Evaluation of Assistant/Associate Practitioner Roles across NHS South Central.

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Acknowledgements

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Executive Summary

The need to develop a flexible workforce that can work across professional boundaries, is focused upon the needs of patients and is responsive to change, is a driving force behind the development of new roles such as the Assistant/Associate Practitioner (AP). Within the Learning for a Change in Healthcare report, a recommendation is made to develop progression pathways into AP roles. It is suggested that this will help to realise a number of benefits, including: Ensuring that sufficient staff are available in the future to provide new, innovative, high quality services which meet changing patient needs, achieving lower levels of staff turnover, increasing recruitment and improving staff morale and commitment. A High Quality Workforce, NHS Next Stage Review (2008) states that changing roles and service reconfigurations will mean that education and training of the wider healthcare team (staff in bands one to four) will be increasingly important if we are to continue to deliver and build on the high quality care that patients expect and deserve.

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

The purpose of this report is to explore the roles currently performed by APs across NHS South Central, assess the benefits and challenges they bring to local teams and consequently inform future development of the role.

Where established within NHS South Central, the AP role has been recognised as contributing greatly to the skills mix of a team. Often AP roles are flexible and they are able to cross professional boundaries, for example physiotherapy and nursing. Managers are able to have a greater number of staff, leading to an increase in service delivery and patient care without higher staffing costs. The role enables registered staff to be freed to perform more complicated clinical tasks as APs undertake the routine tasks and assume responsibility for the supervision of staff in bands one – three. Additionally more space is created for the registered staff to focus on their own CPD.

The development of the AP role, and allied training, has provided opportunities for career progression for many previously unable to move beyond the position of healthcare assistant. This has led to a renewed interest, commitment and drive in their working lives, and an increase in personal self esteem. The ability to continue earning whilst learning was an important element of the scheme. The establishment of the role has not been without its problems, however, many of these are now historical and the full report shows how managers and their teams have worked together to overcome these.
1. Introduction

Across NHS South Central approximately 24,000 staff are employed at Agenda for Change bands one to four, constituting 37% of the total workforce population. Within this group the majority of staff are employed at bands two and three, with fewer posts at band four, see Diagram One. The need to develop a flexible workforce that can work across professional boundaries, is focused upon the needs of patients and is responsive to change is a driving force behind development of new roles, such as the Assistant Practitioner (AP). 1

Diagram One

In NHS South Central, APs are defined as being involved in the delivery of healthcare with a level of knowledge, skill and competence beyond that of a traditional healthcare assistant/support worker. They assume responsibility for delegated aspects of healthcare delivery which may previously have only been within the remit of registered practitioners.

The AP works within a scope of practice under the direction or supervision of a registered practitioner within relevant legal and ethical frameworks and in accordance with organisational protocols and policies. 2 They are educated to Foundation Degree level or equivalent and employed at a minimum of Agenda for Change band four.

Within the Learning for a Change in Healthcare report, a recommendation is made to develop progression pathways into AP roles. It is suggested that successful progression routes into roles such as the AP, will help to realise a number of benefits, including: Ensuring that sufficient staff are available in the future to provide new, innovative, high quality services which meet changing patient needs, achieving lower levels of staff turnover, increasing recruitment and improving staff morale and commitment.

2 SCSHA Code of Conduct for Assistant/Associate Practitioner http://www.nesc.nhs.uk/research_and_innovation/widening_participation/ap_development.aspx http://www.nesc
A High Quality Workforce, NHS Next Stage Review (2008)\textsuperscript{3} states that changing roles and service reconfigurations will mean that education and training of the wider healthcare team (staff in bands one to four) will be increasingly important if we are to continue to deliver and build on the high quality care that patients expect and deserve.

To inform development and expansion of the AP role an evaluation of existing AP posts has been undertaken across NHS South Central. The purpose of this report is to outline the main findings of this study, exploring the roles which APs perform and assessing the benefits and challenges they bring to local teams. Information regarding the current activities of APs and the sharing of best practice will help inform future development of the role.

2. Methodology
The evaluation included the perceptions of APs and their managers regarding benefits to service delivery and patient care. It did not include the perceptions of patients. Individual interviews were conducted with 12 APs and one service manager. Questionnaire responses were received from four APs and five managers. The questions were largely open ended with participants given the opportunity to make additional comments and volunteer to come forward for interview. Areas addressed by the questionnaire included:

- The location of the AP,
- Their current roles and responsibilities,
- Previous training and work experience,
- Training undertaken for their current role,
- Motivation for attaining the AP post, and
- Benefits the AP felt their role brought to service delivery and patient care.

Responses were received from APs and managers in the following fields: Radiography, Radiotherapy, Breast Screening, Rehabilitation, Community Nursing and Medicine for Older People. The questionnaire responses provided the focus for areas to pursue in greater depth during the individual interviews.

All interviews were conducted by the NESC Research and Development manager for continuity. No interview lasted longer than an hour. Participants were sent written information about the aims and objectives of the study and consent forms prior to taking part. Participants were informed that all names would be anonymised in the final report and all data will be held in accordance with the Data Protection Act 1998. The interviews were transcribed verbatim and were returned to the participants for their comment and to confirm accuracy prior to use in this report. Participants were informed that they would be able to withdraw from the study at any stage but all have chosen to continue.

Whilst acknowledging that the participants of this evaluation were self selected, the correlation between the findings of this study and those of larger studies would suggest that the views expressed here are representative of APs in other areas of the country.\textsuperscript{4}

The Transcripts were analysed to uncover predominant themes amongst APs in South Central and these findings form the basis and structure for the sections listed below.

2.1. Assistant/Associate Practitioners – where are they located?
To locate existing Assistant Practitioners contact was first made with the NHS Workforce Review Team (WRT) and then subsequently with the Workforce Strategy Team of South Central Strategic Health Authority (SCSHA). Figures provided by this team, based on returns as at August 2007 indicated that there were 40 members of staff listed as Assistant Practitioners working at Agenda for Change (AfC) band four within NHS South Central. A review of these figures in June 2008, this time broadening the search terms to include ‘Associate’ as well as ‘Assistant Practitioner’, but not limited to band four staff, identified 232 members of staff with this title. However, their AfC banding ranged from band two to band seven. The total number of band four staff employed in clinical roles in NHS South Central at August 2007 was 1678, but these staff were not specifically defined as Assistant/Associate Practitioners.

An invitation by the NHS Education South Central (NESC) Widening Participation Manager was sent to all Trusts and PCTs in NHS South Central to participate in the evaluation, through questionnaire or interview. This revealed further members of staff who did not have either ‘Assistant’ or ‘Associate’ within their titles but who, according to the NHS South Central definition of an AP, were considered by their managers to be fulfilling the role of an AP. For example, a member of staff listed as a Clinical Technician, working at band four, under the supervision of registered nursing staff and who had attained the position via completion of a Foundation Degree in Health and Social Care, a recognised qualification and entry route for gaining an AP post. The SCSHA feel it is likely that there are more members of staff working in a nursing capacity who will not have been uncovered by the search terms used.

The interviews showed that titles could arouse great emotion; one AP felt very strongly that she did not want to be called an Assistant Practitioner and preferred her title of Associate Practitioner. In her mind the title of Assistant Practitioner would not differentiate her enough from healthcare assistants.

> I prefer it because ‘assistant’ often signifies that you are not qualified in an area. But as an ‘associate’, we are qualified to a certain degree because we've done the course, we were able to go through all the modules and pass them and come out with a foundation degree...The only thing that we don't do are the drugs at the moment, but we do an awful lot of the other things that the nurses used to do or do do. So I feel that we're associated with them rather than just assisting them.

The lack of cohesiveness surrounding both the title and the AfC banding showed that data from the SCSHA could only provide indicative, rather than definitive figures of the number of staff currently working in an AP capacity within NHS South Central. The lack of standardisation re: either title or banding also suggests that to avoid confusion, clarification is necessary between all parties when discussing the AP role and its future development. As stated above for the purposes of this study an AP is someone who is

http://www.fdf.ac.uk/files/HealthandSocialCare_casestudy.pdf
5 It must be noted that figures generated by the SCSHA are dependent upon the codes assigned to staff by each Trust in their returns.
working at a minimum of band four and is under the supervision of a registered member of staff.

Figures from the SCSHA provide the basis for the table below. This gives the location, field and numbers of those listed as band four Assistant Practitioners in South Central Trusts as at April 2008.

Table 1: Location, Number and Fields of APs within NHS South Central.

<table>
<thead>
<tr>
<th>Location and Field</th>
<th>Number in Trust/PCT</th>
<th>Number in field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and North Hants NHS Foundation Trust</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berkshire Healthcare NHS Trust</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Buckinghamshire PCT</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hampshire Partnership Trust</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hampshire PCT</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Multi Therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Heatherwood and Wexham Park Hospitals NHS Trust</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Isle of Wight Healthcare</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Multi-Therapies</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milton Keynes PCT</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxfordshire Mental Healthcare NHS Trust</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
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<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Oxfordshire PCT</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portsmouth City PCT</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other Scientific, Technical and Therapeutic Staff (STT)</td>
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<tr>
<td>Portsmouth Hospitals NHS Trust</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other STT Staff</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Radiography Diagnostic</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Radiography Therapeutic</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Southampton City PCT</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>
Table 1 shows that of the 15 Trusts and PCTs listed

- Five have one AP
- Four have between two–four APs
- One has seven APs
- Four have between 11-14 APs
- One has 25 APs.

60% of the Trusts and PCTs listed have fewer than five APs, highlighting that APs comprise a small percentage of the total workforce within these organisations, although as stated above there may be more staff working in this capacity who do are not identifiable using the chosen search terms. Using these figures, APs account for 0.4% of the estimated 24,000 staff employed in bands one to four across NHS South Central. Although indicative rather than definitive, these figures suggest that the Assistant Practitioner role is one that could be further developed within teams across South Central especially in those fields where there is a shortage of registered staff. The figures for Southampton University Hospitals Trust currently listed as having the highest number of APs in NHS South Central is inflated by the comparatively large number of APs in radiography. These figures reflect the drive by the Society and College of Radiographers (SCoR) to develop the AP role nationally to combat a continuing shortage of registered staff.6

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6 Home Office, *National Shortage Occupation List*, July 2008. Radiography has been on the list for 6 consecutive years.
http://ukba.homeoffice.gov.uk/sitecontent/applicationforms/workpermits/businessandcommercial/occupationshortagelist.pdf
Table 2: Number of Assistant/ Associate Practitioners within each field across NHS South Central as at April 2008.

<table>
<thead>
<tr>
<th>Field</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>19</td>
</tr>
<tr>
<td>Dental</td>
<td>13</td>
</tr>
<tr>
<td>Dietetics</td>
<td>2</td>
</tr>
<tr>
<td>Multi Therapies</td>
<td>8</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>10</td>
</tr>
<tr>
<td>Other STT staff</td>
<td>6</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>5</td>
</tr>
<tr>
<td>Radiography Diagnostic</td>
<td>25</td>
</tr>
<tr>
<td>Radiography Therapeutic</td>
<td>4</td>
</tr>
<tr>
<td>Social Services</td>
<td>4</td>
</tr>
<tr>
<td>Speech and Language</td>
<td>1</td>
</tr>
<tr>
<td>Therapy</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>97</strong></td>
</tr>
</tbody>
</table>

Table 2 shows that in NHS South Central the largest number of APs are found in radiography, again reflective of the national drive by the profession to develop the AP role. In Southampton University Hospitals Trust, as a result of the shortage of radiographers and problems with recruitment, Existing radiography assistants were provided with support to undertake the Foundation Degree to enable them to qualify as APs. One of the managers commented:

> When I was talking about recruitment, what we figured was that, since it didn’t seem that the universities were churning out enough radiographers, that maybe if we started the process ourselves and actually chose people from an early stage in their career to develop then we could use their skills all the way along. So we could start them off as Assistants and develop onto Practitioners and then, hopefully, if they had the interest they could then go on to do radiography when the opportunity came up. So we’d have a more self-contained workforce really, from stage one right through....

The Assistant Practitioners immediately saw the benefits to the team of the development of their role:

> …the reason we went on the course is because they were so short of Radiographers. So the whole point was that we could do, say, chest X-rays, and things so that the Radiographer, who was fully qualified could be freed up and would then go to Theatre and do other intensive things, barium enemas, and barium swallows and such. So we would be here doing chest X-rays, abdomens, you know small things – the bread and butter work.

In this department APs did not have to wait until they had completed their Foundation Degree to be able to expand their role and utilise their newly acquired skills to the benefit of the wider team. As they completed a module and were signed off as competent they were encouraged to make that area a part of their job if appropriate. The manager stated:
...obviously they can only work within their scope of practice which will only include the modules they've passed. So, if they've passed the dental module they can start doing dentals even if they haven't finished the complete Foundation Degree. And so...as they increase the number of modules that they've successfully passed, we just increase the scope of practice to include those things. And where people might not have had a particular interest in doing something, they might never go into screening because they work in the Cardiac Units, all they do is chest X-rays - that's all that'll be in their scope of practice. So that's how we've defined what they do.

A national shortage of registered mammographers similarly provided the impetus for the development of the AP role in two breast screening units across NHS South Central.

Pharmacy, various branches of nursing, and speech and language therapy are also on the shortage occupation list for July 2008. This, in conjunction with the figures listed above, suggests that there are several potential staff shortage areas in which the role of the AP could be developed across NHS South Central, dependent upon Trust needs. For example, only one AP is listed in the field of Speech and Language Therapy throughout the whole of NHS South Central. A shortage of registered staff has led the Royal College of Speech and Language Therapists, like the SCoR, to encourage greater development of the AP role. Their website provides information for individuals or organisations wishing to develop this role. Whilst acknowledging that the figures within these tables are indicative, rather than definitive, they are able to highlight that the number of APs within NHS South Central is currently small and the role has the potential to be further developed in several areas.

2.2. Where are they now and where did they come from?

Of the 16 APs who took part in this study, eleven are working in Radiography (Therapeutic and Diagnostic), two are working across occupational therapy and physiotherapy and three are in roles allied to nursing. Only one participant had not previously worked in the NHS in some capacity prior to becoming an AP. Twelve had worked as a healthcare assistant or its field equivalent e.g. radiography assistants (RDAs). Two of the APs had overseas registered status and were working at this level whilst awaiting recognition of their qualifications and acceptance from SCoR. Two had previously worked in an administrative capacity. Whilst no comments were made by managers in this study, one AP felt strongly that a previous healthcare background was essential to ensure successful completion of the training and Foundation Degree, and to gain acceptance for the AP role from registered staff.

I think the difficulty with some people going into Assistant Practitioners, just going straight into it, is they don’t – you don’t have the background that you needed. And that was the initial thing that they said...you had to have at least five years experience as an RDA before they would put you on the course. And then, of course the first year they did it, they put people on that –there was a girl that was put on it that was a clerical officer, and that caused more problems with the Radiographers. So I think you need a bit of knowledge as to how a Radiology Department runs.

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8 A conference for Assistant Practitioners is to be run by the Royal College of Speech and Language Therapists in November 2008 and they currently have a working group looking at Assistant Practitioner Education and Standards.
Other APs felt that previous experience as a healthcare assistant was useful but not essential as long as strong support was in place for the trainees with both clinical placements and the academic study and that a proper assessment of applicants had been undertaken prior to commencement of the course.

…the year that came through behind us all flunked, the whole year collapsed…I think some of them found it tougher than they thought academically. Perhaps they weren’t assessed properly before they started the course Perhaps they didn’t have the support as a group that we were able to give each other. I could not have done it without the support of A&B who were training at the same time. We formed our own support group.

…if I remember correctly there were sixteen initially started the course but only eight out of the sixteen graduated. I think a lot of people, even I didn’t realise how hard it would be. There was a medical secretary who left after the first term, she thought she wanted to do it but… And I didn’t realise it was a science degree. If anybody had told me at the beginning it was a science degree I would have run a mile, because I’ve never done science at school… I left school at 15 with no formal qualifications…and so I can’t believe even now, I never realised how well I did because I never had a single re-sit in my exams.

3. Assistant/Associate Practitioner Training Routes - Full-time or Part-time? NVQ, Foundation Degree or Something else?

The qualifications of the APs who responded included:

- Ten Foundation Degrees
- Two BTECs,
- One certificate in FE
- One NVQ3 plus Mammography Occupational Standard M2.0 and
- Two radiography degrees - with registered status abroad.

A Foundation Degree was the most common qualification undertaken by these APs to reach the standards required for their post. Several APs had taken NVQs prior to study for the Foundation Degree. Only one of the APs was not employed in a permanent position whilst training, and took the Foundation Degree as a fulltime student. Most APs were able to continue to work in their positions as Healthcare Assistants or became employed as band three trainee Assistant Practitioners whilst studying and were enrolled as part time students. The ability to ‘earn whilst you learn’ was viewed as essential by most of the APs. One AP who admitted to having become ‘stagnant’ in a previous assistant post, had not been able to see a way forward in their career, because of personal financial commitments, until the department offered funded places on a local Foundation Degree. A reconfiguration of the workforce within the department created a new AP role.9

I always wanted to go forward within the job and do possibly the BSc in Radiography, but because I had mortgage commitments, I had moved in with my partner, I couldn’t give up the work to go back to college full-time because I had these commitments…

9 When this student undertook training financial support for backfill in the department was provided by the Workforce Development Confederation. Currently the department are looking for funding to support future Foundation Degree students.
Other APs had been keen to study but similar financial and family constraints had also prevented them.

Whilst neither the managers, nor the APs stated that training for the role should be limited to Foundation Degrees, the APs who had undertaken both NVQs and Foundation Degrees were of the opinion that the Foundation Degree gave a higher level of understanding and had deepened their critical thinking skills. In their view the Foundation Degree explained not just how to carry out procedures but gave a theoretical understanding and provided an academic background to relevant clinical procedures. Several APs felt that they could now be of much greater benefit to the registered staff that they worked with by understanding more of what the registered staff were trying to achieve. They could anticipate what might be coming next and how best to assist the registered staff.

...you’re very limited in what you’re taught with the NVQ. It’s very practically based...and you’re basically just showing people what you’re capable of doing. Rather with the Foundation Degree you’re actually going into far more depth of radiography, you’re going into the depths of chemistry, biology, physics, and there was just a better understanding of what it was about.

...I could probably do a chest X-ray but I wouldn’t know why I was doing it, as an RDA...you knew all about the positioning and how to talk to a patient and everything but it was the reasons why, all the technical knowledge behind it that it (the FD) gave me.

You’re not just doing something; you’re understanding the reasons behind what you’re doing...it’s a more holistic view isn’t it? Whereas I think when you’re being delegated a job as, say, a care assistant you’re just doing it but don’t know why you’re doing it.

I feel that, now, with the knowledge that I’ve got I’m – I see things better...I used to hear Healthcare Assistants say ‘Oh we’re as good as nurses, we only don’t do the drugs’. Lots of HAs say that. But I’ve actually turned round since I’ve done this (FD) and said, ‘No, you’re not. You think you are but you’re not. And the thing is you don’t do anatomy and physiology. You don’t know how things work, so, until you do you can’t say that. I might have agreed a bit with you once before but I certainly don’t now’. I think there’s a big difference, there is a definite difference...You had to go and do all the reading up. You didn’t have reading like that to do in the NVQ, nothing like. Some of the things – I had 40/50 different references for essays. So you wouldn’t do things like that on an NVQ, it was totally different.

The Foundation Degree empowered APs to feel more confident in exercising their own judgement, proposing changes that might be made to patient care and in the management of their own caseloads. One AP highlighted that the deeper understanding provided by the Foundation Degree had given them a greater awareness of the things that could go wrong, especially with invasive skills. For this AP it brought home the limits of his knowledge and skills and ensured that he was in no doubts about the boundaries of his scope of practice and the reasons for this. A more holistic approach to work had been the result of study for one AP.
...it certainly changed my attitudes and improved my – sort of holistic approach. Instead of thinking you’re not walking very well, you’ve got a dodgy hip, it’s what has caused that bad hip and what other degenerative signs should we be looking for in other areas and is it just the hip?...I found it absolutely fascinating and it makes me I think and hope, a better practitioner now to be looking out not just for the conditions that the patients are complaining of, but to take a whole look at their physical situation now and the way they want to live and their goals and their aspirations to get a better overall picture of how we can improve it.

In some cases where there had not been an appropriate Foundation Degree available managers worked hard to find a combination of courses that could be studied to give the AP the qualifications considered necessary for the field. A Manager of a one Breast Care Unit explains:

> in addition to an NVQ 3 in Health (AHP Support-Clinical imaging) APs had to complete the M20 unit followed by internal training in taking mammograms where they will be signed off externally as competent by the Jarvis National Breast Screening Training Centre in London, once they have completed 500 mamograms.’

Apart from one, all of the APs had undertaken their study and training as mature students. Most had found the study and training hard whilst continuing to work as an assistant, often with family responsibilities too, but all interviewees exuded a tremendous sense of elation with their achievements. For several who did not feel they had reached their potential at school it had been a second chance to achieve. Three discovered that they were dyslexic but managed with appropriate support to complete the course and, like the other respondents, are keen to undertake further study. Above all there was excitement that a healthcare assistant’s post was no longer the end of career progression for those below registered status.

> I was an RDA, which is a Radiology Assistant for 14 years, and there was no expansion for the job. So you were an RDA and it didn’t matter whether you’d been there 10 years, 15 years, 5 years. The top of the pay scale was the top of the pay scale and there was nowhere to go...And then the Assistant Practitioner thing came up... so they put two of us forward from this hospital.

So successful has this AP been that their manager is now fighting to gain band 5 status for them in recognition of the high standard of their work and the contribution that they make to the team and the department. Most of the APs had a sense of renewed enthusiasm and commitment to their posts, a belief that the skills escalator could now apply to them and was not solely the province of registered staff. The skills escalator was now real and tangible.

4. Training Issues
Several of the respondents were amongst the first in their organisations to become APs and undertake the Foundation Degree and have now been working as APs for two to three years. Consequently some of the problems that they encountered are historical and have since been overcome, or departments are working together to resolve them. The APs initially encountered a fear amongst registered staff that their professional roles were being eroded by the development of APs. One AP cited the fear of nurses that they were being deskilled.
Registered staff related that they were unhappy about having to take on personal professional accountability for staff who would eventually work remotely from them, for example, APs delivering healthcare out in the community. This tension often added unnecessary stress to the APs whilst training. One AP spoke about having to develop ‘broad shoulders’ in order to cope. APs found the most successful way to overcome this fear was by constant communication between Managers, APs and the registered staff. One manager ensured that occasional meetings were held with each group separately so that views could be honestly aired without fear of upsetting colleagues. This enabled the manager to gain a better understanding of perceived problems and subsequently find a way forward.

The APs commented that sometimes it was hard to find mentors able to give them appropriate levels of support whilst on their clinical placements. On the mentors side they themselves were not always sure of the level of skills and competencies required of an AP.

My actual work base was fine, some of the placements weren’t so good. I had a couple of experiences when I felt unsupported in as much as the student nurses were supported but you felt like you were being left, because people knew what student nurses were. Although you said what your needs were, they didn’t seem to include you in anything, whereas they did the student nurses.

In contrast the APs themselves were clear about what they needed to achieve whilst on their placements and were able to define what made a successful placement.

A good placement was a placement that supported you and helped you and showed you what was expected of you…you drew up an agreement, a contract with each placement on what your learning would be in that placement, what they could fulfil within their department. The criteria that you needed to complete for that segment of your university degree. And then, if they couldn’t fill segments in that, could they assist you in anyway to help you get the rest of the segments within that three months, or direct you in who to go and see. But also it was left to you because you’re an adult, the universities don’t run after you like at school.

For all departments, the introduction of the AP role created logistical problems in so much as there was now another level of students competing for clinical placements and this necessitated finding a way to accommodate them. For those APs who were undertaking placements in their normal place of work they sometimes found it hard to fulfil their placement criteria. They had constantly to remind staff that on particular days of the week they were not in the department in their usual capacity as assistants but as Foundation Degree students and as such they had particular clinical tasks that they needed to accomplish. Some had to fight to be able to have study leave and work at home. ‘Our manager insisted that we stayed in the department and did study in case we were needed’. A couple of APs felt that they were occasionally viewed as being obstructive or unhelpful. APs training together developed their own coping strategies to help each other accomplish placement tasks.

When we were doing the first part of the course A and I had difficulty trying to manage our clinical work that we needed to do, so one day I would be the RDA and A would be the AP to do our clinical, and then we would just swap over. I would cover her job and she would cover mine. And if A had done all of the chests that she needed to do
on her book and I hadn't got mine then she would do what I needed and we would just swap over. And that's the way we did it.

One manager felt that the workload and training experience of the APs was made harder when funding was not available for backfill for them whilst studying.

*The APs training could be so much better if the Trust employed staff to cover their previous duties, i.e. employed another helper to take away their old duties from them so that they could concentrate on their training. However, these poor girls are doing two people's roles and struggling.*

Another manager was in a position to address this problem by introducing flexible working and changes in hours to enable the APs to meet their training requirements. In this particular department radiographic staff, now act as trainers and the department education lead acts as point of contact/preceptor to ensure that students have fewer problems and are supported in completing both their academic studies and their clinical placements. APs in another department similarly found the need for someone to act as a link and very much appreciated this role:

*The department appointed a learning co-ordinator. We flagged up holes in our learning and she organised extra tutorials and tailored the learning needs.*

The importance of someone to act as a champion for the AP and be the link between the University and the placement was highlighted by Benson and Smith in their report *delivering the Workforce* (2007), an evaluation of the introduction of the AP role in the Northwest:

*The support needed from practice trainers was often highly intensive as many of the Trainee APs (TAPs) had not studied for many years. Practice trainers acted as key coordinators between the university and the site for the TAP.*

University tutors likewise saw the practice trainers as ‘*absolutely fundamental to the success of the programme***.11

5. **The qualified Assistant Practitioner – employment and use of skills.**

Not all of the APs who were employed as healthcare assistants prior to commencing study were able to move into a band four post on completion of their Foundation Degree. This was despite the belief of several that a position would be available when they finished. Some had to return to their previous healthcare assistant posts, one AP waited two and a half years for the promised post:

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They didn't have a post available for me. They promised us them, but it never materialised. And then AB said – kept saying, ‘Hang in their S, it’s coming, it’s coming, it’s coming’. And eventually, two and a bit years down the line it came in.

Others are carrying out the dual role of healthcare assistant and assistant practitioner because the Trust does not have the money to replace the healthcare assistant post. Those unable to move to an AP post have found it demoralising after what they perceive as a tremendous amount of hard work and effort to have to return to their previous band post, especially when they were encouraged to undertake the study with the belief that on completion, career progression would be almost automatic. In contrast those who studied for the Foundation Degree as fulltime students were aware that they would have to wait for a post to become available and then apply in the normal way.

A few APs have felt frustrated that whilst signed off as competent to practice in a particular area they are not currently able to utilise this training. For example those qualified to give insulin injections or use a defibrillator. One manager noted:

\[\text{The Nursing band 4 Associate Practitioner has not been able to fully meet the requirements of her job description as the Trust does not have policies and procedures in place that would allow her to undertake tasks normally seen to be carried out by qualified nursing staff e.g. insulin injections.}\]

Whilst some managers have been able to overcome this problem through the rewriting of job descriptions and constantly revising the APs scope of practice, others have not found this so easy. One manager holds to the view that the problem could be resolved by a professional register for APs.

\[\text{The role is not included in some policies and so we have had to withdraw some of the tasks originally undertaken and indeed some that the practitioner has received training for. Also there is no professional register which has hampered development in this respect.}\]

Again the issue of the reluctance of some registered staff to either let go skills that they had thought belonged solely to them or the fear of letting unregistered staff practice these skills without direct supervision looms here. The APs themselves were always very clear as to where the boundaries and limits of their scope of practice lay and for the sake of the patients were keen to use all the knowledge that they had acquired. An AP from Radiography explains how supervision and autonomy are balanced in her department:

\[\text{We have all our X-ray request cards checked to make sure that the request matches what the X-ray will be. In the dental room, we work on our own. We still have our cards justified but take X-rays on our own. However, we always ask for help when we need it.}\]

In a very specific area one AP is now signed off as competent to justify her own cards unless the request has come from a ward as opposed to a clinic. ‘I was observed for all the things that I’ve done and then was signed off to say that I can justify my own cards.’ This was a major achievement for the AP, who goes on to say ‘…you can’t just have anybody X-raying someone…You don’t even get newly qualifieds justifying a card.
Newly qualified Radiographers have to wait, I think its three months, before they can look at a card and go, yes that’s ok’. In this department each APs scope of practice is readily available so that new staff who may not understand the AP role can quickly see what activities the AP can undertake. ‘If a new Radiographer comes in they can find the folder and look at the protocols we work to’.

Some APs expressed a desire to attain registered status, in addition to the current voluntary registered status offered by some colleges, because they felt the AP role should have its own professional status. They would like to have accountability for their own actions and this would have the added effect of removing this ‘burden’ from the existing registered staff.

I think we should be registered, I really do…Definitely a level four should be registered, come what may. Because, until you’re registered, they don’t take you seriously because they’re accountable for you. If you’re registered you are then accountable for what you do, full stop. A nurse is accountable for what she does, I’m accountable for what I do but I’ve still got somebody who’s accountable for me if you know what I mean…I think people should be registered because then you are – I think it makes you much more careful about what you do, because then you are accountable for your actions. Much more so than if you are not.

6. Benefits of the Assistant / Associate Practitioner role

6.1 Patient Care

Patient care is the area in which APs are most proud of their roles- the benefits that they can bring directly to patients. Without exception, for the APs who took part in this study, contact with patients was the element that brought the most fulfilment to their working lives. ‘The patients are the most enjoyable part. It’s a vocation, not a job. It’s brilliant, so interesting. You go home and your mind’s spinning’.

There was a strong sense that their roles and their contributions within that role, made a positive difference to the health and wellbeing of the patients and by inference their families. They talked about the continuity of care that they were able to give, they felt that their role permitted more time to communicate with the patients, explain procedures and answer queries. Often they were the member of staff who had the most regular contact with a patient and were therefore in a better position to notice changes and report back if they felt adaptations to the treatment plan were needed. This was felt to be especially important by APs working in radiotherapy:

Because we’re treating all the time and not doing the paperwork duties, we have continuity, so they see us, we’re the same face every day, …and they’re coming every day for treatment, some of them for up to six weeks. Obviously they’re nervous when they come to start with and you ask them how they are every day. We’re not just being polite, we want to know about any changes that are happening to them because of the treatment…if it’s different people you’re seeing each day it’s harder to open up and feel relaxed. So because they’re seeing us every day they build up a trust and so they open up and tell us more perhaps.

One AP working in a rehabilitation role is able to work with, and follow a patient from hospital, to step down bed and finally to home. This team aims, as far as possible, to reach whatever level of mobility and independence the elderly patient had prior to their
hospital visit and the AP plays a major part in the delivery of this treatment plan. 'If they were walking with sticks prior to going into hospital, that’s what we try to achieve for them to go back home with'.

The APs are very conscious that their work frees registered staff to undertake more complex clinical tasks. Two APs working in rehabilitation are able to make initial assessments of straightforward cases before reporting back to the registered staff and together agreeing a treatment plan. These APs then work autonomously and manage their own caseloads, which contributes to cutting waiting lists and allows a larger number of patients to be seen. The AP role often means that there are more staff on the ‘shop floor’ and managers can offer extended opening hours for the department at little or no extra staffing costs, again enabling more patients to be seen. 'I work shifts over seven days so there is access to rehab at weekends and out of normal therapy hours’. Quicker access to tests was a benefit that can be provided by APs:

I think the fact that they don’t have to wait so long to have some tests, or their drip’s not left off for hours because the doctor’s too busy doing rounds with the consultant… because of some of the tests I can do, like, for instance on a Saturday when there’s just one consultant on, one SHO and myself and the consultant says ‘Oh B, can you do a blood gas on this person, can you take some blood and could you do some spirometry as well for me?’ And that’s instant because she’s got the results more or less before she’s left that ward. So things get done really quickly and that is a big advantage…

One AP working in a multi disciplinary team felt the role had a part to play in ensuring patient safety. In this post the AP works jointly with Physiotherapists, Occupational Therapists and District Nurses. In this position the AP is the person who has the most contact between the three fields and plays a part in making sure that nothing is missed in the ‘grey areas’ between disciplines:

I’ve got good immediate contact with the therapists that I work with and I’ve got very good contact too with the district nurses here. So we’re always in and out of each other’s offices and constantly updating each other on patients and so on, so that we make sure that things are done as effectively as possible…

…but the patients are the ones who benefit because things are covered and double covered sometimes to make sure that nothing gets missed.’

APs felt that their work had an important part to play in helping to shorten or prevent hospital admissions. An AP working in a rehabilitation team observed 'If I wasn't there to pull them out they would stay in hospital longer and have more chance of picking up an infection, and we can then release an acute bed'. An AP working in the community was able to quickly spot changes and was proud to relate how her work had prevented a hospital admission:

I was looking after a lymphoedema patient and her leg looked very suspect so I immediately got some silver dressings for her, phoned up and asked the doctor could we have some antibiotics for this lady...when the specialist nurse came out she said ‘You did absolutely the correct thing B’ she said ‘That’s what we needed to do because that lady could have ended up in hospital had she not had the antibiotics’. But by me alerting people straightaway it meant it saved her going into hospital and that’s what we’re about, stopping people going into hospital.
Having a group of APs in a department meant that patients could have a choice regarding who worked with them. The APs recognised that for some conditions men and women might prefer to be treated by someone of their own gender, for example men with prostate problems and women with incontinence problems.

6.2 Service Improvement and Team Benefits.
Several of the APs now act as support for staff in bands two and three. Since February one AP has been involved in supporting five rehabilitation assistants ‘...we’ve recruited five new Rehab Assistants and part of my new job is to get them inducted and settled and all the rest of it...’ This AP also assists with reinforcement of learning provided to new staff by the registered staff ‘her line and clinical supervision has come from the trained therapists, but I’m there as a support to kind of reinforce the learning that she’s had.’ In some departments the support role has been officially incorporated into the job descriptions of APs. ‘APs help to train new band three assistants and assist in the management of their workload, helping practically when required’. All of the APs were keen to be trained as mentors for future trainees, one having already attended a training event for mentors. Others stated that they would like to become NVQ assessors.

The view of several APs was that they could play an important part in providing support and advice to current students, ‘...because we’ve been on that journey recently we can understand what their problems might be. We can reassure them that the questions they ask aren’t stupid...we’re perhaps not as intimidating as some of the senior radiographers...’ In some cases, within defined limits, the APs are able to sign off competences for students. One AP in charge of a dental room can sign off the following:

I can sign off the students at the university and sign off the Assistant Practitioners, but if I train a qualified Radiographer in the room, then a Senior Radiographer will come and watch what they do and sign them off...

Another AP will sign junior doctors off for catherisation but only once satisfied that the doctor is competent. Having worked hard for the skill themselves they are determined to ensure that high standards are perpetuated and this AP will not be intimidated by the higher status of the junior doctor to do otherwise.

I had somebody do a catheter and he wanted me to sign it off and I went, ‘No, I’m sorry, I don’t think you’re competent.’ And I said ‘You didn’t do it on your own’. I said, ‘Another doctor came along and assisted you and I had to direct you.’ I said, ‘No, I’m sorry’. I don’t think he liked it but I thought, I had to work hard for what I’ve got. I’m not saying he hadn’t worked hard for what he’d got but in that particular small skill, he didn’t have the skill at that time to be signed off for it.

One AP reported that they used to be able to sign off competences for students but were no longer allowed to do this. As far as the AP was aware the decision had been taken by a qualified member of staff who felt that in doing this the AP had ‘crossed the line’ and strayed into territory that was restricted to registered staff. This left the AP feeling frustrated and that in some way their skills had been devalued.

APs have successfully helped to smooth the patient pathway, enabling a greater number of patients to be treated in a quicker timescale and facilitating early discharge. In
addition they have also contributed towards examining the processes and procedures used in their place of work to transform the care provided to patients. For example, an AP running an X-ray dental room when appointed to the post made changes to ensure that Radiographers entering the room could immediately gain an understanding of what was happening:

‘...as soon as I went in there I changed the room around. Put boards up to make sure everything – all the information was there for people coming in. And so if you were a Radiographer working in the room, everything is there and you know it’s all there.’

In another Radiography department APs have reorganised the use of rooms to ensure that all paperwork is completed and patients are fully prepped to allow them to go straight in to the X-ray room once it is free, ensuring there are no gaps in service delivery. An incontinence assessment tool has been developed by an AP, which, since its introduction has cut the number of catherisations and has been noted in an infection control audit.

We had very poor documentation for catherisation and excessive use and I designed a poster for the ward which was then used on other wards to show what the clinical reasons for catheterisation are and how and where to document it. There was a reduction in the number of catheters which was picked up from infection control audits.

One AP introduced the use of adjustable disposable tourniquets onto the ward, after reading about cross infection rates from the use of ordinary tourniquets, another wrote a leaflet for those in a nursing role on mouth care called Forget me not, when she realised that no others were available. An AP working across fields has streamlined the paperwork used for patients so that all members of the multi-disciplinary team are now working to the same system and there is less likelihood of problems for patients should a member of staff be absent. This idea came from listening to a colleague who had recently undertaken clinical governance training and the AP viewed their own subsequent work as a progression of that information:

Anything to cut down on the paperwork and the NHS is notorious for that. But to make sure it’s accurate, this is the point that you don’t develop – it’s so easy to develop your own little system for doing things and then somebody goes off sick or gets transferred or something, it just kind of leaves everybody wondering. So there’s no risk of something getting lost, it’s always there.

From these examples it can be seen that the work of the APs and their close observation of not only what they do in their work but how they do it, has resulted in improvements to patient safety, assisted in the smoother running of their teams and contributed to achieving cost savings.

The presence in a team of APs in addition to freeing registered staff for more complicated clinical cases, also creates time for these staff to attend courses and update their own skills. APs can free registered staff from the immediate close supervision of band three staff, again allowing them to spend more time on assessing, planning and evaluating their clinical work. Managers have observed that having APs in a team can ease pressure when staff are sick and can prevent a build up of waiting lists. During this
study the issue of a different uniform for APs has arisen but this has hardly been
mentioned as a subject area by managers in this study. All appear confident in the high
standard of the work of APs and one commented:

Our APs wear very similar uniforms to the Radiographers with just one different
coloured stripe so patients are not necessarily aware of the difference. I do not think
this is a problem because I am confident that they provide an equally good service.
They are well aware of their limitations and will ask for help if required.

6.3 APs and Cost Effectiveness.
In this area managers and APs concur that the AP role can contribute to cost savings
without a loss of service to the patients:

…it’s a cost effective way of working from an NHS point of view, that it’s not always
essential to have qualified staff to be effective and offer effective healthcare.

I can have more unqualified staff so allowing the qualified staff to have more time to
spend with patients at a level requiring clinical expertise. More patients are seen and
are supported by the Band four staff therefore it is hoped, avoiding hospital admissions
whenever possible.

One manager described it very succinctly when observing that I can have two APs for
the price of one mamographer. However, as this manager noted whilst the work of APs
needs to be supervised by qualified staff, there will be a limit to how many APs,
individual qualified staff will feel able to supervise.

6.4 Personal Benefits.
Whilst not directly asked about this, all of the APs were keen to impart the personal
benefits that they had gained by training and subsequently working as an AP. Greater
job satisfaction and enhanced self esteem were the overriding impressions given by all
of the APs who took part in this study. The opportunity to have a ‘second chance’ at
education was appreciated by several. Career progression was important and provided
a strong motivating force to take part in the training. Whilst some would now like to find a
way to progress to fully qualified status others want continuing CPD and expansion of
the job in their current role. A number of interviewees, both male and female, voluntarily
chose to use the following phrases in describing their work – ‘I love my job’ ‘I’m
passionate about my job, I love it and I look forward to coming to work everyday…I think
I’m in a privileged position here’ ‘I have days where I love it, I absolutely love it. The
patients are the most enjoyable part of it, and that’s what makes it interesting’ For some
there was almost a pioneering sense of achievement that despite having to work hard to
overcome fear and prejudice from registered staff about their abilities and the
contributions that the role of AP could make to a team they had succeeded in changing
hearts and minds:

It took time some time for some of the team to adapt to my new role and I spent lots
of time going over the reason why my role was different. There were lots of difficult
times but with the confidence I had gained from the course and the belief I had that
this role was better for patient care, the manager and I kept focussing on the
benefits…but as people have seen the benefits to patients they have gained interest
in my role and supported me more..
Once we came in, I think they realised what our potential – or didn’t realise what our potential was and we were actually achieving so much more than the department, than the management, than anybody thought that we could, even ourselves, we’re doing so much more, which is really satisfying.

One AP who is eligible for retirement does not want to retire yet because of the immense enjoyment they receive from their work. Another has found that their work as an AP has given them personal hope and inspiration for their life beyond retirement and into old age:

*I never thought that I would enjoy working with the elderly population, but I find them fascinating and they’re so important, and I am so encouraged that there is no such thing as ageism in the NHS, certainly not in this part of the world...As I said we’ve got two 100 year olds who we are still rehabilitating and still want to get home...And there’s no such thing as the ‘you’re too old, it’s not worth it’. And that gives me great heart as we get older, it’s nice to know that we’re not written off. Very important to hang onto that thought.*

Managing their own caseload was something that was considered an important element of the role and appreciated by the APs:

*From my point of view it’s more satisfying because I’ve got my own sort of group of patients that I have a greater responsibility for, knowing that I’ve got the support of trained Physiotherapists and OTs to support me if I’ve got any concerns.*

Those APs who are already supervising staff in bands two and three are pleased to be able to have the chance to provide support and development opportunities to others. It is almost a concept of ‘pay it forward’. They may not be able to directly repay those who supported and championed them but they can now do it for others.

7. What Next?

Some APs would like to attain registered status, others are keen to continue studying and expand their existing AP role. Access to courses for the updating of skills or study days seemed to be available to all the APs in this study. Only one AP had encountered any problems with attending a course for further training and was embarrassed to be asked to leave the course because they did not have registered status:

*I was sent on a training course and I was embarrassed and sent out; really embarrassed about it. And I was sent out because I wasn’t a nurse, even though my Manager arranged it for me.*

The major deterrent for the APs wanting to progress to registered status is the loss of income and position whilst continuing their studies. One manager has tried to assist with this by offering to keep the AP position open during the period the staff member is studying for their honours degree. The staff member then works weekends and vacations and to date the department has been able to offer a guaranteed post upon qualification. The department has not however, been in a position to help with the funding of University fees:

*...the arrangement we’ve come to with the people that we’ve had and it’s been favourable and I don’t think they’ve felt exploited by that at all, is that we’ve allowed*
them to keep some hours so we’ve kept their contracts open. We’ve guaranteed them that, when they qualify, they’ll be a post for them so-and that’s-at the moment with the number of people out there looking for jobs that’s quite a good thing to have. So they might work during their holidays, they’ll do some hours and they might do the odd nights or the odd weekend shift here or there as an AP. So that gives them some income while they’re at university. Probably better paid than doing some sort of bar job or something. And they’ve got the security of knowing that, when they graduate, they’ve got a post to come to. So we just put them straight into a Band 5 post when they graduate, and they don’t have to go through the whole thing of having interviews and because they’re already employed by us, it’s just a re-grading exercise really.

Not all APs want to progress to registered status but feel there is still room to expand within the limits of their training and the work that they currently undertake. Others feel that there are training courses they could go on to further enhance their existing capabilities. One AP working in rehabilitation would like to know more about the effects of drugs. This knowledge would greatly assist the AP in their assessment of patients and the development of subsequent treatment plans.

Managers too would like to find a way for some APs to attain Band 5 status without having to become fully qualified. They are aware that this would be a big bridge to cross. One manager who would like to give recognition to an AP who now runs the dental room of the department stated:

I would like B to be able to develop into a Band 5 role, but that’s – that’ll be a huge bridge to cross because of the fact that Band 5 is almost like protected territory for Radiographers. And if an AP became a Band 5 without actually becoming a Radiographer, I can see that there would be tension. I’m sort of thinking of taking that on because B has a role where they run the dental room, a really busy dental room that has good links with the dental clinics and the surgeons and B’s really an expert. B trains other staff, and really knows what they’re doing. And I took a bit of a gamble giving B the responsibility of running the room herself because I knew there’d be some Radiographers that would turn round and say, ‘How can you do that B’s not a Radiographer?’ But basically I knew…because I know how well B works. So now what I’d like to do now is say, ‘Because you’re doing such a good job I would like to make this a Band 5 post’ and interview B for it… But it’s going to be a big bridge to cross to get Radiographers to accept that an Assistant Practitioner can be a Band 5.

Another manager supportive of the possibility of APs reaching Band 5 status felt that this was something that would need support across the Trust.

I would like it to be easier for an experienced assistant to be able to have promotion to a Band 5 but this would need to have some sort of Trust wide monitoring and competency framework for this to happen.

In cases where an AP may have been the only one in their team they often felt isolated and would value the opportunity to meet with other APs. Study days for APs was one suggestion that was made. An AP who had attended a mentoring day appreciated not only the academic content of the day but also the opportunity that the day gave to network and share ideas with other APs.
Whilst some APs were aware that one of the benefits of their training and their role was the ability to work flexibly and across fields, for example those APs working in rehabilitation who were able to move between physiotherapy and nursing, others felt that there were drawbacks. They felt that the work had become much specialised and they were concerned about their ability to transfer to another AP role should family circumstances necessitate a move of location. One group of APs wondered if this was something that might be preventing people from undertaking the training and moving into the role ‘maybe more people would come into it in the first place knowing that it was transferable’, ‘so you could move around the country within the NHS’.

8. Developing the AP role – Managers advice to others.

The overriding advice provided by Managers was the importance of good communication with all members of the department and the importance of prior planning. They felt that the department must look carefully at what its service needs are. There needs to be a clear job description and sound support. All of the APs talked about the importance of having a champion for the role, often this position was taken by a manager. Many of them would not have considered training without the idea having first been suggested to them by their line manager. The support of the manager was often instrumental in the APs successfully completing the foundation degree. Frequently the manager needed to act as a liaison between APs and staff who felt threatened by the development of this new role. The two comments below summarise the opinions of all the managers who responded:

*Decide exactly what tasks you are expecting them [APs] to perform. Ensure that you need them in that role so that other team members will appreciate them and not feel threatened by them. Choose the training route carefully and monitor progress.*

*Ensure that qualified staff understand that APs are not a threat to their jobs – both groups need each other. There should be rewards for the qualifieds supporting this. Have a clear idea of how the service will benefit before going ahead.*

Most importantly for those who have been put forward for training by their departments there needs to be an AP post available for them on successful completion of the course.

11. Conclusion.

Where the Assistant Practitioner role has been established and developed it is a role that is appreciated and valued by practitioners and managers alike and increasingly by others in the workforce with whom the practitioner has contact. Establishing the role and gaining acceptance for it has not been without its difficulties. It has required continued communication on the part of the manager with all involved and at times has required great determination and strength of character on the part of the APs to persevere against fear and prejudice on the part of registered staff. Fear that their professional status was being weakened or that the aspects of their jobs that they most enjoyed – direct contact with patients would increasingly be limited.

However, as mentioned at the beginning of this report many of these attitudes are now historical as the role grows and gains increasing understanding and acceptance. Before undertaking training a supporting educational infrastructure needs to be put in place both for the APs and for those who will be required to supervise their clinical placements or act as mentors. Where possible it is helpful if the AP can undertake their training with others either from the immediate work place or a nearby locality. All the APs stressed
how important it was to have the support of a ‘training buddy’. With prior planning and consultation many of the difficulties encountered by the APs who took part in this study can be avoided.

The benefits of having an AP are several; they are cost effective, they can relieve the workload of the registered staff freeing them for more complex clinical cases and their own development. This has proved particularly important in areas where there is a shortage of registered staff. They contribute greatly to direct patient care, their close contact with patients’ means often they are the first person who will notice changes in a patient and can query if a treatment plan needs altering or a registered member of staff needs to be brought in. The AP frequently provides continuity of care for a patient and this helps to build up the confidence and trust of both the patient and their wider family. Likewise the APs can provide continuity of support for staff within a team. They often have a longstanding employment history with their department and a desire to remain working with the team on completion of their training.

The training of the AP often allows for flexibility of roles and crossing professional boundaries. In a rehabilitation role they may be able to implement a physiotherapy plan and change dressings. Other APs felt that they had become so specialised that they were worried about issues of transferability within the NHS, most particularly APs working in radiotherapy. Whilst APs appreciated the development of this role and were happy to work as APs they were of the opinion that with the appropriate training there was still scope for their role to expand and provide a greater contribution to service delivery and patient care. Especially among those who had trained and qualified in a skill that they were not currently using because Trust policies had not been updated to include their role. Others, having now felt the skills escalator to be real as opposed to hypothetical, were keen to progress to registered status but felt limited by a lack of finances. Particularly those who would be mature students and felt constrained by financial and family commitments. However, as evidenced above, some departments have been able to negotiate a way through these problems and support staff training from a band two through to registered status.

Finally, it must be noted that the overwhelming findings of this study were of positivity, optimism and the immense satisfaction that APs found in their working lives.

*It’s totally changed me altogether. It’s given me confidence, it’s given me a real drive to come to work. It’s- I mean I like nursing but this is really enjoyable. Everyone thinks I’m mad because I say if I won the pools I wouldn’t want to give up work. So it really is a lovely job. I think it’s just – it’s because I see the patient from the hospital right through to their home. It’s just so nice to see that whole process.*
10. **Recommendations**

The main recommendations of this evaluation are outlined below:

- Demand for the AP role should be identified through an examination of local workforce needs.

- A post at Agenda for Change band four should be available for APs upon successful completion of their training programme, via Foundation Degrees or equivalent.

- Awareness of the AP role to be raised amongst teams of staff, to ensure those working with an AP are aware of their main duties and responsibilities and can understand how to support them in the workplace.

- Awareness of the AP to be raised amongst NHS staff working within bands 1 – 3 to ensure they are aware of the progression opportunities available to them.

- All staff working with the AP should be clear about accountability and should help the AP to work within a relevant code of conduct, following organisational policies and protocols.

- Organisations wishing to employ APs should ensure that an adequate learning infrastructure is in place to support their training and ongoing development.

- Continuous development and expansion of the role should be considered by Trusts and PCTs when planning development of the AP.