistant practitioner role into a health care setting. The study objectives were:

- To carry out a review of the literature regarding the introduction of the assistant practitioner grade, and the challenges and barriers to successful implementation.
- To conduct a stakeholder consultation to explore the perceptions of the impact of assistant practitioners in practice, the scope for further implementation, and where assistant practitioners are not routinely employed to determine the perceived barriers to their use in the workforce.
- To develop an action plan with clear objectives and outcomes that will form the basis of future workforce planning in the region.

### **Methods**

To address its aims and objectives the study employed a mixed method design, data collection methods used were semi-structured interviews, and a survey.

- A literature review was conducted to explore current evidence regarding the role of the assistant practitioner and the challenges and barriers to the introduction of the role in different health care settings. The review also included grey literature from the Strategic Health Authority to understand the local policy background and context.
- Interviews were conducted primarily with senior managers with a role in workforce planning, working within local NHS organisations, these included: Directors of Nursing, Chief Nurses, Clinical Services Managers, and representatives from Primary Care.
- A survey of assistant/associate practitioners (trainee and qualified) currently working in the Cambridgeshire and Essex area was carried out.

### **Key Findings**

#### **Literature Review**

- The AP role is perceived to be beneficial to registered practitioners as it enables greater flexibility of the workforce, freeing up registered practitioners to extend and expand their practice. It is beneficial to the individual AP as it facilitates career progression, job satisfaction and increases confidence. The patient benefits as APs

are seen as more approachable and provide continuity of care and build stronger relationships with patients.

- Successful implementation is dependent on effective communication; existing staff need to be made aware of the education, training and competence of APs. Professional staff require professional security and career advancement opportunities, the roles need to be perceived as necessary to the service rather than being imposed by external agencies.
- Threats to successful implementation include financial constraints, and the perception of existing staff of the introduction of APs as a cost cutting exercise, threatening professional identity and job security.

## Survey

- 93 questionnaires were returned 37 (39.8%) Cambridgeshire and 56 (60.2%) Essex.
- There were a number of different job titles used to describe the current role, the most common was Health Care Assistant 35/91 (38.5%). Only 12/91 (13.2%) described themselves as Trainee Associate or Assistant Practitioners, despite the high number of students (82%) in the sample.
- The majority of respondents were employed on band 3 47/89, (50.5%), with only 10 (11.2%) employed on band 4 or above.
- The vast majority of respondents 88/92 (95.7%) saw their role as supporting the work of registered practitioners, with 69/89 (77.5%) sometimes or rarely taking on the work of a registered practitioner.
- 55/92 (59.8%) experienced a good level of support in the workplace for undertaking the foundation degree (FD). Although 90.3% had a workplace mentor, 42.7% reported that their mentor was only sometimes or rarely available to them.
- In terms of the impact of APs in the workplace, 66.3 % thought that APs enhance service delivery. 89.2% believe APs are effective at communicating with service users, and 87% think that APs provide consistent care.
- The questionnaire also asked the respondents about the registered staff working with them and whether the AP role was valued by staff. 33/91 (36.3%) felt that the role was valued by registered staff, and 67/93 (72%) thought that staff knew the level of competence of the individual.

## Interview findings

- There were difficulties in distinguishing between APs and 'band 4s' in general.
- In most cases, APs had emerged in response to local initiatives taken by clinical leaders. A minority of organisations had adopted a strategic approach which increased the chances of reaching the critical mass necessary for significant service change. The care pathway was key to effective design of the AP role, because it enabled cross professional integration around the patient.
- APs were used to increase flexibility, raise the quality of face-to-face care, improve staff retention, develop existing staff, bridge the gap between the level 3 Health Care Support Worker and the registered practitioner, free registered practitioners to undertake more advanced work, and respond to financial pressures.
- Barriers to the introduction of AP roles included: financial constraints and/or reorganisations, absence of leadership by external agencies, perception that the role was untested, senior colleagues holding entrenched negative views, existing skill mix already 'pared to the bone', worries that the AP might take away band 5 jobs, and failure to prepare existing staff.

- Facilitators included: top managers championing the role, a leader with past experience of introducing APs in another organisation, actively engaging with different levels of staff throughout the process of change to minimize resistance.
- Interviewees held conflicting views on the flexibility of the FD. The relationship between the FD programme and the AP role varied: staff might be sent on the FD in case AP posts become available; others believed training numbers should closely match the numbers of planned posts. A key issue was how best to manage the expectations of the staff taking the programme.
- A large majority of interviewees wanted registration for Assistant Practitioners and other healthcare support workers.

### **Recommendations and further work**

- Workplace support for students undertaking Foundation Degree needs to be investigated further.
- Levels of supervision are also a concern and there is a need for clarification regarding supervision of APs and independent working.
- Organisations should be actively encouraged to publicise their successes in local and national media outlets.
- Clarify the AP role, including accessing the views of APs and registered practitioners.
- Undertake detailed case studies to gain a deeper understanding of how organisations can introduce and establish the AP role.
- Run a stakeholder event to encourage dialogue between those organisations which have established AP roles and those yet to make a strategic commitment. The aim would be to show how APs can be successfully introduced into different clinical settings, and to explore alternative forms of sharing experience, such as focused visits, shadowing, joint professional development, and learning networks.

## **1.0 Literature Review**

### **1.1. Introduction**

Over the past decade the health and social care workforce has faced increasing demands as a result of advances in technology, the ageing population, and the worsening economic climate. As a consequence of these pressures there has been a drive to re-consider the way in which health and social care services are delivered, specifically looking at service re-design and workforce re-configuration. A central theme of government policy has been the move towards a more flexible workforce and a key element of this has been the introduction of a new role the 'assistant practitioner'. The definition of an assistant practitioner has changed over time and this has implications for the status of the role and also the levels of responsibility and accountability accorded to the position. Assistant practitioners are not registered professionals and operate below the level of a registered practitioner but are expected to take on more complex tasks than health care assistants, and their education and training has developed to reflect this. The implementation of the role has been patchy throughout country and in this review the possible reasons for this are explored.

The purpose of this project was to carry out a stakeholder consultation in Cambridgeshire and Essex to explore the perceptions of the impact of assistant practitioners in practice, the scope for further implementation, and where assistant practitioners are not routinely employed to determine the perceived barriers to their use in the workforce. This report documents the findings of phases one and two of the commissioned research. A literature review was conducted to identify previous research regarding the introduction of the assistant practitioner grade, and the challenges and barriers to successful implementation. This was followed by interviews mostly with senior managers with a role in workforce planning within local NHS organisations across the two counties, and a survey of assistant practitioners and students undertaking the Foundation Degree. In phase three, case studies of departments where assistant practitioners are working, and those where assistant practitioners are yet to be introduced will be undertaken.

The literature review identified a limited range of research evidence surrounding the introduction of assistant practitioners. Material for the review was obtained from searches of Cinahl, EBSCO and Science Direct. Google was also searched to identify grey literature from different Trusts. The search terms 'assistant practitioner\*' 'associate practitioner\*' 'foundation degree' 'role development' and 'skill mix' were used and citations in retrieved articles provided an additional source of information. The literature review explains the political context in which the introduction of new ways of working has developed and how that has led to the introduction of the assistant practitioner role. The changing definitions of 'assistant practitioners' are explored with consideration of the issues of accountability and responsibility, the barriers to implementation are reviewed with particular reference to professional boundaries and professional identity, and finally the education and training of assistant practitioners is out-lined. The literature review informed the development of both the interview schedule and the survey questions.



## **1.2. Policy context: The move to a new way of working**

The typical skill mix of staff in a health care system will depend upon resource availability, the regulatory environment, culture, custom, and practice (Buchan and Dal Poz 2002). In addition in the United Kingdom (UK) the National Health Service (NHS) faces increasing demands due to the changing health needs of the population linked to demographic factors, changing public and patient expectations, and advances in medical technology. In 2001 Derek Wanless was commissioned by the then Labour Government to undertake an independent review of the long term resource requirements for the NHS, and he reported that one of the main determinants of the capacity of the health service and therefore one of the key issues for Government in addressing reform of the NHS was the size and composition of the workforce, and specifically the potential shortfall in numbers of doctors and nurses (Wanless 2002). Within the review the potential for skill mix change was explored and it was recommended that there was considerable scope for a shift of workload between doctors and nurse practitioners and from nurse practitioners to health care assistants.

Currently, policy and regulation governing the NHS is set at a national level, the *NHS Plan* (DH 2000a) outlined the Government's strategy for modernising the NHS, with increased levels of funding and reform of the delivery of services. A central theme of the proposed reform was to increase the number of health care staff, however, there were insufficient numbers of health care staff and particularly doctors being trained. Furthermore, the introduction of the European Working Time Directive which required doctors to work no more than 48 hours a week by 2009 was recognised to have major implications for service delivery, and therefore a 'new way of working' was proposed. This concept of a new way of working referred to the breaking down of traditional hierarchical structures and professional boundaries and replacing them with more flexible team working. In this environment it was suggested that nurses, midwives and allied health professionals would extend their roles and take on additional responsibilities, thus reducing the pressure on doctors. It was also anticipated that support workers would be able to extend their roles to take on the work previously done by the nurses, midwives and allied health professionals. The *NHS Plan* (DH 2000a) referred to a pilot study of assistant practitioners in the NHS Breast Screening Programme as an example to demonstrate where this role change had already been implemented.

As part of the Government's strategy to implement the proposals outlined in the *NHS Plan* the Modernisation Agency was established in 2001. The Modernisation Agency created a Changing Workforce Programme and the New Ways of Working team responsible for this programme focussed on the key priorities outlined in *HR in the NHS Plan* (DH 2002). The priorities included an increase in staff numbers with a major re-design of jobs, the creation of a 'skills escalator' to develop career options and enable staff to develop and extend their careers, and the introduction of a new, simplified structured pay scale that recognised core competencies; this was known as the "Agenda for Change".

Agenda for Change was introduced in conjunction with the NHS Career Framework (Figure 1). This framework consisted of nine tiers for career progression within the NHS, and set out a process which enabled people to enter at any point within the framework dependent on

qualifications and/or experience, and to progress upwards through gaining experience and further training.

Figure 1: NHS Career Framework (from Skills for Health 2010)



The concept behind the framework was to allow role extension, however its purpose was not only to provide opportunities for career progression but also to improve the transferability of roles and skills across the NHS (Skills for Health 2009). Assistant Practitioners (APs) are intended to occupy the intermediate position at band 4 of the career framework, below professionally qualified staff but above health care assistants and support workers, however perusal of the NHS jobs website reveals posts advertised for assistant practitioners ranging from band 2 to band 5.

A constant theme of government policy in the 21st Century has been the modernisation and re-configuration of the health care workforce with a political drive to shift emphasis onto staff competence rather than traditional professional roles (Martin, Currie and Finn 2009). Although there was a change of government in 2010 there remains a political drive for a flexible workforce responsive to the changing needs of the population. Indeed the White

Paper *Equity and Excellence: Liberating the NHS* (DH 2010) published in the face of economic recession, and the need to cut budget deficits further set out the requirements of a major programme of change in the NHS, and placed emphasis on the need of employees to reconfigure their workforce and to take an active role in workforce planning, and the commissioning of education and training. According to Spilsbury et al (2011) APs have the potential to contribute to the Quality Innovation Productivity and Prevention (QIPP) initiatives, introduced in *High Quality Care for all* (DH 2008a) and which aimed to identify how services can be re-designed to improve quality and efficiency. This is acknowledged in the QIPP summary documents of Cambridgeshire and Essex (e.g. NHS Cambridgeshire 2011, South East Essex NHS 2011, North East Essex NHS 2011) with specific reference to the need for reviews of skill mix and the need for staff to work differently.

Despite such publications as *High Quality Care for all* and *A High Quality Workforce* (DH 2008a, 2008b), care failings have recently come to light in the NHS and specifically in the Mid-Staffordshire NHS Foundation Trust, raising concerns with the quality of care in a number of other Trusts. The recent publication of *The Francis Report* highlighted poor basic nursing care and a lack of dignity and respect for patients in the hospital, and reported that there were inadequate numbers of nursing staff, and that staff were insufficiently qualified to cope. One of the recommendations of *The Francis Report* (DH 2013) is that there should be enshrined within the NHS Constitution and Regulations a commitment to a hierarchy of standards and the first of these, the fundamental standards should apply to all who work and serve in the health care system. It is recommended that the fundamental standards should have set indicators and metrics to monitor compliance with standards. In the case of staffing levels, it is recommended that the National Institute of Clinical Excellence (NICE) should include evidence based tools for the establishment of the staffing needs of each service. If these recommendations are adopted the skill mix of the NHS will come under more close scrutiny in the very near future.

In addition to existing concerns regarding the size and configuration of the health care workforce a further recent change to the training and education of nursing staff is likely to have a significant impact on the implementation of the AP role. This change sees the move to all graduate entry for nursing, this is perceived to have two potential effects; firstly, that the higher entry level and requirement for higher level of decision-making and analytical skills will lead to a reduction in successful applicants to nursing courses, and secondly, that graduate nurses will progress faster and this will lead to a shortage of nurses at Band 5 to deliver the hand on care of patients (Ferry et al 2010).

The current political climate with the re-emergence of neo-liberal managerial principles emphasising freedom, choice, the free market, minimal state intervention and the primacy of the individual (Joseph and Sumption 1979 cited in Moon 1997), will underpin any re-distribution of resources on the basis of skills and competencies rather than the traditional hierarchies which have previously defined roles within the health and social care workforce (Nancarrow and Borthwick 2005). The increased emphasis on the primacy of the individual, and the desire for person-centred care and interprofessional collaborative working putting the needs of the service user before the needs of professional groups has the potential to enable greater flexibility in working practices and delivery of services. Thus the political, economic, cultural and social landscape provides the opportunity for unskilled workers such as health care assistants to extend their roles and take on tasks previously the domain of

professionals. However the introduction of assistant practitioners throughout the country has been patchy with some areas embracing the new role and others being more reticent in its introduction.

### **1.3. Defining assistant practitioners**

The definition of 'Assistant Practitioner' has developed over the years. In 2003 the NHS Modernisation Agency (DH 2003) defined an Assistant Practitioner as..

*“ ‘higher level’ support workers, introduced in the UK to complement the work of registered professionals and work across professional groups in both hospital and community settings. Assistant Practitioners have a remit to deliver protocol-based clinical care and cover activities previously associated with the work of registered practitioners”*

However it was explicit that the protocol- based care would be undertaken under the 'direct supervision' of a state registered professional, a position also adopted by The Royal College of Radiologists and Society and College of Radiographers who stipulated "that there is no delegation or transference of care to APs. These are supervised roles" (2007). In the report by the House of Commons Health Committee on Workforce Planning (2006-07), Assistant Practitioners are described as non-professionals trained in a particular skill set used by professional staff.

In 2004-05 the work of the Modernisation Agency was decentralised and shifted from national to local levels, and the specific responsibilities for role re-design moved to new organisations including NHS Employers and Skills for Health. Skills for Health developed core standards for Assistant Practitioners (Skills for Health 2009) and defined an Assistant Practitioner as follows..

*“An Assistant Practitioner is 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 be the remit of registered professionals. The Assistant Practitioner may transcend traditional boundaries. They are accountable to themselves, their employer, and more importantly, the people they serve”*

Looking at these definitions there has been a shift in emphasis and the significant points worthy of note is the reference in both to working across boundaries, and that in the later definition Assistant Practitioners are no longer expected to deliver protocol-based care or complement the work of registered professionals but **deliver** care with knowledge and skills beyond a health care assistant or support worker and that they are accountable for their actions.

Such subtle changes in wording may not seem too important but making individuals accountable for their actions does potentially alter the position and status of Assistant Practitioners within the health and social care arena. The New Oxford Dictionary defines 'accountable' as a person, organisation, or institution required or expected to justify actions

or decisions. Yet the concept of 'accountability' has been described as elusive, difficult to define, it has even been described as a chameleon word (Day and Klein 1989 cited in Mackay and Nancarrow 2005). So for example whilst the NMC (2004) defines accountability as "being responsible for someone or something", Caulfield (2005) sees accountability as the inherent confidence of a professional that enables them to take pride in being transparent about the way in which they carry out their practice, two quite different interpretations of the same concept. Caulfield develops the notion of 'accountability' further and situates it within the four pillars of professionalism, ethics, law and employment. Where professionalism relates to the published standards of professional practice by professional statutory bodies, ethics derive from social values and moral codes, civil and criminal law governs all practice, and contracts of employment set out the roles and responsibilities and expectations on individual posts (cited in Colyer 2012). So in terms of assistant practitioners they are 'non-professional personnel' (DH 2003), but as health and social care employees they are accountable to their employer, and although they are not currently registered with professional or statutory regulatory body there is an expectation that they will conform to the core standards for assistant practitioners produced by the Sector Skills Council for Health (Skills for Health 2009). Furthermore being accountable to themselves and others goes beyond what may be expected for a role that is only to be undertaken under direct supervision, so it appears that there is some contradiction and confusion around their ability to be held accountable.

#### **1.4. Introduction of assistant practitioners**

According to the Royal College of Nursing (2010) the first Assistant Practitioner roles were introduced in the north west of England in 2002, but in reality the first Assistant Practitioner roles were piloted in Radiography as part of the NHS Breast Screening Programme in 2000. During the development of the NHS Cancer Plan (DH 2000) it was recognised that the Radiography workforce lacked the capacity to deliver some of the key priorities proposed to improve the delivery of Cancer services in England and Wales. The two key aims of the NHS Cancer Plan, which would have direct implications for the radiography workforce, were firstly, the commitment to extend the NHS Breast Screening Programme and secondly, a commitment to reduce waiting times for diagnosis and treatment across all cancer types. To achieve these goals it was recognised that it would be necessary to expand the workforce, and in preparation for the changes in service delivery and the increased demand on resources the Skills Mix Project in Radiography (DH 2003) was implemented. The project introduced the concept of the four tier service delivery model, the four tiers were composed of the assistant practitioner, the state registered practitioner, the advanced practitioner, and the consultant practitioner. The aim of this delivery model was to promote new roles, extend roles and advanced practice, to improve recruitment and retention, but also to define multiprofessional teams not by profession but by the skills and competencies that best met the patients/clients needs. Each tier was defined according to the skills and competencies required or expected from a practitioner working at that level, and the Assistant Practitioner was defined as someone undertaking protocol-limited clinical tasks under the direction and supervision of a state registered practitioner.

In radiography the first Assistant Practitioner roles were introduced in 2000 in the Breast Screening Programme, followed in 2001 in Radiotherapy and 2002 in Clinical Imaging departments. The introduction of these roles was strategic and planned at a national level

through negotiation with the professional and regulatory bodies, but in some other areas the introduction of the AP role has been *ad hoc* with posts being developed to fit local needs or being seen as an opportunity to develop existing support workers (Ferry et al 2010).

### **1.5. The role of the assistant practitioner**

There is no consistent job title or job description for individuals working at band 4, and the terms assistant and associate practitioner are used interchangeably throughout the country. Wakefield et al (2009) examined the job descriptions of assistant practitioners from one NHS Trust, the purpose of the project was to determine whether assistant practitioners were indeed working in an assistive capacity or whether the roles were being expanded and assistant practitioners were acting as substitutes for registered staff or working in autonomous clinical positions. Following analysis of the job descriptions the authors developed a framework to categorise the AP job descriptions with five distinct levels of practice:

Fully assistive: Post-holder who worked in assistive roles and did not take on tasks that fell outside this remit. In reality this post-holder was expected to do little more than a Health Care Assistant (HCA).

Supportive assistive: Post-holder who undertook tasks which were largely supportive of the work of the registered practitioner and predominantly assistive in their orientation.

Blended supportive assistive/substitutive: Post-holder 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: Post-holder who predominantly substituted for the registered practitioner. However, there were occasions when the post-holder was expected to act more independently and not require any form of supervision.

Fully autonomous/independent practitioner: Post-holder that functioned as a fully independent practitioner.

The authors concluded that it was important for job descriptions to be accurate and unambiguous, because otherwise there is a difficulty in ensuring accountability and responsibility. Furthermore they also reflect that how a new policy is introduced will depend upon the interpretation and actions of key stakeholders in different contexts. This is no different to the historical implementation of policy throughout all levels of the service, and is why a postcode lottery of care exists.

There have been a number of benefits of the Assistant Practitioner role reported, for the individual undertaking the role, the nursing team, and the patient (RCN 2010). Some of the benefits to the AP include: career escalation, job satisfaction, increased confidence and recognition. For the nursing team amongst other things the role increases the capacity of the registered professionals, and frees up their time, and increases productivity. The patients benefit because APs are seen as more approachable, there is continuity of care and as they have more time to spend with service users they are able to develop stronger relationships

with patients. These findings were taken from existing literature and also from responses to the scoping exercise undertaken on behalf of the RCN (RCN 2010).

Much of the literature written about the role of the assistant practitioner is produced by 'champions' of the use of unqualified support staff which does introduce an element of bias, furthermore as in any other research area, published studies tend to present positive findings (Buchan and Dal Poz 2002). For example Leach and Wilton (2009) reported on an evaluation of the AP role in the NHS South Central, the Assistant Practitioners who were interviewed stated that they worked autonomously and managed their own case load, they believed that they help to smooth the patient pathway, enabled a greater number of people to be treated in a shorter timeframe therefore facilitating early discharge, that they contribute to examining processes and procedures used in their place of work and therefore contributed to transforming patient care. The sample size for this study was very small and a very positive perspective was put forward with no negative findings reported. Although the majority of studies written about specific areas of practice do present the introduction of APs in a positive light (Huddleston and Scoins 2006, McGowan & Campbell 2010, Bennion & Irvine 2011, Thurgate & Macgregor 2012), Norrie et al (2012) in a short report present the accounts of a small cohort of APs where friction and hostility was experienced from colleagues who resented lack of cover for study time and refused to acknowledge the change of status, and confusion about the role and foundation degree qualification led to a reluctance to delegate to APs due to worries about accountability.

#### **1.6. *Facilitators and barriers to the implementation of assistant practitioners***

The introduction of APs throughout the UK has been patchy with some Trusts taking the lead in the development of the role, and with others yet to recruit to the role (Skills for Health 2011). Nancarrow and Mackay (2005), in their evaluation of a skill mix project into a large community-based occupational therapy service made recommendations that at a national level there is a need for clarification of the supervisory and accountability relationships of assistant practitioners. They also identified the need for supervisory professionals to be trained in order to facilitate the AP role and to have awareness of the education and training of APs to enable delegation and verification of competence. A key point made was that there is a need for professional security and career advancement for professional staff; this would help to ensure that the introduction of roles would be welcomed rather than being seen as a threat to professional practice and job security.

The delay in implementation may be due in part to the resistance of some Trusts to the role; A survey of Directors of Nursing found resistance to the AP role because they see no perceived need for the role and are uncertain as to whether there is evidence for effectiveness, there were also concerns around professional and patient safety. Further factors include financial constraints limiting amount of funds available to develop the role, and lack of registration and regulation, (Spilsbury et al 2009). Benson (2004) reported on an early implementation programme of assistant practitioners and found that the three main reasons given for not introducing the AP role, were lack of funding, lack of NVQ assessors, and managers not valuing AP role. In a scoping study in the East of England, Ferry et al (2010) reported that resistance to introduction of APs into wider nursing workforce was attributed to a lack of confidence in the APs' skills and knowledge to undertake traditional nursing role and resistance on the part of nurses to give up tasks traditionally seen as their

own. Some nurses also seek to protect their own role and see AP roles as a threat both to their professional identity and the viability of their position and income.

There has been a shortage of trained perioperative practitioners for a number of years and one of the solutions has been to develop HCAs to expand their roles, and in theatres assistant theatre practitioners (ATPs) have been in post since the mid 2000s, Huddleston and Scoins (2006) describe ATPs as health care assistants with additional training, extending their practice to include limited supervised roles in scrub and recovery support. ATPs are seen to increase the flexibility of the theatre team and also to aid the retention of critical staff, but as in other disciplines the uptake of the role within theatres has been varied across the country. For implementation to be successful Huddleston and Scoins recommend that documentation such as job descriptions, person specifications and guidelines for delegation are put in place, the scope and limitations of the role are communicated effectively, staff should have an appropriate level of education and training, and that there should be an appropriate level of supervision.

There are therefore a number of factors which help to ensure successful introduction of the assistant practitioner role. In addition, Spilsbury et al (2009) suggested that AP posts introduced in response to a perceived need of the organisation were viewed more positively and with acceptance compared to those enforced by an external agency. Indeed it was noted above that in the case of radiography the active involvement by the professional and regulatory bodies facilitated the introduction of the assistant practitioner grade to meet a specific need. Furthermore, Ferry et al (2010) reported the need for strong leadership and sound change management skills in order to prepare registered staff addressing such issues as morale, motivation, acceptance, commitment and value.

#### *1.6.1. Professional boundaries and professional identity*

The introduction of a new grade of staff can be seen as a threat by existing staff both to their professionalism and also their job security. Health and social care is the responsibility of many different professional groups each of which have their own distinctive professional culture, identity, and areas of expertise. Membership of a social group such as an occupation provides a point of reference from which individuals make meaning of their work and manage their identity (Allen and Pillnick 2005). Health care professionals operate within recognised boundaries which are dependent on levels of knowledge, skill, and competence and maintained through education and training and professional codes of conduct. These differences between professionals create boundaries and there is an imperative by some to maintain and defend these boundaries, and to some extent these boundaries are protected by legal frameworks, and the codes of conduct and practise. Some professions have greater status and are placed higher within the professional hierarchy, and this enables them to exert greater control over their activities and to protect them from other groups seeking to expand and extend their roles.

The introduction of the Assistant Practitioner role allows occupational boundaries to shift as the opportunity for task delegation downwards by professionally qualified staff enables them to take on increasingly complex tasks whilst passing the more routine work to Assistant Practitioners (Wakefield et al 2010). Disciplinary boundaries change as health care providers identify new areas of work or through adopting new roles normally undertaken by other



providers (Nancarrow and Borthwick 2005). For example in Accident and Emergency Departments advanced practitioner nurses are assessing patients and requesting x-ray examinations, a role previously undertaken by medical practitioners, advanced practitioner radiographers are interpreting and reporting x-ray images a role until recently the preserve of radiologists. For such specialisation to develop within a profession and enable the practitioners to pursue higher status autonomous roles (Hugman 1991 cited in Nancarrow and Borthwick 2005) suggest the practice of 'internal closure' whereby sub-ordinate sub-groups are created within the profession to undertake the lower status duties. Such role development allows movement of the workforce in four directions; diversification, specialisation, horizontal substitution and vertical substitution (Nancarrow and Borthwick 2005).

For the re-designing of services and re-configuring of workforce to be successful it will be necessary to take account of the 'negotiated order' which is longstanding and recognised by all participants. Much of the literature surrounding the division of labour in the hospital environment focuses on social interaction and the 'negotiated order' (Allen and Pilnick 2005: Freidson 1994 [1975] cited in Carmel and Baker-McCleary 2011:3), and specifically on the professional boundaries and tensions existing between the medical profession and nurses. At the macro level the division of labour is determined by political and legal frameworks, and is concerned with various occupational forms, the structure of an occupation and how the division of labour changes over time, this is what is meant by a 'negotiated order', and to an extent is imposed on the workforce. On the other hand at the micro level which constitutes the practical or technical aspect of work (the 'factory floor') workers social interactions and activities govern the day to day delivery of care, and this according to Allen and Pilnick (2005) comprises of the moral division of labour in a system of work. It is the social interaction between actors where "participants are continuously engaged in attempting to define, establish, maintain and renew the tasks they perform and the relationship with others" (Freidson 1976: 311, cited in Allen and Pilnick 2005) whilst operating within the rules and regulations.

Where there is inter-disciplinary change and expansion of historical professional boundaries for example between nurses and doctors, or radiographers and doctors this is vertical substitution, where there is intra-disciplinary change or expansion of professional boundaries within a single discipline such as assistant practitioners and consultant practitioners then this is described as diversification and/or specialisation. The assistant practitioner role is not seen as a professional role because of its non-registered status and lack of professional regulation; however it fulfils more than a traditional support role as APs are expected to do more than HCAs, because of this Wakefield et al (2009:293) describes the AP role as "role substitution, reassignment and delegation"

Substitution has the advantage where there are workforce shortages at particular levels, but it can be limited by regulatory aspects of a particular practitioners work, professional indemnity and protectionism (Nancarrow and Borthwick 2005). Indeed, Buchan and Dal Poz (2002) reviewing the skill mix literature identified that in the 1990s concerns were raised regarding the substitution of qualified staff by cheaper care assistants. This was partly about protectionism and feeling devalued but there were also concerns around the hidden costs of substitute staff. Specifically that care assistants have less autonomy and capacity to act independently and would therefore use time less productively, and also that they would

potentially be working beyond their technical and legitimate capacity and could harm those they were caring for.

In the literature surrounding professional identity and the division of labour the focus has been on interprofessional boundaries, the introduction of the advanced practitioner role and the assistant practitioner role, their impact on the division of labour, and delivery of care appears so far to have been neglected. But there is a growing interest in intraprofessional boundaries and their impact on service delivery and organisational change. It has been suggested that intraprofessional boundaries and their associated hierarchies lead to independent working and to members of the same discipline competing for patients, resources and influence (Currie et al 2008 cited in Powell and Davies 2012).

### **1.7. Education and training of assistant practitioners**

There is currently no specified or agreed training route for assistant practitioners, in England the training and education follows one of three routes NVQ level 3, BTEC Higher National Diploma, or the Foundation Degree (Skills for Health 2011). In Scotland though assistant practitioners working in imaging departments undertake a Higher National Certificate approved by the College of Radiographers (Colthart, et al 2010). When APs were introduced in the North West of England the local organisations involved in the development of the role, took the view that as it was an emerging role the training and development of individuals should take the form of a formal educational approach and the newly launched foundation degree would be the most appropriate route (Kilgannon and Mullen 2008). Foundation degrees were introduced as a new higher education qualification in 2000 to address skill shortages and as part of the widening participation agenda, and since their introduction the numbers of students enrolled has increased substantially (Lee Harvey 2009). Foundation degrees are designed with employers and combine academic study with workplace learning, they are flexible both in the way that they can be delivered and the design of the programme is such that it can be adapted to suit organisational needs. The principle behind this approach is that learning is not just based on competencies but also there is an underpinning knowledge base. The Council of Deans of Health has recently argued that policy makers should consider putting in place the requirement that workers operating at assistant practitioner level should be educated at Foundation Degree or Diploma of Higher Education level (Council of Deans of Health 2013).

The student assistant practitioners are supported in the workplace by a mentor, where the mentor “helps the student to identify their individual learning needs, apply knowledge to practice and acts as a resource for the students development” (Wilson et al 2005 cited in Lee Harvey 2009). Locally, mentors help the students to construct a learning contract, meet regularly with the students and are responsible for signing the students’ formative and summative assessment of work based learning. Nursing mentors are trained for mentoring nursing students via NMC approved programmes but Trainee Assistant Practitioners (TAP) have different needs. According to Griggs (2012) the focus for mentors of nursing students is the development of the students’ clinical skills, whereas those undertaking the foundation degree they are familiar with practice but need help with the underpinning theory. A further difficulty facing the mentor/TAP dyad arises where the TAP has worked in the same team as a healthcare assistant, the relationship can be challenged by the change in status of the TAP from work colleague to student. There is currently no recognised formal route for assistant

practitioner training, and there are some Trusts which offer their own in-house training or accept alternative educational qualifications there is therefore no consistency. This is an issue as the skills and knowledge obtained by an assistant practitioner in one area may not be accepted and therefore transferable between different Trusts, which is limiting both for the individual practitioner and the organisation.

### **1.8. Summary**

The potential shortfall of appropriately trained staff to meet the demands of the 21<sup>st</sup> Century health care needs of the population was a driving force behind government policy; assistant practitioners were introduced as part of an overall strategy of service re-design and workforce re-configuration. Since the introduction of the role the definition of assistant practitioners has changed and with this there has been a subtle shift in their status and level of accountability. The roles are on the whole perceived to be beneficial as they allow greater flexibility and free up registered practitioners to expand and extend their practice, it also provides support workers with the opportunity for career progression. Successful implementation requires effective communication so that existing staff understand the level of education and training assistant practitioners undertake and also their level of competence, so that they can be confident in delegation of appropriate tasks. It is also important that the roles are perceived to be necessary by the workforce and not imposed by external agencies. A threat to successful introduction of assistant practitioner roles would be if staff perceives them to be a cost cutting exercise substituting for registered practitioners, as this threatens professional identity and job security.

### **1.9. Implementation of the assistant practitioner role in the East of England**

The East of England developed a strategy for the implementation of the assistant practitioner role, to address the Modernising Healthcare Careers and QIPP agendas, and to ameliorate the impact of the reducing supply of registered professionals. The County Workforce Groups (CWGs) were responsible for administering the strategy and clinical areas with an interest in becoming an implementation site had to provide evidence of the following: that a service and workforce re-design demonstrates that APs will be delivering care across clinical pathways, there is strong clinical leadership in the clinical area, there is a critical mass of AP roles being introduced within the clinical area, QIPP criteria are met, APs will work flexibly across existing professional boundaries, and the benefits of the introduction of APs to the workforce have been detailed. It was determined that the underpinning educational preparation for the assistant practitioner role was to be a two year Foundation Degree, with work-based learning and on day release to a HEI or FE College (NHS East of England 2010). The total number of APs in post in Cambridge and Essex is unknown and in common with other parts of the country implementation has been patchy. The purpose of this project is to establish the barriers and facilitators to successful implementation of the AP role in different health care settings.

## **2.0. Methods**

Assistant/Associate Practitioners are higher level support workers introduced in the UK to complement the work of registered health and social care practitioners working across a range of acute and community settings within different professional groups. In the East of England a regional strategy for the implementation of the assistant practitioner role was introduced to ensure the role was implemented in a timely and consistent manner. The purpose of this project is to explore the current assistant practitioner workforce in Cambridgeshire and Essex.

### **Overall aim and objectives**

The aim of the project was to assess the key factors necessary to ensure the successful implementation of the assistant practitioner role into a health care setting.

The study objectives were to:

- To carry out a review of the literature regarding the introduction of the assistant practitioner grade, and the challenges and barriers to successful implementation
- To conduct a stakeholder consultation to explore the perceptions of the impact of assistant practitioners in practice, the scope for further implementation, and where assistant practitioners are not routinely employed to determine the perceived barriers to their use in the workforce.
- To develop an action plan with clear objectives and outcomes that will form the basis of future workforce planning in the region

To address the aims and objectives of the study a mixed method design was employed (Cresswell & Plano Clark 2007). The data collection methods used were semi-structured interviews, and a survey.

### **2.1. Plan of Investigation**

#### *2.1.1. Literature Review:*

A literature review was conducted to explore current evidence regarding the role of the assistant practitioner and the challenges and barriers to the introduction of the role in different health care settings. The review also included grey literature from the Strategic Health Authority to understand the local policy background and context.

#### *2.1.2. Stakeholder Consultation:*

The main stakeholders involved in the consultation process are Assistant/Associate Practitioners and mostly senior managers with a role in workforce planning working within local NHS organisations, these included: Directors of Nursing, Chief Nurses, Clinical Services Managers, and representatives from Primary Care.

Two different data collection methods were used for the consultation. Firstly, interviews were conducted with managers with a role in workforce planning. Interviews took place in the provider organisations at a mutually agreed convenient time. The interview schedule (see

appendix) was devised from evidence in the literature and was reviewed and agreed with the project steering group. The interviews were recorded, reviewed and transcribed in part. A thematic approach to the analysis of the qualitative data was undertaken influenced by the structure adopted within the interview schedule.

A survey of assistant/associate practitioners (trainee and qualified) currently working in the Cambridgeshire and Essex area was carried out. It had been planned to use an on-line survey tool for this purpose however due to difficulties accessing up to date email addresses it was decided to use a hard copy questionnaire. The questionnaire was developed from the literature and the steering group were invited to review the questionnaire and comment on the content validity. Following revision, the questionnaire was distributed accompanied with a letter of invitation and an envelope to return the questionnaire (a copy of the questionnaire and letter of invitation can be found in the appendix). The questionnaires were distributed to trainee assistant practitioners in the universities and via the ELMs in the workplace. The actual number of assistant/associate practitioners working in the Cambridgeshire and Essex is unknown but a total of 280 questionnaires were distributed.

The questionnaire was split into three sections:

Section one

The aim of this section was to determine respondents' current role and grade and to ask them how they feel about their current practice in relation to the level of supervision and autonomy

Section two

This section aimed to capture information about the respondents' education and training and the level of support experienced in the workplace and from the Higher Education Institute whilst undertaking training.

Section three

This section aimed to explore the respondents' perceptions of the impact of the AP role in their workplace.

At the end of the questionnaire a space was left and respondents were invited to add any points they wish to make about their experiences of undertaking the foundation degree or their employment as an AP.

## 2.2. Data Analysis

The Data was entered into an Excel file and then exported into SPSS for analysis. The responses to the questions were coded as follows

|                   |   |                  |   |
|-------------------|---|------------------|---|
| Strongly agree    | 1 | Always           | 1 |
| Agree             | 2 | Most of the time | 2 |
| Not sure          | 3 | Sometimes        | 3 |
| Disagree          | 4 | Rarely           | 4 |
| Strongly disagree | 5 |                  |   |

Data analysis was undertaken using descriptive statistics, and is presented in Chapter 4 survey findings.

### 3.0. Interview Findings

All 16 NHS provider organisations across Cambridgeshire and Essex were invited to participate in the project. The initial point of contact was the Director of Nursing or Chief Nurse. If the Director of Nursing felt s/he was not the appropriate person to be interviewed s/he nominated an alternate. 15 provider organisations participated in the interviews and 18 individuals were interviewed (three organisations put forward two representatives for interview). The breakdown of posts held by the 18 interviewees is as follows.

- 6 Directors of Nursing/Chief Nurse
- 1 Chief Operating Officer
- 1 Director of Workforce
- 1 Director of Education
- 1 Associate Director of Organisational Development
- 1 Assistant Director of Practice Development
- 1 Education Manager
- 1 Practice Educator
- 1 Clinical Nurse Specialist
- 1 Head Radiographer
- 1 Clinical and Education Lead
- 1 Training Manager
- 1 Service Support Manager

The emerging issues are presented under a number of headings relating to the questions asked within the interviews.

#### 3.1. Defining the assistant practitioners

Some interviewees had difficulty in distinguishing clearly between Assistant Practitioners (APs) and 'band 4s' in general. In some cases this appeared to be down to database limitations, but in others it reflected a lack of clarity about the definition of the role and its place in the organisation. Within organisations there are staff paid at band 4, but not described as APs, who have roles that conform closely to the definition of the AP as set out by the Skills for Health<sup>1</sup>. The two clearest examples are found in the mental health field: Support, Time and Recovery Workers (STRs), and Activity Co-ordinators. Determining the number of APs employed in an organisation is bound to be problematic unless organisations are very clear about the definitions behind the data. These ambiguities over definition are also referred to in the Skills for Health expert paper (*ibid*).

#### 3.2. Numbers in post

Interviewees were often unclear about the number of APs employed. In a couple of cases, interviewees had printed off staff lists in preparation for the interview, but these tended to list staff at 'band 4', rather than those holding the title of AP. In other cases, interviewees could only answer for those APs within their area of professional responsibility – so nursing managers were often unable to provide information about APs supporting the allied health professionals.

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<sup>1</sup> [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)

The most APs employed in any organisation was 49, some organisations have no AP nurses but APs in allied health departments.

### **3.3. Reasons given for introducing assistant practitioners**

A number of reasons were given to support the introduction of APs, including the desire to exploit the greater flexibility of the AP role, to provide more appropriate care and to bridge the gap between HCA band 3s and the registered practitioner.

*“For me it’s about getting some really high quality practitioners into roles that actually we don’t need registered staff to do.”*

*“An AP can do a lot more than our band 3s have done .... they are able to start relieving the band 5s to do more advanced practice.”*

It also allowed organisations to plug the potential gap left by expected reductions in the numbers of registered nurses.

*“I think we’ll have fewer registered nurses in future, it’s the way the profession is evolving .... their key role is about standards and ensuring others maintain those standards.”*

Furthermore it was hoped that it would improve retention in the unregistered workforce through allowing development opportunities for existing staff, but it was also identified as a pragmatic response to increasing financial pressures, seen as the ‘burning platform’.

An additional financial factor for introducing APs was the potential opportunity to free registered practitioners to undertake more advanced work allowing for a rebalance of the skill mix without damaging patient care; thus reducing the need for expensive staff to do more basic tasks. There was a clear aim to improve the quality of face-to-face patient care. Those who had successfully introduced the AP role were perplexed as to why the role had not been adopted more widely.

*“I think they’re an absolute asset for any area. I can’t see why you wouldn’t use them.”*

*“I have tried to explain this to colleagues but they don’t really buy into it ... I can’t think why they haven’t embraced it because it will release money and improve quality.”*

### **3.4. Designing the role**

The care pathway was generally considered to be the key to effective design of the role. This focus enables cross professional integration around the patient because the pathway is rarely profession specific. (‘What does the patient get now, what do they actually need, who needs to give it to them, what skills does that person need?’) It was felt to be essential that the process of role design linked with skill mix reviews, carried out in collaboration with clinicians, alongside service redesign.

*“We met with the clinicians, did a skill mix review, what is a definite task or responsibility, what isn’t, what is a maybe? We looked at the benefits, what you would expect to do in a service redesign, we did all that. The care pathway is the key.”*

*“The AP role needs to develop strategically from pathway change and service redesign.”*

Successful areas encouraged a culture of learning in which registered staff think creatively and think differently, about how new roles can improve patient care. In some NHS employment sectors, national bodies have embedded the AP role within a career framework, e.g. the Society of Radiographers, and Modernising Scientific Careers. However, there can still be differences between local requirements and national expectations, such as where roles have been established locally before the appearance of the national framework.

In many cases, APs have evolved through a process of ‘grafting’ them onto what ‘works quite nicely thank you’, in place of a more radical, system wide alternative. It was acknowledged that this could be problematic.

*“We won’t push the boundaries unless we give something up, you can’t keep adding and adding.”*

Where AP roles are determined by a specific care environment – where impact and meaning should be maximized – could create problems in the future with ‘isolated people doing isolated things’. In turn this may threaten the development of a career path and inhibit the emergence of a generic skill set. Indeed the generic potential of the AP role was often considered attractive, but something for the future.

*“The generic worker has always been a topic of conversation .... a bit of an OT, a bit of a social worker, a bit of a nurse, not too much of a doctor.”*

### **3.5. Settings where assistant practitioners have been introduced**

Across the two counties, there are examples of APs undertaking the spread of roles seen nationally. However, as the project brief recognised, their deployment is patchy and in most cases does not reach the critical mass necessary to make a significant impact.

From the numbers in post and the interviews, it seems many organisations found it more difficult to place APs in inpatient areas as compared with specialist or community settings.

Specific examples of AP deployment included:

- Orthopaedics – blending occupational therapy, physiotherapy and nursing.
- Stroke rehabilitation. *“Stroke care cries out for it – a multicompetence role – some physiotherapy, and speech and language.”*
- Diabetics – blending dietetics and education.



- Tissue viability.
- Breast screening, phototherapy, radiotherapy, radiography.
- Community, including the Support, Time and Recovery Workers (STRs) in mental health field.
- A few organisations have allocated APs to ward areas, e.g. in mental health APs are implementing a falls initiative, physical healthcare monitoring, monitoring mandatory training, and supporting psychological interventions.
- Anti-cholinesterase inhibitor monitoring in mental health outpatients clinics.
- Infection control, manual handling.
- Crisis resolution, assertive outreach.
- Clinical practice assessor.

In one case, evidence was provided of a measurable service benefit; shorter stays in preadmission for hip surgery.

### **3.6. Introducing the AP role**

Box 1. An Example of an organisation which has introduced the AP role successfully

**Associate Practitioners at Southend University Hospital NHS Foundation Trust**

Our Trust is committed to the development of our health care support workers. Over the past 3 years we have supported health care support workers to undertake their Foundation Degree, with the participants selected from a range of settings across the organisation. Initially the selection process was individual led, with current health care support workers looking for an opportunity to develop their career. There was little discussion with managers about what may happen once the course was successfully completed.

The approach has now evolved with a robust internal selection process to ensure the most suitable candidates are put forward to undertake the demanding course. Students from both our second and third group have all been offered the opportunity to go directly into the 2 year BSc programme. Inevitably the programme offers opportunities to move forward into the professional nursing graduate role should they wish to.

We have now moved to a position where we are supporting our health care assistants to undertake the Foundation Degree with the understanding that we will then offer a post upon successful completion of the course. Currently there are a number of Band 4 Associate Practitioner roles available within the organisation, mainly in physiotherapy, rehabilitation and the laboratories. These are established roles and will be able to support individuals from these disciplines undertaking the Foundation Degree. It is fair to say that Associate Practitioner roles within Nursing are still in their infancy. However, job descriptions for both Band 3 and 4 (AP) have been finalised and we hope to employ in nursing in the next year once roles have been finalised. Clinical areas and departments are involved in our skill mix reviews, which will enable the areas to determine where it will be possible to create band 4 positions to address service need that will complement the clinical workforce and support the delivery of patient care.

While a trust-wide strategic approach was widely admired as the way to introduce APs into the organisation, this was only evident in a minority of cases. In the majority, APs emerged in response to local initiatives by clinical leaders. The outcomes from this bottom up approach were often unpredictable. Sometimes it was a response to 'hot pockets' of senior care assistants at level 3 who were carrying out slightly extended roles. In those circumstances, the AP role was seen as an incentive to reward and retain good staff.

*"Services change every year and new services come in and we lose some services. You can't say, I need 100 APs or 5% of the workforce – you have to be opportunistic – any new service has to factor in an AP role."*

With some local initiatives, strict feasibility conditions had been imposed, e.g. one group was allowed to proceed as a project which was evaluated after 12 months. The project period included in-house training and proved to be a success.

*"The role has not really been promoted in the hospital ... the Trust was a bit wary of it so it started off as a project."*

### *3.6.1. Taking the strategic approach*

Some organisations adopted a strategic approach to the introduction of the AP role, though the style and details varied. Firstly, they took the decision that they needed the role, and then used a process of change management to roll it out across the organisation. In this way, organisations were better able to deploy APs in a wide range of clinical settings, so enabling them to reach the critical mass necessary for significant service change.

*"It's about the process around the patient, the pathway ... what does the person actually need, what are they getting now, who needs to give it to them, what skills does that person need?"*

Others had considered or were considering the role in a strategic way but felt unable to proceed without the leadership of external agencies, e.g. Strategic Health Authority, Local Education and Training Boards, the wider NHS. They felt that, without these external drivers, the organisation would not risk investing in a new and - what they saw as - an untested role. Often these organisations also felt their room for manoeuvre was frustrated by challenging financial conditions and/or changes to the organisational structure.

*"I'd have thought it's something that the LETB would take the lead on. The more we can do as an NHS system the easier it would be for Trusts to engage."*

Reference was sometimes made to the apparent lack of evidence for the effectiveness of the AP role. *"Not enough information about what it can give you."* The point was made that the APs should be seen as part of wider workforce planning and service redesign; they should not be seen in isolation – *"they won't save the day, but are part of a broader solution"*.

*"What stands out is they are in too small pockets – 'penny packets'. They don't have an AP on every shift – they won't change practice unless they are there at all times."*

Some organisations had responded in the past to SHA requests for staff to fill places on Foundation Degrees, but the momentum had slipped before the AP role could become embedded in their workforce strategy. One Director of Nursing sets targets for each director to create additional AP posts every time a new or redesigned service appears. Managers now want the roles and are creating them automatically.

*“It’s a target within each of the Director’s portfolios of responsibility to create additional AP roles ... we are growing them year on year and have had some great results across all services.”*

A new leader can make a dramatic difference. One Director of Nursing arrived in post with experience of introducing APs in two different trusts in two different parts of the country. Local resistance was overcome to implement a successful trust-wide AP strategy in under two years.

### **3.6.2. Promoting the AP role**

The role of champions was variable and problematic. Sometimes the role was fully embedded at a senior level, elsewhere there were enthusiastic champions who lacked adequate power or influence. In the absence of a strategic approach, successes were down to individuals pushing for APs and spreading the word locally.

*“It’s a selling job, hearts and minds, getting people to understand what the role is, targeting the people we think would block the system and either persuade them or persuade them to keep away from it.”*

Where a strategic approach was adopted, engagement with different levels of staff throughout the process of change minimized resistance.

*“We need a clear strategy and sell that to the staff through a change management process.”*

HCA band 3s could become instigators of change when they begin to ask for further training. Where implementation had been successful it was uncommon for this to be publicised through professional journals or other media.

*“In some cases the AP will replace registered nurses. People want one to replace a band 3 but I don’t think that’s the point of them ... there’s a lot of persuading and selling to do, to articulate the argument clearly.”*

### **3.7. Reasons why the AP role has not been widely implemented**

Several interviewees referred to the attitudes of senior colleagues who held entrenched negative views about the AP role or about unregistered staff development in general. The failure to take a strategic view of AP implementation did not assist with this issue. The imperative to fill FD places, rather than redesign services exemplified this – so that staff could end up qualified but without posts to fill. Alternatively the ‘wrong’ people were sent on the course – especially where small departments put forward HCAs to retain them, but without proper academic screening.

*“We don’t have that flexibility and luxury we had before we started the real workforce review ... and maybe that was an oversight on our part collectively as an organisation.”*

*“Support for the role is variable. I believe that’s based on beliefs about professional practice which are out-dated or ill informed.”*

*“One of the stumbling blocks around here is that we have a professional lead nurse who is ‘it’s professionals or nothing’.”*

The problem of registered practitioners holding onto tasks just because they can was noted and others felt that the existing skill mix was already pared to the bone. Concerns that the AP might take away band 5 jobs were also expressed.

*“Registered nurses need to get more comfortable with the role ... the AP role is a bit threatening.”*

*“Qualified staff have to take the risk of giving something away ... they hold onto tasks just because they can.”*

The perception that the AP role lacked an evidence base, associated with the failure to promote the role across an organisation and between organisations or to prepare existing staff for the changes required, were identified as contributing to the limited development of the role.

*“Where we are struggling is to identify the value added of having a band 4 AP to a really good band 3 HCA because like most organisations we are at the minimum staffing levels.”*

*“What is missing is the marketing of the assistant practitioner, the positives, how this can be good for you, and we haven’t done that ... if you don’t know what it is, why would you look at it?”*

Others felt that it was better to increase the skills of band 3 staff to close the gap with band 5s rather than develop the AP role. This was linked with the challenges of financial constraints and different funding streams.

*“It’s more about upskilling HCA band 3s and giving them more skills and responsibilities. It’s possible the AP role is being squeezed. Everyone wants more for less.”*

### **3.8. Qualifications, the foundation degree and continuing professional development**

In the large majority of cases APs were recruited internally. STRs were the main exception where wider experience and qualifications were actively sought. There were interesting variations in the training models used for the APs – most notably where the first year was run in-house. Some variations were historical because the AP role had emerged before the current FDs appeared. In a few cases concerns were expressed about the length or the

perceived inflexibility of the FD programmes; others praised the universities for their willingness to tailor programmes to meet local needs.

The relationship between the FD programme and the AP role is complex. Staff may be encouraged to take the FD so they are ready for when posts become available (the qualification being seen initially as personal development); others seeing this approach as inappropriate, i.e. proper planning should align training numbers with posts. In some cases staff are offered 'trainee assistant practitioner' posts when they start the FD.

The key issue seems to be to manage the expectations of the staff taking the programme. By and large mentoring is provided by staff already qualified to support student practitioners, supplemented by those in training or otherwise experienced. Some organisations provide both a clinical and an academic mentor, and some continue to support APs after the course through regular clinical supervision for the whole group or less formal types of peer support.

*"We do monthly clinical supervision for the whole AP group."*

*"Now I go and talk to them at the outset of the FD, halfway through and at the end of their course, and I explain the realities of life to them."*

Competency frameworks provide the opportunity to do quite a lot of CPD in-house, although some thought that HEIs could offer more courses for unregistered staff. It was highlighted that career progression is overwhelmingly directed towards the registered practitioner.

### **3.9. Regulation and registration**

A large majority of interviewees wanted registration for Assistant Practitioners and other healthcare support workers. Some interviewees were concerned that registration might limit flexibility in role design, but others felt that flexibility could be built in. Internal accountability frameworks have been widely adopted to protect the patient, the health worker and the organisation.

The principal arguments for registration included the following:

- registration would give registered practitioners greater confidence when delegating;
- individual APs would take greater pride in their role because there would be more at stake for the individual;
- greater standardization across the country;
- reduced risk of an incompetent AP being employed elsewhere.

While discussing registration, many interviewees highlighted the case of the State Enrolled Nurse and mused over whether the nursing profession had really learned the lessons of history.

*"In my job I've been instrumental in getting rid of things only to think later 'that was really quite a good idea!'"*

In the following chapter the findings of the survey of assistant practitioners are presented/

## **4.0. Survey Findings**

As previously stated the actual number of Assistant Practitioners or trainee Assistant Practitioners working in Cambridgeshire and Essex is unknown and therefore the total number of questionnaires distributed to the Universities and Trusts was 280 in an effort to try and capture the views of all those potentially in post. However, the fact that the total population of Assistant Practitioners in post is unknown means that it is not possible to calculate actual response rate. Overall 93 questionnaires were returned 37 (39.8%) Cambridgeshire, and 56 (60.2%) Essex. Of the questionnaires completed 28 (30.1%) were ARU Foundation Degree students, 49 (52.7%) were Essex Foundation Degree students, 7 (7.5%) were returned through the Essex Workforce Commissioning Group area, and 9 (9.7%) from the Cambridgeshire Workforce Commissioning Group area.

### **4.1. Current role**

In Section One of the questionnaire the participants were asked to provide demographic factors relating to their current job title and to state their current band and how long they had been working in their current post. The participants were not asked to give information about gender, age, or place of employment to maintain their anonymity.

There were a number of different job titles used to describe the current role (see Figure 1) These were categorised into Trainee Associate or Assistant Practitioner, Health Care Assistant, Health Care Support Worker, Senior Health Care Assistant, and 'Others'. The most common were Health Care Assistants 35/91 (38.5%) and Senior Health Care Assistants 13/91 (14.3%), Health care support workers 11/91 (12.1%). Only 12/91 (13.2%) described themselves as Trainee Associate or Assistant Practitioners, despite the high number of students (82%) in the sample –The 'others' included a range of diverse roles such as Community Matron Assistant, Team Support Worker, and Diabetes Care Technician and contributed 14 (15.4%) to the sample.

Respondents were asked to state which band they were currently employed on and the majority of respondents were employed on band 3 (47/89, 50.5%), with only 10 (11.2%) employed on band 4 or above. One person was on Band 5 and described themselves as a Senior Health Care Assistant. The remainder were employed on band 2 (See Figure 2).

The numbers of years in post ranged from 3 months to 23.5 years with a mean of 4.93 years. Some of the respondents had been in their current post for many years including two who had been in post for 22 and 23.5 years respectively, overall a third of respondents had been in their current post for more than 5 years (see Figure 3).

Figure 1: Current Job Title

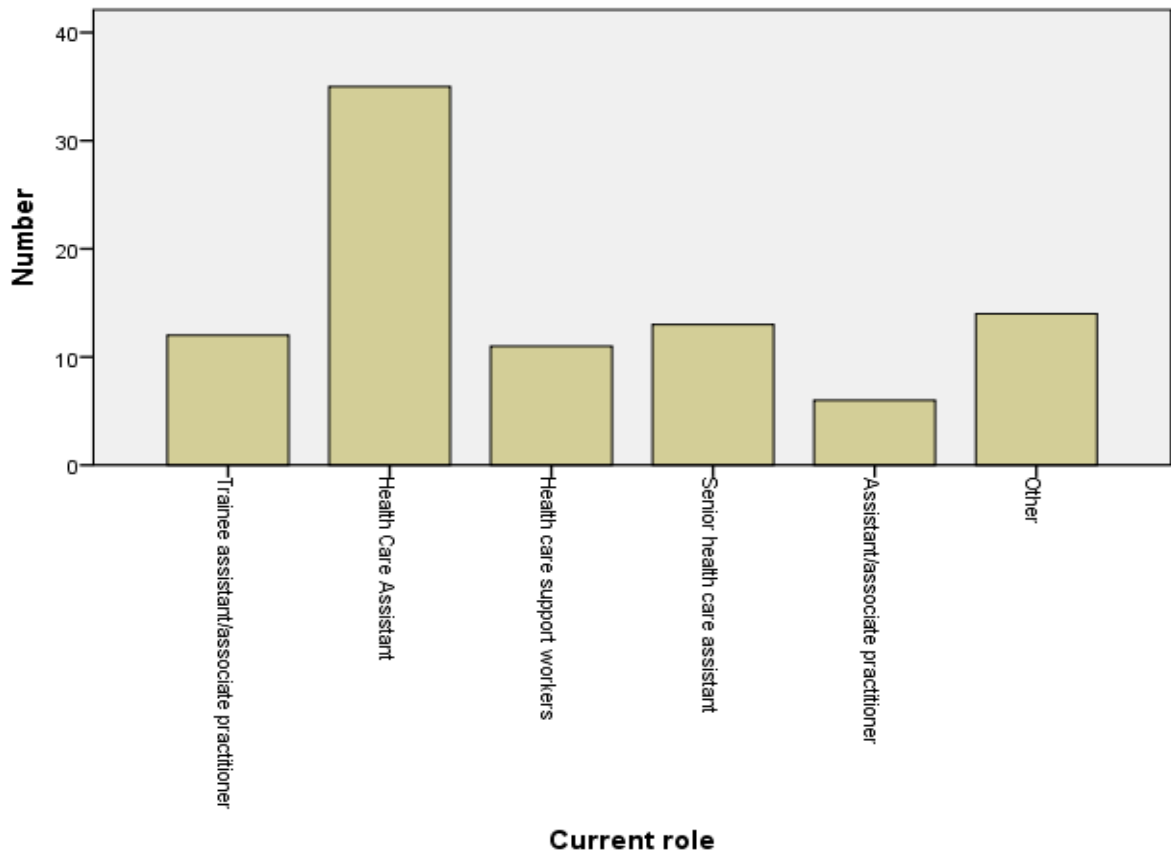


Figure 2: The Band respondents are currently employed on

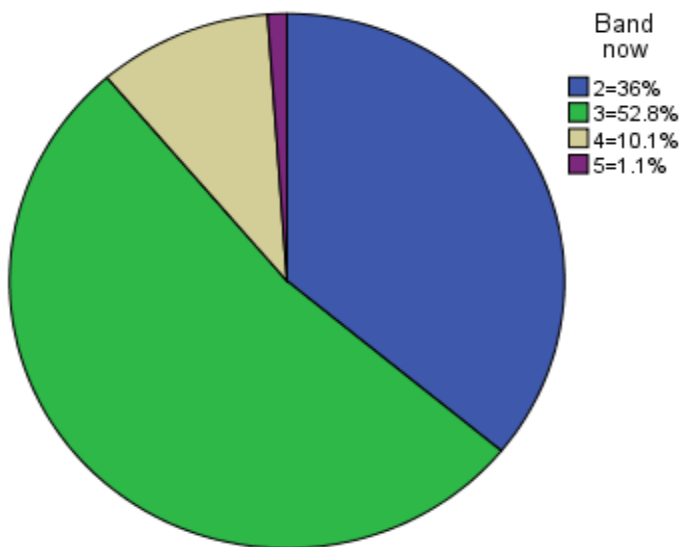
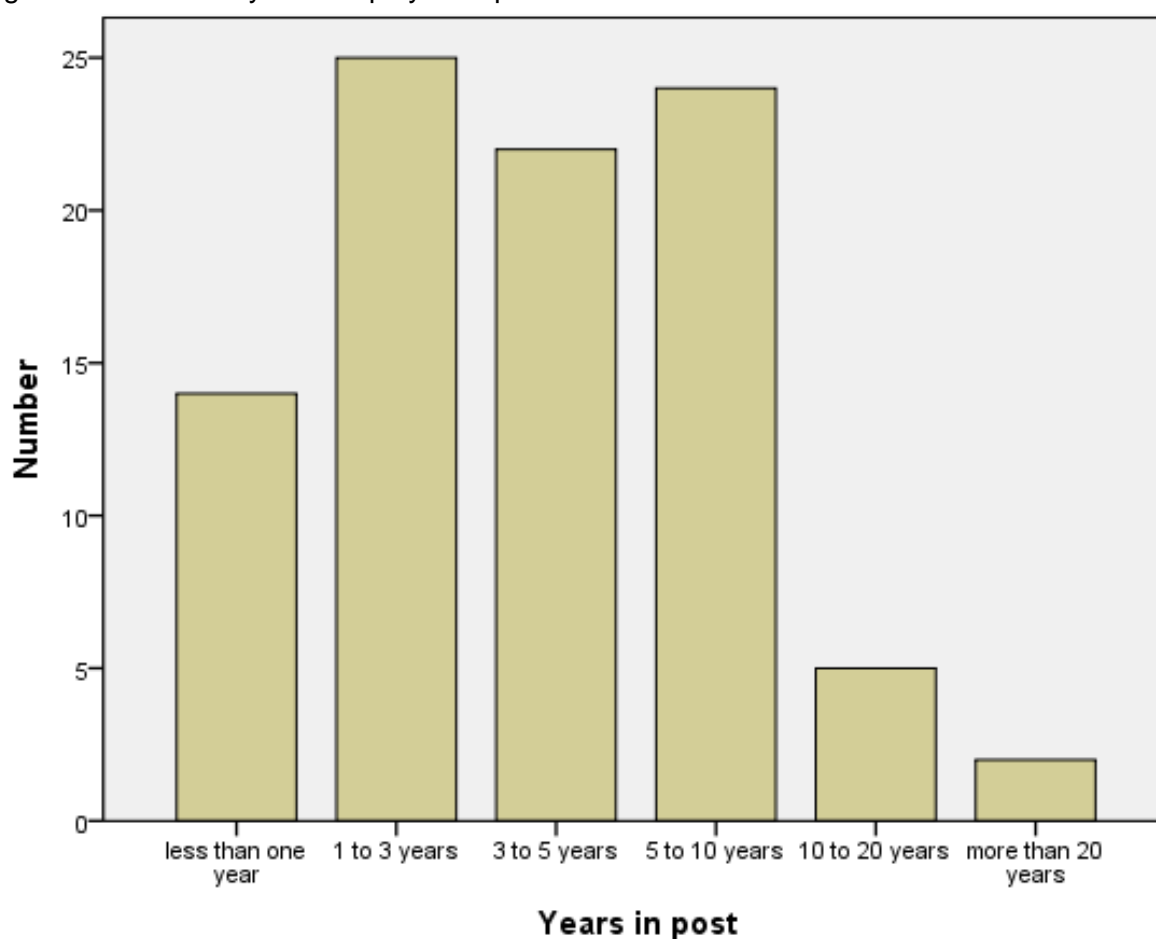


Figure 3: Number of years employed in post



#### ***4.2. Assistant Practitioners perceptions of their current role***

In the literature Wakefield et al (2009) described a framework to categorise the job descriptions of Assistant Practitioners (see literature review). To capture the participants' perceptions of their current role in relation to the work of registered practitioners, questions 4-7 in Section One asked respondents to indicate whether they support, or take on the role of for registered practitioners, and whether they are supervised or work independently.

The vast majority of respondents 88/92 (95.7%) saw their role as supporting the work of registered practitioners, with 69/89 (77.5%) only sometimes or rarely taking on the work of a registered practitioner, although there were 20 (22.5%) who reported that they always or mostly take on the role of registered practitioners. An interesting anomaly arises where 40/92 (43.5%) report being supervised in their role always or most of the time, with 35/92 (37.6%) supervised some of the time and 17/92 (18.3%) rarely supervised. Yet in response to the question about independent working 62/92 (67.4%) state that they work independently always or most of the time. This could be explained by a lack of understanding of the



questions, or of what it means to work independently, or whether supervision is direct or indirect.

### **4.3. Education and training**

Section Two of the questionnaire asked the participants about their education and training and also about their grading prior to starting foundation degree. Comparing the grades prior to starting the foundation degree with current grade it was found that 8/86 (9.3%) had been promoted, most changing from band 2 to band 3, although two had changed from band 2 to band 4.

Only a small proportion of the sample 10/92 (10.9%) had completed the Foundation Degree (FD). The FD was thought to be a good basis for the Assistant Practitioner role by 88% of the overall sample; however it was also thought to be challenging by 93.5%. Despite this 76/93 (81.7%) would consider further study in the future.

Academic support from the University was thought to be good with 80.4% strongly agreeing or agreeing that the level of academic support was good. Unfortunately only 55/92 (59.8%) experienced a good level of support in the workplace for undertaking the foundation degree, and although 90.3% had a workplace mentor, 42.7% reported that their mentor was only sometimes or rarely available to them. A number of the written comments (12) in response to the open question at the end of the questionnaire inviting respondents to add additional feedback about their experiences of undertaking the foundation degree or their current employment raised issues around support in the workplace and access to mentors. The following comment is illustrative of the majority of views expressed

*“We are students but because we also work full time we are not treated as students therefore we are not given time to study and develop clinical skills. We do not have enough time with mentors we need supernumery time.”*

Participants were also asked whether undertaking the FD provides opportunities for career progression and 75/92 (81.5%) strongly agreed or agreed with this statement, with one respondent writing that the award of the qualification was essential for their career progression. However, several also expressed disappointment that there would be or had been no opportunities to progress in their current department as the following quote demonstrates...

*“I was hoping to become an Assistant Practitioner in my department and that has not happened. I believe I have proved myself after completing the course but to date there have been no opportunities for career progression forthcoming which I find disappointing.”*

In addition to the overall impression that undertaking the FD provides an opportunity for career progression 92.4% of the respondents reported that they were more confident in their work as a result of undertaking the FD. But only 41/92 (44.6%) felt that they had been given

more responsibility as a result of doing the FD, with 35 (38.1%) disagreeing that they had been given more responsibility.

#### 4.4. Impact of Assistant Practitioners in the work place

The questions in Section Three explored views of the respondents on the impact of Assistant Practitioners in the workplace. The first question asked whether the presence of assistant practitioners enhanced service delivery and 66.3% agreed or strongly agreed that Assistant Practitioners enhance service delivery, with 28.3% being unsure as to whether Assistant Practitioners made a difference to service delivery. Perhaps unsurprisingly 89.2% believe Assistant Practitioners are effective at communicating with service users, and 87% think that Assistant Practitioners provide consistent care.

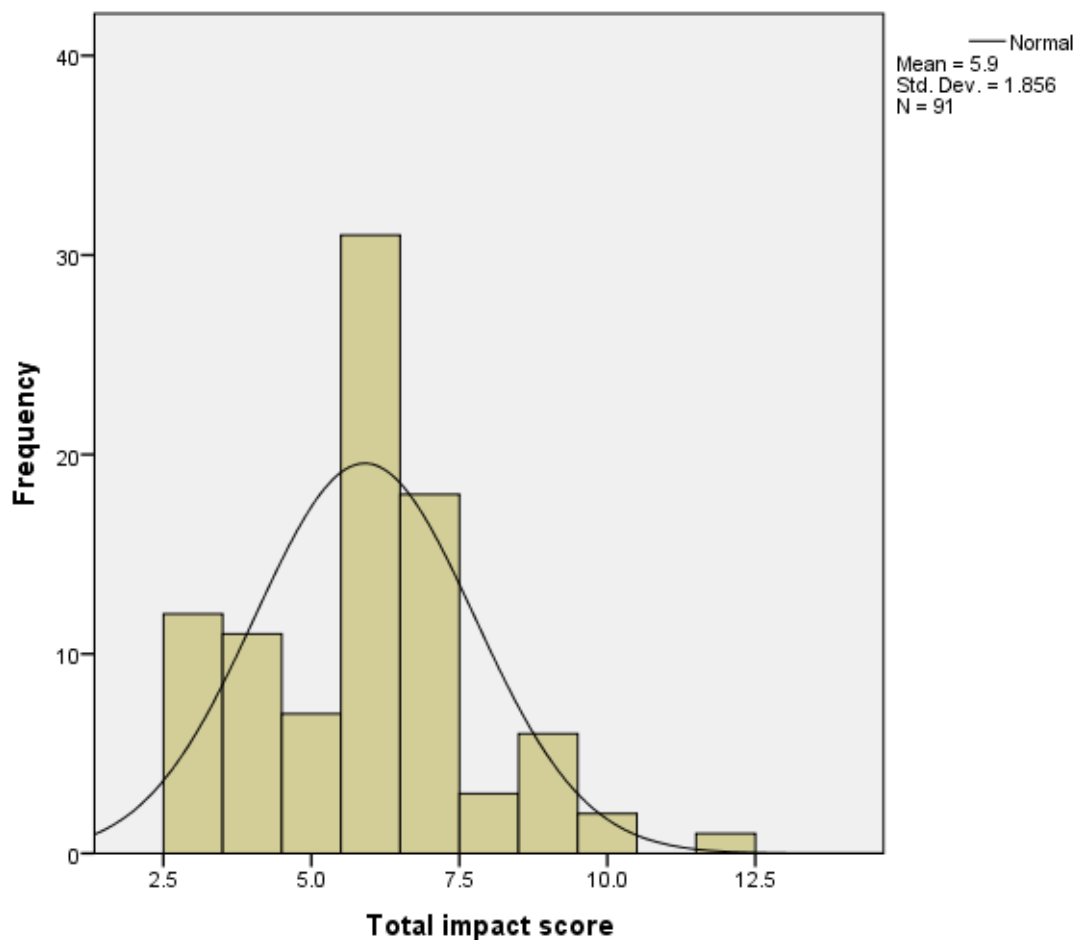
To assess how positively each of the respondents perceive that Assistant Practitioners impact on the workplace the responses to questions 1,2, and 3 in section 3 were added together to create a total impact score. The questions were as follows:

S3 Q1- The presence of assistant practitioners in a term enhances service delivery.

S3 Q2- Assistant Practitioners are effective at communicating with service users.

S3 Q3- Assistant Practitioners are able to provide consistent care for service users

Figure 4 Impact of Assistant Practitioners in the workplace



This provided an overall score (see Figure 4). The scores could range from 3 (a strong positive response) to 15 (a strong negative response). It was found that the range was 3 to 12 with a mean value of 5.9 (Standard Deviation 1.85). This suggests that respondents overall perceive the impact of the assistant practitioner role in the workplace to be positive.

The questionnaire also asked the respondents about their perceptions of the attitudes of registered staff working with them, whether they thought registered practitioners felt threatened by the Assistant Practitioner role, and whether registered staff valued the Assistant Practitioner role. The results suggest that the Assistant Practitioners perception of staff attitudes to the role are generally negative, with 38% believing that registered staff were threatened by the role, and only 33/91 (36.3%) thinking that the role was valued by registered staff, with 45/91 (49.5%) unsure if other staff value the Assistant Practitioner role.

Although there appears to be uncertainty about the role and its value, individual levels of competence do appear to be mostly recognised by the registered practitioners around them with 67/93 (72%) believing that other staff knew their level of competence. The majority of managers of the department where respondents worked were supportive the role (67.7%) with 21 (22.6%) of the respondents being uncertain as to whether the manager was supportive or not. Again to assess how positively the respondents think that registered practitioners view the role of the Assistant Practitioner in the workplace the responses to the following questions were added together to give an overall rating.

S3 Q5- Some registered practitioners feel threatened by the Assistant Practitioner role (because this was recording a negative attitude the scores for this question were reversed i.e. strongly agree [1] was recoded as 5, and Agree [2] was recoded as 4 etc.)

S3 Q7- The registered practitioners I work with value the Assistant Practitioner role

S3 Q8- My manager is supportive of the Assistant Practitioner role.

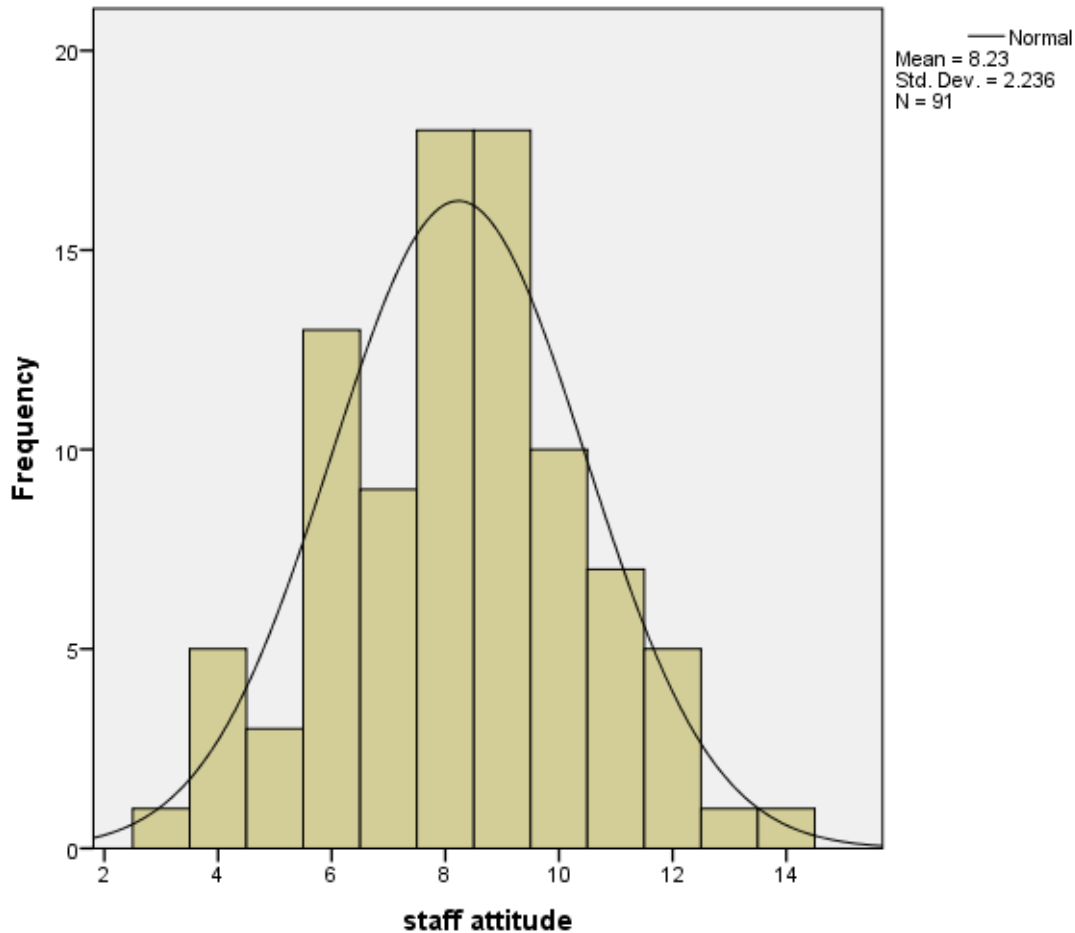
Again this provided an overall score related to perceived staff attitudes (see Figure 5). The scores could range from 3 (a strong positive response) to 15 (a strong negative response). It was found that the range was 3 to 14 with a mean value of 8.23 (Standard Deviation 2.24). This suggests that respondents overall are less certain that those working with them view the introduction of the assistant practitioner role in the workplace positively.

Among the written comments there were a number of references to the uncertainty of registered practitioners around the Assistant Practitioner role and the need for more clarity and recognition of the role. For example...

*"I feel in my area of work my colleagues are unaware of what the course involves. I feel there are barriers between senior-staff- possibly due to them not being aware of the associate practitioner role. The role is still quite restricted in my workplace and not always valued."*

*“There are no clear guidelines for my role as a band 4 and I have come against some hostility from other health care assistants who have been in their role for a lot longer than I have. I am well supported by both my ward manager and deputy sister though”*

Figure 5 perceived staff attitudes to Assistant Practitioner role



*“I do believe that Assistant Practitioners are a useful addition to the team. However, I strongly believe that the role of an AP would be much more effective if we had more distinction and understanding of our role. The term ‘glorified support worker’ springs to mind and this is somewhat demeaning considering the effort needed for the course”*

The final question in Section 3 asks the respondents whether they think there is potential for more Assistant Practitioners to be employed in their area of work, 40 out of the 93 (43%) agree/strongly agree that there is potential for more Assistant Practitioners to be employed, and 39/93 (41.9%) were unsure.

#### **4.5. Responses to the open question**

Thirty nine of the respondents wrote additional comments on the questionnaires some of which have already been presented above. There were five main themes identified: career progression, staff attitudes, support, and uncertainty surrounding the role and confidence.

##### Career progression

The issue around career progression was centred round the lack of opportunity for career progression on completion of the Foundation Degree and frustration was expressed that once the FD was completed that there was no guarantee of an Assistant Practitioner post for most people.

*“Biggest problem is lack of jobs/positions within my Trust for qualified Assistant Practitioners many just return to previous role of health care support worker”*

##### Staff attitudes

The staff response to the AP role was very variable, some reported that they were well supported by their manager and senior staff, whilst others experienced resentment from registered staff and also from other Health Care Assistants working with them.

*“Other health care support workers resent the fact that I am on this course and some of the registered staff also feel this way”*

##### Support

Part of the problem with support in the workplace lies with identity, as students the respondents require support from their workplace mentor and others in the team, however they also work full-time and are considered full time members of the workforce, and as a result it can be difficult for people to get time with their mentor, time for study and also to have opportunities to learn new clinical skills.

*“Although there are some staff who want to support us the majority do not being so busy on the ward and always counted in the number there is never enough time to work with mentors”*

##### Uncertainty surrounding the role

There appears to be a lack of recognition and understanding of the Assistant Practitioner role and also what is involved in undertaking the Foundation Degree and the skills and knowledge gained through completing the course. However, this is not just at a team level but also at an organisation level as Assistant Practitioners wear the same uniform as Health Care Assistants and some appear to be put on the course with no clear idea of whether job will be available in the future.

*“In my area of work many of my colleagues are unsure of my role and where I fit into the team. My role is still to be defined by my ward and the Trust I work for”*

## Confidence

Six of the respondents reported that a result of undertaking the course they felt more confident and their knowledge and understanding had increased and they valued the experience overall.

*“Since starting this course I have more confidence in challenging situations”*

This project aimed to explore the perceptions of different stakeholders of the impact of the introduction of the assistant practitioner role in practice, explore the scope for further implementation, and to examine the perceived barriers and facilitators to the successful introduction of the role. In the following section the findings from the interviews and the surveys will be examined in depth to address the study objectives, in addition the education and training of assistant practitioners will also be discussed.

## **5.0 Discussion and Conclusions**

Essentially the study has found similar findings to that reported in the literature which suggests that the position locally has not shifted significantly over the past few years despite the increasing fiscal pressures on services. There are champions of the role who are enthusiastic and are driving the implementation of the role forward, but implementation overall remains patchy across the two counties. There are still health care assistants and senior health care assistants being funded to undertake the foundation degree, and there are some trainee assistant/associate practitioner roles in existence, which could suggest that the role is gradually gaining wider acceptance.

### ***5.1. Stakeholder perceptions of the impact of practitioners in practice***

The views of those interviewed in respect to the implementation of the assistant practitioner roles appear to reflect national policy with regard to the potential impact in terms of re-configuration and the skill mix balance. For some of the participants the introduction of the AP role was perceived to provide the opportunity for task delegation as outlined by Wakefield et al (2010). Through this process the skill mix is rebalanced thus freeing registered practitioners to undertake more advanced work by reducing the requirement for them to perform more basic tasks. This was identified as giving greater flexibility within the team and enabling registered staff to specialise and diversify, whilst appropriate care is provided by the assistant practitioners. In the survey this was supported by the respondents who saw the introduction of the AP role as a positive; enhancing service delivery, effectively communicating with service users and delivering consistent care. However, despite the potential for registered staff to extend their level of practice, in the survey over a third of the respondents agreed that registered practitioners felt threatened by the introduction of the role, and only a third reported that the role was valued by other staff. This is perhaps contrary to what may be expected if registered practitioners saw the new roles as opening up opportunities for them.

This may be explained by protectionism – the desire to maintain control of the tasks undertaken and indeed a few interviewees did remark that some registered staff hold on to tasks. There is the threat of substitution, and the concern that band 5 posts will be lost. Therefore whilst task delegation downwards is a desirable from a management perspective in terms of ensuring that expensive qualified staff are not taking on tasks that could be performed by suitably trained individuals on a lower band, this can cause issues for some staff. There were a fifth of respondents to the survey who described themselves as taking on the role of registered practitioners and it this ‘substitution’ of qualified registered staff which was reported in the literature as a concern for qualified staff (Buchan and Dal Poz 2002).

The assistant practitioner role was also perceived as being a method of bridging the gap between the between health care assistants on band 3 and the registered nurse. There are senior care assistants carrying out slightly extended roles and AP role was described as an opportunity to be an incentive to reward and retain good staff

## **5.2. The scope for further implementation**

Across the two counties there are examples of assistant practitioners undertaking the range of roles seen nationally. Indeed, there are examples of innovation and good practice which could be built upon, both in terms of specific clinical roles and in the strategic approaches to the implementation of the AP role. In some organisations the assistant practitioner role had been embedded through the drive and enthusiasm of senior managers, and past experience of introducing assistant practitioners could accelerate the pace of change. When making changes organisations who took a strategic approach to implementation engaged different levels of staff to minimise resistance. Organisations often found it more difficult to place assistant practitioners in inpatient areas compared to specialist or community settings.

Several interviewees made the point that the introduction of assistant practitioners should be part of wider workforce planning and service re-design. It appears that in the majority of cases assistant practitioners have emerged through local initiatives by clinical leaders, and in some specialist areas roles have evolved around an individual. When considering the further implementation, the care pathway appears to be the most effective place to start as this is focussed on the needs of the patient rather than the individual or a specific professional group. It was surprising that in the survey more of the respondents weren't supportive of there being more assistant practitioner roles in their place of work.

## **5.3. The barriers to implementation of assistant practitioners into the workforce.**

In some organisations, successful implementation is perceived to require external strategic drivers because without this the organisation would not be prepared to risk investing in a new and untested role. This is contrary to the view expressed by Spilsbury et al (2009) who reported that assistant practitioner roles introduced in response to the perceived needs of the organisation were viewed more positively and with acceptance compared to those enforced by an external agency. It is important however to consider the distinction between external forces that appear to "demand" compliance without consultation and an external influence that makes the case for a role, provides long term commitment to it and works in partnership with the provider organisation to redesign services. It appeared that greater support to consider how services could be redesigned and the potential for the AP role to contribute may have given some organisations the confidence to consider the role more effectively. Interviewees also felt constrained by financial challenges and ongoing structural reorganisations, and some held the view that there was currently no evidence of effectiveness of the role, both concerns expressed in the Spilsbury et al study (*ibid*). In the same way that a champion of the assistant practitioner role can facilitate the introduction, entrenched negative views of senior staff can create a barrier to the implementation of the role.

## **5.4. Education and training**

The majority of the respondents who completed the questionnaire were currently undertaking the Foundation Degree at either ARU or the University of Essex. Most of these individuals were employed on Band 2 or 3. In the interviews it emerged that staff may be encouraged to enrol on the FD so they are prepared when posts become available. In some cases staff are offered training assistant practitioner posts when they start the programme, and others advance to band 4 midway through the programme. The survey data also shows



that a large number of the respondents have been in post for many years. Undertaking the Foundation Degree should increase individuals' knowledge and understanding of the procedures and tasks they perform on a day to day basis and this in itself is a positive outcome. However, if people are encouraged to undertake further education, in order to avoid disappointment and frustration, managers need to explain the implications for career progression. The advantages of the FD as a qualification should mean that the skills and knowledge gained should be transferable across different organisations. The majority of the respondents were students on the foundation degree employed on Bands 2 and 3, so a further study should be conducted contacting previous students who have completed the FD to determine where they have been working since completing. It had been hoped that these people would be captured through the distribution of questionnaires in the workplace but this did not prove to be an effective means of reaching this group, and it may be better to send questionnaires to the last known home address.

There were issues identified by the survey respondents regarding the level of support they experience in the workplace and also the access to their workplace mentors. Wareing (2011) conducted a qualitative study of workplace mentors and interviewed mentors supervising health care assistants undertaking the Foundation Degree. It is noteworthy that mentors also found it a problem for the students being recognised as a learner in their own right and were unable to relinquish their previous identity as a HCA. There was also an issue around the lack of awareness of the Foundation degree, and the nature of work-based learning which further support the survey findings.

## **5.5. Conclusions**

- Across the two counties, APs are undertaking a range of roles comparable to that seen nationally. However, their deployment is patchy and in most cases numbers do not reach the critical mass necessary to make a significant service impact.
- In some cases, genuine innovation is taking place which deserves to be more widely known and understood.
- There are inconsistencies in how organisations view the nature of the AP role, its links with grading, and which staff should or could be defined as APs.
- Introducing APs can be a way of building a more flexible and cost effective workforce to enhance organisational resilience and enable more patient-centred services.
- While *ad hoc* local initiatives can improve patient care, substantial organisational benefits are best realised by adopting an organisation-wide strategy.
- Leaders of organisations where the AP role has been embedded are characterized by personal commitment and enthusiasm, high expectations, effective analysis of workforce needs, and expertise in leading change.
- Organisations which have introduced the AP are not taking the opportunity to publicise their successes.
- There appears to be a mismatch between the perceived level of competence of APs and how they are valued by registered staff, and this needs to be addressed if registered staff are to accept further implementation of the AP role.

## **5.6. Recommendations and further work**

- Clarify the AP role, including accessing the views of APs and registered practitioners.
- Undertake detailed case studies to gain a deeper understanding of how organisations can introduce and establish the AP role.
- Run a stakeholder event to encourage dialogue between those organisations which have established AP roles and those yet to make a strategic commitment. The aim would be to show how APs can be successfully introduced into different clinical settings, and to explore alternative forms of sharing experience, such as focused visits, shadowing, joint professional development, learning networks.
- Workplace support for students undertaking Foundation Degree needs to be investigated further.
- Levels of supervision are also a concern and there is a need for clarification regarding supervision of APs and independent working.
- Organisations should be actively encouraged to publicise their successes in local and national media outlets.

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## Appendices

### **Assistant Practitioner (AP) project interview schedule**

1. Do you have APs in your organisation?
2. If not, have they been considered, and why were they rejected? Can you tell me about the decision-making process which led to their introduction (or non introduction)?
3. How would you describe the organisation's attitude to APs?
4. What would you say are the main advantages and disadvantages of APs?
5. How many APs do you have working in your organisation? If not known at this stage, how can we find out? What salary bands are used for APs?
6. What roles do APs undertake in your organisation?
7. Did an individual (a 'champion') or group promote the introduction of the role? If so, what was their status in the organisation?
8. Have you been involved personally in establishing any AP roles?
9. What are the main challenges to introducing APs in your organisation?
10. How can barriers to the introduction of APs be overcome?
11. What were the attitudes of existing staff to the introduction of APs?
12. How did you prepare existing staff for the introduction of APs?
13. In which areas have APs been most successful?
14. What were the main factors influencing this success?
15. Are you aware of any areas where the introduction of APs has failed or been problematic?
16. What were the reasons for failure?
17. What training and support is provided to mentors and supervisors of APs?
18. What do you think are the educational/training needs of APs?
19. What opportunities for career progression exist for APs?
20. Would you like to put forward any exemplars/case studies for the report?



Cover letter survey

## **What are the key factors in the successful implementation of assistant practitioner roles in a health care setting?- A service evaluation**

We have been commissioned by the East of England Local Education and Training Board (LETB) to examine the local Assistant Practitioner workforce and determine where the role has been implemented, and identify the key factors which facilitated their successful introduction. An important part of this study is to find out about the experiences of people who are working as Assistant Practitioners and who are undertaking or have completed the Foundation Degree.

This survey asks questions about your current job role, your education and training, and your views on the impact of the Assistant Practitioner role in your place of work. It is hoped that the information gathered in this study will be used to facilitate the introduction of Assistant Practitioners in the future. We would value your contribution to this study, but your participation is voluntary and we would understand if you do not want to take part.

The questionnaire is anonymous, please do not put your name on it, and to maintain confidentiality only members the research team will have access to the information provided. Once you have completed the survey please return it to us in the envelope attached, If you would like further information you can contact Hilary Bungay on telephone number xxxx or via email xxxx

Thank you for taking the time to read this.

The Research Team

Sue Lord Anglia Ruskin University  
Jo Jackson University of Essex  
Hilary Bungay Anglia Ruskin University



# What are the key factors in the successful implementation of assistant practitioner roles in a health care setting?- A service evaluation



*There are no right or wrong answers to the questions in this survey. We are interested in finding out about your views and experiences. Please try and answer as many of the questions as you can, the results of this survey may inform workforce planning and help assistant practitioners in the future.*

## **Section 1**

*The following questions ask you about the job you are doing now*

1) What is your current job title?

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2) What band are you currently employed on?

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3) How long have you worked in your current position?

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*For each of the following questions please circle the answer that comes closest to the way you feel about your current practice*

**4) In my role I support the work of registered practitioners**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

**5) I take on the work of a registered practitioner**

*Always      Most of the time      Sometimes      Rarely*

**6) I am supervised in my role**

*Always      Most of the time      Sometimes      Rarely*

**7) I work independently in my role**

*Always      Most of the time      Sometimes      Rarely*

## Section 2

*The following questions ask you about your education and training*

- 1) When did you start the Foundation Degree? \_\_\_\_\_
- 2) When do you hope to complete/ when did you complete (please delete as appropriate) the Foundation Degree? \_\_\_\_\_
- 3) Before you started the Foundation Degree what band were you employed on? \_\_\_\_\_

*For each of the following questions please circle the answer that comes closest to the way you feel about the education of Assistant Practitioners*

- 4) **The Foundation Degree provides a good basis for the Assistant Practitioner role**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

- 5) **The Foundation Degree is challenging**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

- 6) **The University provides a good level of academic support for people doing the Foundation Degree**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

- 7) **Staff in the workplace are supportive to people undertaking the Foundation Degree**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

- 8) **Doing a Foundation Degree provides opportunities for career progression**

*Strongly Agree      Agree      Not sure      Disagree      Strongly Disagree*

- 9) **Undertaking the Foundation Degree gives me more confidence in my work**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**10) I feel that I have been given more responsibility because of studying for the Foundation Degree**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**11) I would consider undertaking further study in the future**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**12) I have a named workplace mentor      YES/NO**

**13) My workplace mentor is available to me**

*Always*      *Most of the time*      *Sometimes*      *Rarely*

### ***Section 3***

***For each of the following questions please circle the answer that comes closest to the way you feel about the impact of the Assistant Practitioner role in your workplace.***

**1) The presence of Assistant Practitioners in a team enhances service delivery**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**2) Assistant practitioners are effective at communicating with service users**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**3) Assistant Practitioners are able to provide consistent care for service users**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**4) Service users are able to identify Assistant Practitioners from other members of staff**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**5) Some registered practitioners feel threatened by the Assistant Practitioner role**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**6) The registered practitioners I work with know what my level of competence is**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**7) The registered practitioners I work with value the Assistant Practitioner role**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**8) My manager is supportive of the Assistant Practitioner role**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

**9) There is potential for more Assistant Practitioners to be employed in my area of work**

*Strongly Agree*      *Agree*      *Not sure*      *Disagree*      *Strongly Disagree*

*In the space below please add any points you would like to make about your experiences of undertaking the Foundation Degree or your current employment as an Assistant Practitioner (Please continue overleaf if you wish)*

***Thank you for taking the time to complete this questionnaire***