Exploring assistant practitioners’ views of their role and training


Abstract

**Aim:** To examine the views of assistant practitioners and trainee assistant practitioners regarding experiences of practice in relation to the autonomy of the role and level of supervision, the training involved and support experienced in undertaking the foundation degree, and the effects of the assistant practitioner role in the workplace.

**Method:** A service evaluation was undertaken in which a small cross-sectional quantitative survey was distributed to trainee assistant practitioners undertaking the foundation degree, and assistant practitioners who had previously completed the foundation degree or who had qualified via another route.

**Results:** A total of 93 questionnaires were returned. The data indicate that there is some uncertainty surrounding the skills and competence of those undertaking the foundation degree, and a lack of opportunity for career progression for unregistered staff.

**Conclusion:** Increased understanding of the scope and role of assistant practitioners and the academic requirements of the foundation degree is required to increase assistant practitioner numbers.

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THE ASSISTANT PRACTITIONER role was introduced in the UK to address the shortfall in appropriately trained staff required to meet the demands of health care (Skills for Health 2009). This article presents the results of a survey that formed part of a service evaluation commissioned by the local county workforce groups in the NHS East of England region. These groups were responsible for role development and commissioning education to support service requirements (Bungay et al 2013), and have since been replaced by local education training boards. Assistant practitioners may be also be referred to as associate practitioners. In this article, the term assistant practitioner is used for both roles.

Modernising the healthcare workforce

The Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) identified suboptimal nursing care and a lack of dignity and respect for patients in the Mid Staffordshire NHS Foundation Trust. It reported that staffing numbers were inadequate and that staff were insufficiently qualified to manage their roles. The report emphasised the potential consequences of having too few appropriately trained staff available to care for patients.

UK government policy has been shaped by modernisation and reconfiguration of the healthcare workforce. *Equity and Excellence: Liberating the NHS* (Department of Health (DH) 2010) set out the requirements of a programme of change in the NHS in England and Wales. This programme emphasises the need for employers to restructure their workforce and to have a role in workforce planning and the commissioning of education and training.

Various social and economic factors have placed pressure on the NHS and its workforce, including: the ageing population (both NHS staff and the general public), economic restraints, technological developments and changes in nurse education (Ferry et al 2010). The UK government responded to a potential shortfall in NHS staffing by proposing a new way of working (DH 2002),
which aimed to break down traditional hierarchical structures and professional boundaries and replace them with more flexible team working. It was suggested that nurses, midwives, and allied health professionals should take on greater responsibility, thereby reducing the pressure on doctors. It was anticipated that support workers would expand their roles to include work previously carried out by nurses, midwives and allied health professionals (DH 2002).

The NHS Modernisation Agency was established to implement these staffing reforms. Among other initiatives, the agency created a ‘skills escalator’ to develop career options and enable staff to develop and progress their careers (NHS Modernisation Agency 2002). This was accompanied by a revised pay scale, Agenda for Change: NHS Terms and Conditions of Service Handbook, that recognised core competencies (NHS Employers 2005). The Agenda for Change pay scale system places staff in one of nine bands, depending on their role, knowledge, responsibility and skills. The system was intended to allow role expansion, provide opportunities for career progression and improve the transferability of roles and skills across the NHS (Skills for Health 2009).

The new role of assistant practitioner was created. This role was intended to occupy the intermediate position at band 4 of the career framework; below the entry level for registered staff but above the level for healthcare assistants and support workers (Skills for Health 2009). In addition, the European Union’s Working Time Directive (2003/88/EC) required that, by 2009, doctors should no longer work more than 48 hours per week. This ruling had implications for health service delivery in the UK.

The introduction of all-graduate entry for nursing will further increase the pressure on the healthcare workforce. Two potential effects on the nursing workforce are expected (Ferry et al 2010):
- The higher entry level and the requirement for higher level decision-making and analytical skills will lead to a reduction in the number of successful applicants to nursing courses.
- Graduate nurses will progress faster in their careers, leading to a shortage of registered nurses at band 5 to deliver care to patients.

### Assistant practitioner role

The assistant practitioner role was introduced to address the potential skills gap. The definition of the role has changed over time. In 2003, the NHS Modernisation Agency described assistant practitioners as ‘higher level’ support workers who complement the work of registered professionals and have the remit to deliver protocol-based clinical care, involving activities previously associated with registered practitioners (DH 2003). The DH (2003) was explicit that protocol-based care would be carried out under the direct supervision of a registered professional, who would remain professionally accountable for the care.

Skills for Health (2009) defined an assistant practitioner as ‘... a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend traditional boundaries. They are accountable to themselves, their employer, and more importantly, the people they serve.’ Therefore, assistant practitioners are able to work across professional boundaries, rather than deliver protocol-based care or complement the work of registered professionals. They may deliver care with knowledge and skills beyond those of a healthcare assistant or support worker and are accountable for their actions. Thus, Core Standards for Assistant Practitioners (Skills for Health 2009) provides the basis for the scope of the assistant practitioner role.

There is no specified or agreed training route for assistant practitioners. In England, training and education for assistant practitioners follows one of three routes (Skills for Health 2011):
- National vocational qualification (NVQ) level 3.
- Business and Technology Education Council (BTEC) higher national diploma.
- The foundation degree.

In Scotland, assistant practitioners working in imaging departments undertake a higher national certificate approved by the College of Radiographers (Colthart et al 2010).

### Foundation degree

Foundation degrees were introduced as a new higher education qualification in 2000 to address skill shortages and as part of the widening participation agenda (Harvey 2009). Foundation degrees are two-year programmes of study that can be delivered flexibly and adapted to suit organisational needs. Generally, they involve day release to a university or further education college. In this approach, learning is not only based on competencies, but also requires a supporting knowledge base.

When assistant practitioners were introduced in north west England, local organisations involved in development of the role considered that the
training and development of individuals should take a formal educational approach since this was an emerging role. The foundation degree was considered to be the most appropriate route for training (Kilgannon and Mullen 2008).

Many students undertaking a foundation degree in health care are healthcare staff whose course is funded by the NHS. They are given time off work to attend lectures and are allocated a workplace mentor to support them. Policy makers should consider implementing a requirement that all workers at assistant practitioner level should be educated to foundation degree or diploma of higher education level (Council of Deans of Health 2013). Foundation degrees are one of the main components of the Skills for Health (2015) report Higher Apprenticeship in Health (Assistant Practitioner) (England). This report sets out the ‘apprenticeship framework’, which is a pathway designed to provide the skills and knowledge required to become a competent assistant practitioner in healthcare settings.

**Assistant practitioners in the NHS East of England region**

In the NHS East of England region, a strategy was developed to introduce the assistant practitioner role into the local workforce to manage care quality issues and lessen the effects of a reduced number of registered professionals (Ferry et al 2010). Educational preparation for the assistant practitioner role was to be a two-year foundation degree, with work-based learning and day release to a higher education institute (HEI) or further education college.

**Aim**

The purpose of the service evaluation was to identify factors that facilitated or were barriers to successful implementation of the assistant practitioner role in different healthcare settings (Bungay et al 2013). The evaluation had two phases. The first phase consisted of interviews with service managers involved in workforce planning in local healthcare organisations (Jackson et al 2015). The second phase forms the basis of this article and involved surveying assistant practitioners and trainee assistant practitioners who had completed or were undertaking the foundation degree, and assistant practitioners who had qualified via another route (Bungay et al 2013).

The second phase of the evaluation had three main aims:

1. To determine the respondents’ roles and grades, as well as their views and experiences of practice in relation to the autonomy of the role and level of supervision.
2. To obtain information about the respondents’ education and training, including the level of support they experienced in the workplace and from the HEI while undertaking the foundation degree.
3. To explore the respondents’ perceptions of the effects of the assistant practitioner role in the workplace.

**Method**

A small-scale, cross-sectional quantitative survey was undertaken in 2013 using a structured questionnaire (Bungay et al 2013). The questionnaire was developed through a review of the literature and from analysis of interviews conducted in the first stage of the service evaluation with service managers (Jackson et al 2015). The project steering group reviewed the questionnaire for face and content validity before distribution, to ensure the questions were relevant and reflected the aims of the study (Ross 2012).

The questionnaire requested demographic data from respondents relating to their job title, grade and length of service. Using Wakefield et al’s (2009) framework as a basis for categorising the job descriptions of assistant practitioners, questions were included using a Likert scale to determine respondents’ perceptions of their role in relation to the work of registered practitioners. This included whether the respondent supported the role of registered practitioners, undertook aspects of the role of registered practitioners, and whether they were supervised or worked independently (Bungay et al 2013).

Questions were included to record information about the respondents’ education and training; Likert scales were also used to evaluate the level of support respondents received in the workplace and from the HEI while undertaking training; and their perceptions of the effects of the assistant practitioner role in the workplace. Respondents were invited to add any further comments about their experiences of the foundation degree and/or their employment as an assistant practitioner (Bungay et al 2013).

A written copy of the questionnaire was distributed to assistant practitioners (trainee and qualified). The number of band 4 staff and assistant practitioners working in the area was unknown, so questionnaires were given to education managers in local healthcare organisations for distribution. In addition, local HEIs distributed questionnaires to trainees undertaking the foundation degree. A total of 280
practitioners felt about the assistant practitioner role and the need for greater clarity and recognition of their role:

‘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’
(Healthcare support worker 8).

However, individual levels of competence were mostly recognised by registered practitioners:

‘My team have great respect for me and allow me to work independently and value my input’
(Senior healthcare assistant 2).

A majority of respondents (67/93, 72%) believed that other staff knew their level of competence, and a majority of managers were perceived to be supportive of the role (63/93, 68%).

Effects of the foundation degree
Only a small proportion of the respondents (10/92, 11%) had completed the foundation degree. The foundation degree was thought to be an effective basis for the assistant practitioner role by 81/92 (88%) respondents; however, it was thought to be challenging by 86/92 (93%).

The majority (74/92, 80%) of respondents considered academic support from the HEIs to be good, while only 55/92 (60%) experienced a good level of support in the workplace for undertaking the foundation degree. The majority (83/92, 90%) of respondents had a workplace mentor; however, 39/92 (42%) reported that their mentor was only ‘sometimes’ or ‘rarely’ available to them.

Several written comments raised issues around support in the workplace and access to

Results
Overall, 93 questionnaires were returned, giving a response rate of 33%. Of these, 76 (82%) were from students on the foundation degree programme in two HEIs. Not all the respondents replied to every question and the small sample size meant it was difficult to draw any inferences from the results. Therefore, only descriptive statistics were used to analyse the data. There were 38 responses in the section for further comments, which were analysed thematically. Quotations from these responses are used to support the descriptive data.

Different job titles were used to describe roles. These were categorised into assistant or associate practitioner, trainee associate or assistant practitioner, healthcare assistant, healthcare support worker, senior healthcare assistant and ‘other’ (Table 1). The length of service in the role ranged from three months to 23.5 years, with a mean of 4.93 years. Twelve of the respondents had been in their post for ten years or more, including two who had been in post for 22 and 23.5 years, respectively.

Respondents were asked to state their employment band. More than half of respondents were employed at band 3 (47/89, 53%), with 10/89 (11%) employed at band 4 or above. One respondent, whose role was described as a senior healthcare assistant, was at band 5. The remainder (32/89, 36%) were employed at band 2.

Assistant practitioner role
The majority of respondents (88/92, 96%) believed that their role supported the work of registered practitioners: 69/89 (78%) took on the work of registered practitioners ‘sometimes’ or ‘rarely’, and 20/89 (22%) took on the role of registered practitioners ‘always’ or ‘most of the time’. In their written comments, several respondents made reference to the uncertainty that registered

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<tr>
<td>Job title</td>
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<tr>
<td>Healthcare assistant</td>
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<td>Senior healthcare assistant</td>
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<td>‘Other’ (community matron assistant, team support worker, diabetes care technician)</td>
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*Data relating to this question were omitted from two questionnaires
mentors. The following comment represents the majority view:

‘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 supernumerary time’ (Healthcare assistant 3).

The comments indicated that part of the problem with receiving support in the workplace related to their being both a student and a full-time member of the team. Consequently, many found it difficult to spend time with their mentor, find time to study or have the opportunity 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 numbers there is never enough time to work with mentors’ (Healthcare assistant 5).

Respondents were asked what grade they had been before they began the foundation degree. It was found that 8/86 (9%) respondents had been promoted. Most respondents moved from band 2 to band 3, although two had moved from band 2 to band 4. Respondents were also asked whether they thought undertaking the foundation degree provided opportunities for career progression; 75/92 (82%) respondents agreed or strongly agreed with this statement. One respondent commented that the award of the qualification was essential for career progression. However, ten respondents expressed disappointment that there would not be, or had not been, opportunities to progress in their department. Some respondents also expressed frustration that having a foundation degree did not guarantee obtaining an assistant practitioner post:

‘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’ (Healthcare support worker 7).

‘Biggest problem is lack of jobs or positions within my trust for qualified assistant practitioners, many just return to previous role of healthcare support worker’ (Healthcare support worker 5).

Undertaking the foundation degree appears to increase confidence, with 85/92 (92%) respondents stating that they were more confident in their work as a result. Six of the respondents commented that after undertaking the course, their knowledge and understanding had increased, and they valued the experience overall:

‘Since starting this course I have more confidence in challenging situations’ (Healthcare support worker 2).

‘My confidence in my work performance and the improvement in my academic writing has been very significant. I would recommend this course to any healthcare assistant who wants to progress… Because of the foundation degree I have been accepted for a new position in the trust’ (Assistant practitioner 1).

The opportunities for promotion appear limited. However, 41/92 (45%) respondents reported that they had been given greater responsibility and many respondents were expected to work at a higher level after undertaking the foundation degree:

‘Undertaking the foundation degree has opened my eyes and mind to do good things to others and in the workplace. I feel I have been given more responsibility because of studying the foundation degree’ (Healthcare support worker 1).

**Effects of the assistant practitioner role**

Respondents answered questions about the effect of assistant practitioners in the workplace: 61/92 (66%) respondents ‘agreed’ or ‘strongly agreed’ that assistant practitioners enhance service delivery, 82/92 (89%) ‘agreed’ or ‘strongly agreed’ that assistant practitioners are effective at communicating with service users, and 80/92 (87%) ‘agreed’ or ‘strongly agreed’ that assistant practitioners provide consistent care.

The questionnaire also asked respondents about their perceptions of the attitudes of registered staff working with them. Responses were varied: 35/92 (38%) assistant practitioners considered that registered staff felt threatened by their role, 33/91 (36%) thought their role was valued by registered staff, and 45/91 (49%) were unsure if registered staff valued the role.

In the written comments, seven respondents commented that they had experienced resentment from registered staff and other healthcare assistants working with them:

‘Other healthcare support workers resent the fact that I am on this course and some of the registered staff also feel this way’ (Healthcare support worker 4).
However, six respondents reported that they were supported by their managers and senior staff:

‘I feel that I have been greatly supported by my manager and mentor’ (Healthcare assistant 7).

**Discussion**

This service evaluation represents the views of staff working at band 4 and those aspiring to achieve band 4 status through completion of the foundation degree. It provides insights into respondents’ experiences of undertaking the foundation degree and of the assistant practitioner role, as well as their perceptions of how the role and the foundation degree are viewed by other members of staff working with them.

There were limitations to this evaluation. It was a small-scale survey undertaken in one organisation that primarily reported the views of staff undertaking the foundation degree, who were not working as assistant practitioners or at band 4 level. Nevertheless, by undertaking the survey and trying to identify the assistant practitioner population, it appears that the role in NHS East of England has not changed significantly in recent years. This is despite increasing pressure on NHS services. That said, some healthcare assistants and senior healthcare assistants are being funded locally to undertake the foundation degree, and there are some trainee assistant practitioner roles in existence. This suggests that the role is gradually gaining wider acceptance.

More than one third of the respondents in the survey agreed that registered staff felt threatened by the introduction of the role, despite the potential for registered staff to expand their responsibilities. There are a number of possible explanations for this. Staff may resent the assistant practitioner role because they have more opportunity than registered staff to undertake ‘hands on’ care. Registered staff may also feel that the assistant practitioner role is a cost-cutting exercise and that their jobs are threatened as a result (Bungay et al 2014). Furthermore, registered staff may feel that their specialist knowledge and skills are being devalued, while at the same time registered staff are taking on tasks previously carried out by others (Dubois and Singh 2009).

The results of this survey reflect other studies that have explored experiences of the role of assistant practitioner and the foundation degree (Wareing 2011, Norrie et al 2012, Griggs 2013). For example, Norrie et al (2012) explored the experiences of foundation degree graduates and their mentors, and found that there was friction between the assistant practitioners and registered staff and healthcare assistants. It was felt that this was because job security was threatened. There was confusion about the assistant practitioner role and qualifications, which meant that colleagues were unwilling to delegate because of concerns about accountability. This result is understandable, since although Skills for Health (2009) describes assistant practitioners as being accountable to their employer, themselves and the people they serve, they are not registered with a professional body. As such, they are not professionally accountable for practice in the same way as registered staff. Although assistant practitioners have had additional training, they are supervised by a registered professional, and the supervising practitioner is accountable for them (Skills for Health 2011). If something goes wrong, the registered professional delegating the task would potentially be liable under the terms of their registration.

Foundation degree graduates reported greater knowledge at work following completion of the foundation degree, improved communication skills, and that they felt better able to articulate what was happening to the people in their care (Griggs 2013). They also reported greater confidence in relation to their work (Griggs 2013). This corresponds to the results of this survey. In terms of career progression, the participants in Griggs’ (2013) survey were mostly satisfied with their grade. However, 5/35 (14%) had sought promotion and were disappointed to be unsuccessful. This finding was also reported by Norrie et al (2012). Such findings have implications in terms of career development for support workers and assistant practitioners. It appears that the band 4 role is limited in terms of career progression and that the main route for staff to achieve promotion beyond band 4 is through a professional degree in one of the healthcare disciplines (Bungay et al 2014).

Workplace mentors have a role in assessing the completion of work-based learning activities and enabling practice-based assessment. However, respondents to the survey indicated that it was difficult to spend time with their mentors because of the assistant practitioner’s work commitments as members of the team and not being viewed as learners in their own right. This echoes the findings of Wareing (2011), who interviewed work-based mentors supporting students on the foundation degree. There were problems with role boundaries as students found it difficult to relinquish their previous identity as a healthcare assistant despite having an additional role as a work-based learner. A recurring theme in Wareing’s (2011) study was a lack of awareness of the foundation degree and the nature of work-based learning. These issues were both identified in the current survey.
Conclusion

The potential shortfall of appropriately trained staff to meet the demands of health care has had a significant influence on government policy. The assistant practitioner role was introduced as part of an overall strategy of service redesign and workforce reconfiguration. The definition of assistant practitioners has changed since the role was introduced and there has been a slight change in their status and level of accountability. Health care is the responsibility of many different professional groups. Each of these groups has a distinctive professional culture, identity and area of expertise. These are not clearly defined for assistant practitioners. There is unlikely to be any further increase in numbers of assistant practitioners until their areas of expertise and competence are known and valued by those working with them.

References


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