

Mapping the introduction of Assistant Practitioner roles in Acute NHS (Hospital) Trusts in England

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Aims This mapping study describes current or planned introduction of assistant practitioner roles in English National Health Service Acute Hospital Trusts.

Background In the last decade there has been a growth in nursing support workforce numbers and their scope of practice. An important United Kingdom support worker development is the Assistant Practitioner role.

Method A national census was carried out (April 2007) via an emailed questionnaire to Directors of Nursing. Quantitative data were analysed using descriptive statistics. Qualitative data were analysed using thematic analysis.

Results Eighty-five per cent (143/168) of Directors of Nursing, from all 10 English Strategic Health Authorities, responded. Forty-six per cent ($n = 66$) of Trusts had introduced assistant practitioners and 22% ($n = 31$) were planning to implement the role before 2009. There is wide variation in assistant practitioner numbers across and between Strategic Health Authorities, Trusts and clinical areas. Resistance to the role existed in 32% ($n = 46$) of Trusts. Reasons for resistance included no perceived need for the role, lack of evidence of effectiveness, financial constraints and professional and patient safety concerns.

Implications for nursing management These findings, which contribute to the international evidence-base on health care support workers roles, provide nurse managers with numbers of assistant practitioners and their deployment. This is useful for Nurse Managers making workforce decisions.

Keywords: changing roles, grade mix, health care support worker, nursing management, surveys

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Introduction

The skills of registered healthcare professionals and their support staff are much in demand to meet global

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healthcare needs. Nursing personnel, both registered nurses and non-registered assistive staff, constitute a limited resource that needs to be deployed in the most efficient and cost effective way (Meadows *et al.* 2000,

Buchan *et al.* 2001, Buchan & Dal Poz 2002, Buchan & Shocalski 2004, Department of Health 2004, Oulton 2006). Nurse Managers are faced with important decisions about the proportion of funding to be used on registered nurses (RNs) and health care support workers (HCSWs) in their workforces; that is the skill mix required to deliver patient care (Hurst 2002, O'Brien-Pallas *et al.* 2005, Buchan 2008). These decisions require making better use of the staff resource and their skills, sometimes through role expansion, role extension and role redesign (Department of Health NHS Modernisation Agency 2002, 2003, 2004, Buchan & Calman 2004). More flexible working at all levels throughout the nursing workforce is being encouraged internationally. An important aspect of this in the UK National Health Service (NHS) (Table 1) is developing roles and careers for support staff (Department of Health 2000, 2002, 2004, 2006a). Increasing numbers of HCSWs are being used in the delivery of nursing care (Buchan & Seccombe 2002). HCSWs work closely with patients and are involved in direct care activities to supplement, complement or replace (substitute for) some of the duties and responsibilities of RNs (Gardner 1991, Krapohl & Larson 1996). A significant UK workforce policy initiative and important career development for HCSWs is the assistant practitioner (AP) role.

APs are 'higher level' support workers, introduced in the UK to complement the work of registered professionals and work across professional groups in both hospital and community settings (Department of Health NHS Modernisation Agency 2003). APs have a remit to deliver protocol-based clinical care and cover activities previously associated with the work of registered practitioners. For example, APs are expected to deliver direct care and treatment to patients, undertake a variety of clinical skills (such as catheterization,

swallowing assessment, mobility exercises or venepuncture), manage patient care (where relevant), assist in the assessment of patients and undertake health promotion work (Sargent 2006). This protocol-based care should be undertaken under the direction and supervision of a state registered practitioner (Skills for Health 2007). The role is graded at level 4 under the UK Agenda for Change (AfC) Framework (Department of Health 2005), requires formal training (national vocational qualification or foundation degree) and is being developed alongside pay structures that reflect their levels of preparation and practice for healthcare work: the starting salary for a Band 4 AP is currently £13 914 (rising to £19 248) compared with £16 389 (rising to £24 198) for a Band 5 RN (NHS Staff Council 2007). These characteristics distinguish APs from HCSWs who are graded at level 3 and 2 (AfC) and are not required to have any formal training or to hold a recognized qualification.

Currently, HCSWs and APs in the NHS are not registered (licensed) or regulated. This has raised concerns about patient safety and quality of care (McKenna *et al.* 2004). However, *The Career Framework for the NHS* (Department of Health NHS Modernisation Agency 2004) has emphasized a more structured approach to training and role competence for the entire healthcare workforce, including workers supporting the roles of RNs. Recent reviews have highlighted the need for support staff regulation, particularly for 'enhanced' support roles such as APs (Department of Health 2006b, Royal College of Nursing 2007). This is because of their increasing responsibilities for patient care. In theory, the more structured approach of the UK NHS modernisation agenda should mean that registered nurses (graded at level 5 and above) are supported by APs (level 4), Senior HCSWs (level 3) and HCSWs (level 2).

Anecdotally, the development of AP roles in acute NHS Trusts across England has varied in terms of numbers, job remit and preparation for practice. To date, these roles and their impact on service delivery and patient care have not been evaluated nationally. A limited number of studies report on the introduction of occupational therapy assistant practitioners (Mackey & Nancarrow 2005, Nancarrow & Mackey 2005) and the training of APs in one geographical area (Benson 2005). There are anecdotal reports of the potential benefits of AP roles, such as freeing up the time of professional staff to focus on complex activities requiring professional skills, but also of organizational, cultural and professional concerns associated with their introduction (Warne & McAndrew 2004). A national-funded study

Table 1

Definitions of UK healthcare terms

The **National Health Service (NHS)*** provides healthcare services to UK residents. Services are provided through five types of NHS Trusts – Primary Care, **Acute Hospital**, Ambulance Services, Mental Health and Care Trusts. All NHS Trusts provide services to UK residents. Primary Care Trusts also commission services (within allocated resources) across all service sectors. Regional **NHS Strategic Health Authorities (SHA)** (of which there are ten in England) are responsible for ensuring that NHS Trusts in the region implement national UK government health and social care policies.

(*Bold text indicates terms used)

<http://www.nhs.uk/aboutnhs/pages/about.aspx>

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134649

(Spilsbury *et al.* 2007–2009) using mixed methods is exploring the impact of introducing the AP role (level 4) in acute NHS (hospital) Trusts in England. In particular, the study aims to understand how these roles are developing and being deployed, and the ways in which they are impacting on the organization and management of patient care. It will also address how these roles might be influencing work and activities within existing nursing team structures, that is, the ways in which the introduction of the role has led to changes in the activities of RNs and HCSWs.

An important first stage for this national study was to establish which acute NHS (hospital) Trusts in England employ APs and to identify in which clinical areas they are being deployed. This information was essential to inform the sampling frame for in-depth case study data collection for the national study. No national data were available to fulfil these requirements.

Aims

The aims of this mapping study were to gather relevant existing data to describe current or planned:

- introduction of the AP role in acute NHS (hospital) Trusts in England;
- distribution of the role across acute Trusts and strategic health authorities (SHAs) in England; and
- deployment of the role across clinical specialities within these acute Trusts.

The mapping study also explores key factors influencing the introduction (or not) of the AP role.

Method

In April 2007, a national census of the AP role in acute NHS (hospital) trusts in England (Figure 1) was carried out through email distribution of a brief, descriptive, cross-sectional questionnaire. The ques-

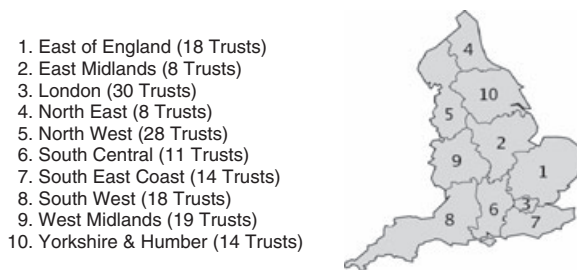


Figure 1
Overview of the ten National Health Service Strategic Health Authorities and acute NHS (hospital) Trusts in England.

tionnaire was sent to all Directors of Nursing (DoNs) in acute English NHS Trusts ($n = 168$). The covering email provided background to the national study, the purposes of the mapping study and our request for their help to provide information about the introduction and deployment of the AP role within their organization. The DoNs were asked to complete the questionnaire (or to nominate a person from their organization to complete the questionnaire on their behalf), with a maximum of five questions, with space for more qualitative comments. The questionnaire was returned by email to K.S. (Figure 2). The questionnaire was developed specifically for mapping the AP role. Other practical points for consideration included: ease of distribution via email; brief and simple so as to encourage maximum response rate; and applicable to all Trusts. It was important to capture data from Trusts with and without APs in position, or planning to introduce the role in the future.

The mapping study was considered 'service evaluation' rather than 'research', based on criteria proposed by the National Patient Safety Agency National Research Ethics Service (2007). As such, ethical review by a Research Ethics Committee was not required. However, ethical principles guided data collection, management and analysis. The national study (for which these data were gathered) was approved by a Multi-centre Research Ethics Committee (07/MRE04/20). Potential respondents were informed in the covering email (using 'undisclosed-recipients' function) that the data they provided would be anonymized and analysed at NHS Strategic Health Authority (SHA) level ($n = 10$), rather than by the Trust ($n = 168$). It was emphasized that no existing data were available on the national implementation of the AP role and so they would be contributing to the knowledge base of nurse managers, practitioners, policy makers and researchers. After initial distribution of the questionnaire, non-responders were followed up with a reminder email at 3 weeks (May 2007), re-administration of the questionnaire at 6 weeks (June 2007) and a final reminder email at 8 weeks (June 2007). Reminders were not sent once a response was received.

Quantitative and qualitative data were entered into an MS Excel (2003) spreadsheet. The only persons with access to Trusts' responses were K.S. and L.S. Data were anonymized at the data entry stage to protect Trust anonymity by assigning an ID at SHA level: SHAs were labelled 1–10 with a corresponding Trust ID. Other members of the research team had access to the anonymized data. Data were stored on a double password protected university PC to comply

Questions we would like you to answer:

Are there assistant practitioners (or level 4 support workers) employed in your trust?

YES/ NO (please delete as appropriate)

If you answered **yes** to this question, **please answer questions 1 to 3 and 7**

If you answered **no** to this question, **please answer questions 4 to 6 and 7**

1. How many assistant practitioners do you employ in your trust? _____

2. Which year was the role first introduced in your trust? _____

3. Please indicate which areas the assistant practitioners work in:

- | | |
|----------------------------|--|
| a) medical wards | YES/ NO (please delete as appropriate) |
| b) surgical wards | YES/ NO (please delete as appropriate) |
| c) intensive care | YES/ NO (please delete as appropriate) |
| d) accident and emergency | YES/ NO (please delete as appropriate) |
| e) care of the elderly | YES/ NO (please delete as appropriate) |
| f) rehabilitation | YES/ NO (please delete as appropriate) |
| g) maternity | YES/ NO (please delete as appropriate) |
| h) out patient departments | YES/ NO (please delete as appropriate) |
| i) theatres | YES/ NO (please delete as appropriate) |
| j) other (please state): | _____ |
| | _____ |
| | _____ |

4. Are there any plans to introduce the assistant practitioner role in your trust?

YES/ NO (please delete as appropriate)

If NO, please answer question 7

5. If there are plans, then please indicate which year you anticipate this will occur?

6. If there are plans, please indicate which areas they will work in:

- | | |
|------------------|--|
| a) medical wards | YES/ NO (please delete as appropriate) |
|------------------|--|

Figure 2

Questions for Directors of Nursing.

with the 1998 Data Protection Act (c.29) (Office of Public Sector Information 1998). Quantitative data were imported into SPSS 14.0 for Windows (SPSS Inc., Chicago, IL, USA; Release 14.0.1, 2005) and analysed using descriptive analysis techniques. Means (standard deviations), medians (where relevant) and proportions (95% confidence intervals) were calculated for continuous and categorical data, respectively. These data are presented at SHA level. Qualitative data (provided as additional comments by Directors of Nursing to question 7) were analysed for thematic content. As such, the analytic process involved (1) data management, using a spreadsheet to preserve respondents with their responses, (2) descriptive accounts to identify key

dimensions and map the range and diversity of respondents' comments about APs, and (3) explanatory accounts, to establish patterns of association and conflict in the data, with subsequent exploration of why such patterns may be occurring (Ritchie *et al.* 2003). For example, once data were coded and grouped into a theme, it was explored further to establish whether the theme (and its key dimensions) applied to only a particular group (such as Trusts with the AP role) or whether it was a more general theme. Qualitative data were given a Trust ID (numbered 1–168) and are not presented at SHA level to ensure comments can not be linked to a particular Trust in a regional SHA.

- | | |
|----------------------------|--|
| b) surgical wards | YES/ NO (please delete as appropriate) |
| c) intensive care | YES/ NO (please delete as appropriate) |
| d) accident and emergency | YES/ NO (please delete as appropriate) |
| e) care of the elderly | YES/ NO (please delete as appropriate) |
| f) rehabilitation | YES/ NO (please delete as appropriate) |
| g) maternity | YES/ NO (please delete as appropriate) |
| h) out patient departments | YES/ NO (please delete as appropriate) |
| i) theatres | YES/ NO (please delete as appropriate) |
| j) other (please state): | _____ |
| | _____ |
| | _____ |

7. Do you have any additional comments that you would like to make about the introduction (current or planned), or lack of plans for introduction, of the assistant practitioner (level 4 support worker, Agenda for Change) role in your organisation?

Thank you very much for your help

Please return the completed questionnaire to Karen Spilsbury ks25@york.ac.uk

Figure 2
(Continued).

Results

Of the 168 acute NHS (hospital) Trusts that were sent the questionnaire, 143 (85%) DoNs (or a nominated person from the organization) responded. Trusts from all ten SHAs were represented in the responses (Table 2). Additional qualitative comments were provided by Trusts from all the SHAs, and included Trusts that had introduced the role (from East of England, East Midlands, London, North East, South Central and South West) or plan to introduce the role (from East of England, East Midlands, London, North West, South Central, South East, South West, West Midlands and Yorkshire and Humber), as well as Trusts that do not plan to introduce APs (from East of England, West Midlands and Yorkshire and Humber).

The national picture

Forty-six per cent of responding trusts ($n = 66$) had introduced the AP role in their organization. However,

the introduction of APs in each Trust is not evenly spread across the SHAs (Table 2). This ranges from 84% of Trusts in NHS North West, compared with only 25% of Trusts in South East Coast, West Midlands and Yorkshire and Humber (Table 2). North West SHA comprises almost one-third (32%) of all responding Trusts with APs.

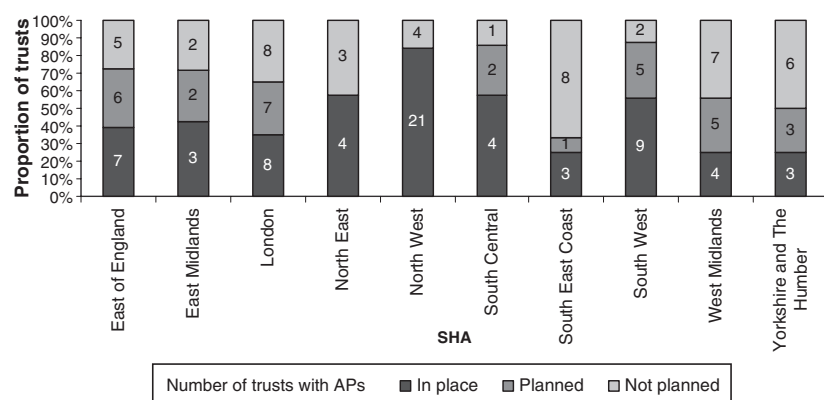
Thirty-one (22%) of the responding Trusts ($n = 143$) indicated that the organization had plans to introduce the AP role (Figure 3). Two SHAs (North West and North East) did not have any Trusts planning further introduction of the AP role. The highest number of Trusts planning to introduce APs was within NHS London ($n = 7$; 30%). The latest projected date for introduction of the role in these Trusts was reported as 2009. By 2009, and if Trusts introduce the role as planned, there will be APs in over two-thirds ($n = 97$, 68%) of acute NHS (hospitals) in England. Just under one-third ($n = 46$, 32%) have no plans to develop the role.

Sixty-four (of the 66) Trusts currently employing APs provided details of their numbers. There is wide

Strategic Health Authorities	Trusts in the Strategic Health Authorities (n)	Trusts responding to questionnaire n (%)	Trusts reporting to have Assistant Practitioners n (%)
1. East of England	18	18 (100%)	7 (39%)
2. East Midlands	8	7 (88%)	3 (43%)
3. London	30	23 (77%)	8 (35%)
4. North East	8	7 (88%)	4 (57%)
5. North West	28	25 (89%)	21 (84%)
6. South Central	11	7 (64%)	4 (57%)
7. South East Coast	14	12 (86%)	3 (25%)
8. South West	18	16 (89%)	9 (56%)
9. West Midlands	19	16 (84%)	4 (25%)
10. Yorkshire and The Humber	14	12 (86%)	3 (25%)
Total	168	143 (85%)	66 (46%; 95% CI 38–55%)

Table 2

Response rate by Strategic Health Authorities and number of Trusts with Assistant Practitioners

**Figure 3**

Pattern of introduction of the assistant practitioner role across the Strategic Health Authorities.

variation in numbers of APs employed within and between the SHAs (Table 3). NHS North West has the largest number of APs ($n = 330$); comprising 39% (95% CI 36–42%) of all APs identified and the lowest numbers are employed in Yorkshire and Humber ($n = 8$; 0.95%, 95% CI 0.4–1.9%). The numbers of APs employed by a Trust range from 1 to 50. Distribution of the number of APs at each Trust was

positively skewed; over half the Trusts ($n = 36$) reported to have 10 APs or less (median 9, mean 13, SD 12.52).

Sixty-two (of the 66) Trusts employing (or planning to employ) APs provided a date for when the role was introduced or planned introduction date (Figure 4). From 2002–04, there has been a gradual increase in the numbers of APs being employed by acute NHS

Table 3

Size of Assistant Practitioners teams within Strategic Health Authorities

Strategic Health Authorities	Trusts with Assistant Practitioners in SHA (n)	Total number of Assistant Practitioners in SHA n (%; 95% CI)	Trust level: number of Assistant Practitioners	
			Mean (SD)	Median
1. East of England	7	92 (11%, 95% CI 9–13%)	13 (17.7)	4
2. East Midlands	3	97 (11%, 95% CI 9–14%)	32 (21.1)	38
3. London	8	64 (8%, 95% CI 6–10%)	8 (10.3)	4
4. North East	4	39 (5%, 95% CI 3–6%)	10 (11.4)	6
5. North West	21	330 (39%, 95% CI 36–42%)	17 (12.0)	12
6. South Central	4	59 (7%, 95% CI 5–9%)	15 (8.0)	14
7. South East Coast	3	10 (1%, 95% CI 1–2%)	5 (1.4)	5
8. South West	9	107 (13%, 95% CI 10–15%)	12 (10.1)	8
9. West Midlands	4	39 (5%, 95% CI 3–6%)	10 (6.4)	9
10. Yorkshire and The Humber	3	8 (1%, 95% CI 0–2%)	3 (2.1)	2
Total	66	845 (100%)	13	9

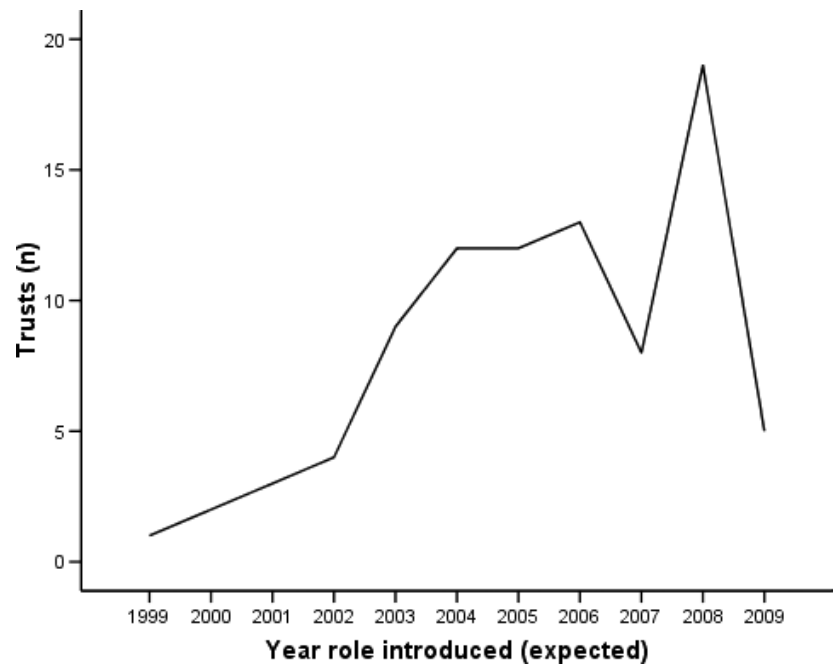


Figure 4

Annual introduction of the AP role across all Strategic Health Authorities.

(hospital) trusts. The rate of growth has remained steady since 2004, with a slight dip in 2006/2007. The rate of introduction of the AP role has varied across the ten SHAs. For example, NHS North West implemented the role from 2002, peaking in 2004. This contrasts with NHS South West where the role was not introduced until 2005.

Introduction of the assistant practitioner role across specialities

Sixty-five Trusts with APs (of 66) provided detail of clinical specialities utilizing the role. APs are deployed across a range of specialities but, currently, the largest population is in medical and surgical wards; 45% ($n = 29$; 95% CI 32–57%) of Trusts with APs have APs in these wards (Figure 5). In addition to the categories offered in the questionnaire (Question 3, Figure 1), respondents provided data of other specialities employing APs and these were classified as paediatrics,

imaging and therapies. An 'other' category was used to include specialities such as pathology and pharmacy. Trusts with APs reported employing APs in more than one clinical speciality. Such as the findings for those Trusts already employing APs, the majority of trusts planning to implement APs indicated that this would be in medical and surgical ward areas (Figure 5).

Workforce strategies and clarity of role expectations for 'assistant' staff

Reviewing workforce strategies and skills mix were identified as key features of workforce planning by DoNs of acute NHS (hospital) Trusts. Introducing (or plans to introduce) the AP role is embedded in workforce development plans of strategic health authorities and organizations:

'There is a regional plan to support the development of the Assistant Practitioner role. We will

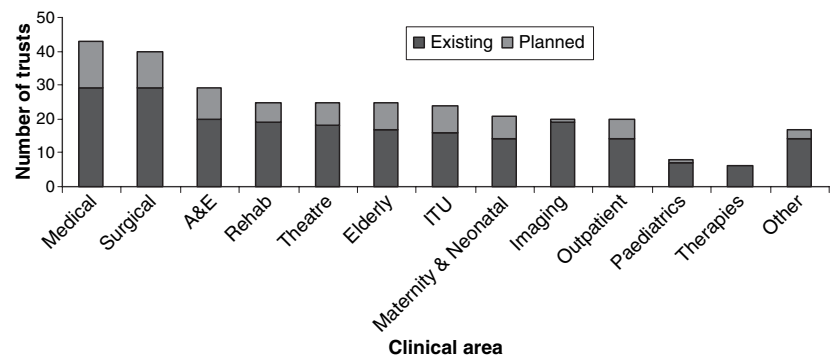


Figure 5

Clinical areas where assistant practitioner role is utilized or there are plans to use the role.

participate in this and would plan to introduce the role into appropriate areas. However, this will be seen in the context of the whole workforce development strategy for the Trust'. (Trust 136)

However, DoNs suggested there were problems associated with planning for the introduction of level 4 workers in the health care workforce because of a lack of definitional clarity and evidence of their suitability across clinical specialities. In hospitals where the role is already introduced, there still remains some uncertainty in the differences between level 3 and level 4 assistant workers:

'At band 3 and 4, Agenda for Change has not resulted in identical banding of similar posts and, as a result, linking a title to a banding is not necessarily helpful in determining the role'. (Trust 15)

In Trusts where the AP role has not yet been introduced, DoNs reported HCSWs at Band 2 and 3 working in 'extended' roles. Therefore, they perceived that there would be no 'added value' to services by introducing the Band 4 worker. However, this also raised questions among some DoNs as to whether assistant staff on lower bandings were being rewarded adequately for their work:

'HCAs are employed in the Trust at level 2 and 3, but probably should be a [level] 4 because of the type of work that they are doing. Agenda for Change is a "curse" because it hasn't actually rewarded people for the work that they do'. (Trust 25)

Trusts planning to introduce the role identified uncertainties about which clinical areas would most benefit from the role. Trusts already implementing the role report using it in a variety of areas (both general and specialist) but indicate they have no evidence as to which clinical areas gain most benefit from the introduction of the role. There is wide variation in the areas using level 4 workers, including differences within clinical areas of organizations. Despite the introduction of the role in medical, surgical and critical care environments, one DoN reported:

'Rehabilitation are developing their own [support] role and maternity are using the support worker role'. (Trust 16)

This indicates that even within organizations there is lack of consistency in the use of Band 4 assistant staff. In other Trusts, the role is being introduced exclusively within specialist areas and not in more general ward settings:

'Only last week we appointed the first Assistant Practitioner as part of a Nursing Intravenous

Infusion Team, as a pilot for one year. The purpose of the post is to monitor the care of peripheral cannula on medical wards; part of our strategy to reduce MRSA'. (Trust 72)

DoNs across Trusts and SHAs questioned the suitability of the AP role for operating theatres. Whereas some Trusts had introduced the role in theatres, and others reported planning to do so, questions were raised relating to the development of individuals for this role:

'In some situations it would not make sense for these workers to undertake training for certain areas. For example, why would they study for a band 4 in theatres when they could do Operating Department Practitioner training and gain a band 5?' (Trust 27)

However, for most clinical areas, the Band 4 role was perceived as an opportunity for assistant staff to develop their careers. Trusts reported that existing health care support workers undertook the foundation degree programme and so level 4 staff were (in the main) 'home-grown' from health care support workers. Yet it appears that there is a lack of further opportunities for individuals to continue their development, unless they undertake training as a registered professional:

'Our sector set up an assistant practitioner programme and we would welcome the further development of this role. However, those practitioners in our Trust have moved on, or are about to, because there was no clear [career] pathway for them to follow. A national programme should address this'. (Trust 55)

External pressures to develop the role and concerns about patient care

About one-third of Trusts are resisting the introduction of the level 4 worker. Some DoNs indicated that the lack of evidence of the effectiveness of the role and enforcement by external agencies (rather than perceived needs of the organization) had hampered development of the role. In other areas, lack of development was attributed to a paucity of available funds to support the emergence of the role:

'The funding to develop the training for this role was not made available, primarily because of the excess numbers of student nurses completing training without NHS jobs. It is unlikely that we will be developing the role without external educational funding'. (Trust 162)

However, in other organizations, DoNs expressed concerns as to why another level of nurse with different educational preparation was required in the nursing workforce:

'In my view these roles devalue themselves and devalue nursing. Why for instance would an assistant practitioner be educated to [foundation] degree level and not want to have the opportunity to become a qualified nurse? We have seen these arguments before in the history of nursing, in particular the [enrolled nurse] role, and the resulting travesty of nurses training for, in some circumstances, up to 6 years to get a basic nursing qualification'. (Trust 11)

Variations in preparation for the level 4 role were described by DoNs. In most areas these workers undertook a foundation degree that had been developed collaboratively between the Trust and local universities. However, in a limited number of areas other qualifications were being used to prepare assistant staff for the banding:

'We have not gone down the foundation degree route for academic preparation, but rather a level 1 certificate course that we have developed with our Higher Education Institute provider. This was being funded by our SHA but is changing this year'. (Trust 131)

In other organizations, it was lack of registration and regulation of the level 4 workers that had deterred the Trust from introducing the role. Some concerns were expressed about patient safety:

'Assistant practitioners are neither one thing [registered professionals] nor another [health care assistants]. Specifically, however, they are not post holders that are under the auspices of the Nursing and Midwifery Council and yet in some instances are involved in patient care where highly skilled invasive procedures are being practiced by them'. (Trust 11)

In areas deploying the role, it was also suggested that there were variations in acceptance and recognition of the role and its future directions:

'There is a lack of recognition of the role and in some circumstances professional jealousy; that is role boundaries are being constructed to prevent development of the assistant roles... [There is a] general feeling of anxiety about where the role is going and what these workers will do. Importantly these roles should be patient centred

to support care delivery by health care team rather than focused on what tasks [they do]'. (Trust 27)

Discussion

Ensuring that patient care is delivered by a workforce fit for purpose is an international priority and in the UK is made explicit in plans for NHS Modernization. The assistant workforce has an important role to play in this agenda. Their numbers (across health and social care) are steadily increasing and their scope of practice extending in response to service delivery demands. The UK Department of Health (2006a) envisages that future nursing care will be delivered by a nursing team that utilizes the assistant practitioner role. This study describes the introduction of the AP role in acute NHS (hospital) Trusts in England. This is a (relatively) new workforce initiative that seeks to make better use of staff resources and skills through expansion of support worker roles. This policy initiative has been recognized and supported by all ten SHAs in England. The role has been introduced in almost half (46%) of acute NHS (hospital) Trusts. This paper describes, for the first time, the national picture in terms of where the role has been introduced, plans for its introduction and the clinical specialities that are utilizing this relatively new role to support the work of registered nurses in acute NHS (hospital) Trusts only.

Since 2002, the role has been introduced across acute Trusts (and SHAs) at differing rates; initially introduced by Workforce Development Confederations (abolished in 2006) and subsequently supported by SHAs. Some Trusts reported that the 'equivalent' of a Band 4 role had been introduced as early as 1999. However, the numbers of these are very small and it is not clear whether their remit corresponds with that of the Changing Workforce Programme (Department of Health NHS Modernisation Agency 2003). There is a concentration of the role in the North West of England and this is most likely attributable to Trusts in that SHA being pilot sites for the Changing Workforce Programme. However, growth in this SHA is slowing down, while there are projected increases in other SHAs, such as London and East of England. If Trusts introduce the role as planned, by 2009 there will be APs in over two-thirds of acute Trusts in England. However, this means that about one-third of acute Trusts have no immediate plans for introducing the AP role. This raises tensions between national policy visions of future nursing care delivery by a nursing team that utilizes the

AP role (Department of Health 2006a) and recognition and enactment of these policies at a local organizational level. DoNs resisting introduction of the AP role highlight the importance of establishing local need for a change in their workforce rather than having to respond to an enforced policy.

Numbers of APs working within Trusts varies considerably. This scoping study indicates that the role is most widely used in medical and surgical ward areas, with expected increases in numbers in these clinical areas. In addition, the Band 4 role is being used for specialist service delivery, such as intravenous infusion and in critical care environments. Again, this seems to vary between and within Trusts. Further, the impact of APs on patient care and service delivery in different clinical specialities is not yet understood. It is also difficult to determine why the introduction of the role is so varied, such that some Trusts have no imminent plans to introduce the role over the next couple of years. According to DoNs the reasons for this include lack of evidence for effectiveness of the role, lack of perceived need for the role by the organization, financial restraints and concerns about patient safety and professional jurisdiction. Further exploration of workforce planning strategies in relation to the introduction of the AP role is therefore warranted. In particular, there is a need to explore the acceptability and appropriateness of national workforce policy initiatives with DoNs who are determining the appropriate nursing skill mix for the delivery of care at a local level.

Responses from the DoNs reveal levels of confusion about the differing contributions of support staff at Band 2 and 3, when compared with Band 4. This confusion was apparent in Trusts both with and without the Band 4 practitioners. Some Trusts have introduced 'extended' roles for support staff at level 3 and therefore dismissed any added contribution of the Band 4 assistant. Some DoNs identify the Band 4 role as a route for career progression for support staff, and in particular staff from within the organization. In contrast, others are actively resisting introduction of the role because it constitutes another tier in the nursing workforce. Uncertainty surrounding the introduction (or not) of APs in the NHS is exemplified by the Nursing and Midwifery Council's lack of resolution regarding the regulation of support staff, including Band 4 AP roles. Professional and policy debates concerning possibilities for the regulation of healthcare support workers are long standing with strong support for regulation to ensure patient safety and public protection (Department of Health 2006b, Royal College of Nursing 2007). A pilot of employer-led regulation of all health care

support workers is underway in Scotland (Scottish Executive Health Department 2006) and the Welsh Assembly has recently announced plans for future regulation of the assistant workforce (Tweddell 2008). In addition to protecting patient safety, it is anticipated that regulation will control the expansion of the assistant workforce and their scope of practice, ensure standards for conduct and education and provide recognition and career pathway for the assistant role (Hopkins 2008). It remains to be seen whether regulation will provide any further clarity of differentiation between the Band 3 health care support worker and Band 4 AP. This study highlights that there are already differences in the educational preparation and training of staff for Band 4 positions; 2-year foundation degrees and 1-year higher education certificates are currently deemed as acceptable in organizations responding to our questionnaire. However, this raises an important issue regarding the transferability of these varied qualifications. Lack of standardization may impact on career progression for APs if the qualification for their role is not accepted in another organization.

Currently, it would appear that, the potential contribution of Band 4 staff is not being fully recognized as a result of confusion about the role because it sits between an 'assistant' and 'professional'. In addition, this confusion may result in exploitation of Band 3 support workers, by expanding their scope of practice with lack of reward, or under-utilization of Band 4 APs as a result of a lack of understanding of the role they have been prepared to undertake. Lack of role clarity for support staff and varied preparation for practice have been identified in other studies (Allen 2001, Spilsbury & Meyer 2004). The contribution of the AP role – in particular the extent to which the role supplements, complements, or replaces some of the duties and responsibilities of registered nurses, preparation for the role and its position within the nursing workforce – is certainly worthy of future study. This would lead not only to understanding more about APs, but also a way of exploring the ongoing management of skill mix within health care.

Study limitations

This is a cross-sectional mapping study providing data of the AP role at one point in time, with an indication of planned future introduction. In addition, the study focuses on a UK workforce policy initiative which does not directly translate to international settings. Nonetheless, the findings will be of interest as a result of pressures on nurse managers to ensure their nursing

workforce is fit for purpose. The data were generated through self-report by DoNs and therefore relies on their accurate reporting of the AP role in organizations. In addition, future introduction of the role relies on projections which may not actually occur for a variety of reasons (such as financial restrictions or policy changes). Any interpretation of future growth should therefore be treated with caution. Not all DoNs offered additional comments about the AP role and so qualitative data may only be provided by those who support the role or have opinions they wish to voice. Exploring the perspectives of DoNs when considering the Band 4 role as part of their workforce strategies requires further in-depth exploration. However, data offered by DoNs provides some useful insights for the purposes of this descriptive study of current and planned service provision through use of the AP role.

Conclusion and implications for nursing management

This study makes an important contribution to the sparse evidence base about introduction and development of the AP role in English acute NHS Trusts. The UK national workforce policy initiative of introducing a Band 4 AP is being recognized in over half of acute Trusts in England and their numbers are set to steadily increase in future years. As such, DoNs and Nurse Managers will be faced with decisions about whether the Band 4 AP role has a place in their nursing workforce strategies. Providing detail of the growing numbers of these workers and the areas where they are employed will be useful for the decision making of Nurse Managers for these purposes. However, further empirical evidence is required to ascertain the impact of the role on patient care and service delivery and the potential effects of its 'patchy' introduction across clinical specialities and acute Trusts.

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