Assistant practitioner scoping project
Assistant Practitioner Scoping Project November 2010
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Appendix 1: Numbers of APs across the UK - NHS

Acknowledgement

With grateful thanks to the participants of the study and to Dr Joanna Leaviss for her research and input into the report.

All information used in this report was accurate at the time of publishing.
1. Executive summary

- Workforce figures and growth in foundation degree provision demonstrates that there are increasing numbers of APs in areas across the UK.

- Regulation of the AP workforce continues to be a key issue for APs, nursing colleagues, employers and patients. Lack of regulation has meant that there is little control over entry to employment and little standardisation of roles, competencies and education (Griffiths et al., 2010). Regulation is a key factor in public protection and considered by APs and their colleagues to be essential to the safe development of their role.

- In organisations where the role has been developed there is evidence of benefits to patients, APs and the nursing team. However, there are challenges which include maintaining adequate levels of training, supervision and support by nursing staff. Confusion remains around accountability despite considerable available information.

- The role of the AP in some areas includes high level and complex tasks, and this, together with evidence that some AP roles are seen as substitutive, can create tensions in terms of accountability and role definition. There is also concern that the role could be used as a cost-cutting measure by the employer.

- There is little continuity of training provision for APs, and this will have an impact on transferability of roles and the understanding of the role between employers and across all four countries of the UK.
2. Background

The role of the AP was first introduced in the north west of England in 2002. 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 (DH) NHS Modernisation Agency, 2003).

Decreasing numbers of registered health staff, coupled with a surplus of applications for support roles, prompted the development of a role which sat in between traditional support workers and registered staff. Set against a backdrop of an ageing population, increasing demands on the health service and a demand for a more patient-centred approach to health care, the role of the AP was developed in order to fill the skills gap and provide care at an appropriate level for patients requiring a range of services which frequently transcended the traditional professional boundaries.

There has been considerable interest in workforce development in recent years, and the widening participation agenda highlights the importance of developing a workforce that maximises capacity to deliver safe and high quality care, ensures the workforce represents the community it serves and meets future skill shortages for nurses (DH, 2010).

The AP role has since been developed across the UK, and several evaluation papers document these developments and chart the impact of the introduction of this role into the health care workforce (Selfe et al., 2008; Spilsbury et al., 2008).

Aims

The aim of the current scoping exercise was to review the existing up-to-date available information relating to the development of APs, and to map the current UK wide support workforce with an emphasis on those working at or towards level four of the National Career Framework.

The report aims specifically to analyse:
- numbers of APs across the UK in the NHS and independent sectors
- demographics of the AP workforce
- range of job titles and job descriptions related to the role
- range of tasks performed by APs including what professional boundaries they work across.

The report also explores:
- the educational systems used to train APs
- the career pathways into and beyond the role of the AP
- the consequences of the role of the AP to the patient, APs themselves, and the wider nursing team
- the aspirations of the HCAs to become APs.

Methodology

A literature review was performed and an email sent out to key contacts and stakeholders across the UK requesting basic information covering the aims of the project. The email was followed up by telephone calls to respondents in order to collate more specific information, as detailed in the report.

The report outlines the information collated in the literature review and that obtained by the current scoping exercise.
3. Literature review

**Numbers of assistant practitioners across the UK - NHS**

There is currently no pooled data available that enables a comprehensive examination of the numbers of APs working in the UK.

England, Wales and Northern Ireland do not currently collect information on numbers of band four nursing staff. NHS Scotland Workforce Information distinguishes between bands for nursing staff. Anecdotal reports suggest that some APs may be working in Scotland at bands five and six.

*Note:* the Nursing and Midwifery Codes available within the *NHS Occupation code manual* (NHS, 2010) are being updated to reflect the structure of the modern nursing workforce and fulfil the needs of local, regional and national workforce planning. While there have been codes available for APs working in the health care scientist area for some time, the addition of APs into the nursing area in 2011 will complete the roll out of this coding and allow consistent recording and monitoring of this important and growing staff group across the NHS. The manual is available at: [www.ic.nhs.uk/webfiles/data%20collections/NHS_Occupation_Code_Manual_Version_8_1.pdf](http://www.ic.nhs.uk/webfiles/data%20collections/NHS_Occupation_Code_Manual_Version_8_1.pdf)

**Demographics of assistant practitioners**

There is limited information currently available that explores the demographics of APs. A large-scale study of APs in the UK (Spilsbury et al., 2010) found that the majority of APs tended to be white British females in their mid-forties, who had considerable experience of the NHS as HCAs. Benson et al. (2006) also found the majority of their sample of APs to be female. Over half had children or dependents, and an average age of 40. Ninety per cent were white British. Selfe et al. (2008) found 92 per cent of their sample of APs in the North West to be female. Most of the APs were in their forties. Ninety per cent had been currently employed in a support role before undertaking a foundation degree. This information corresponded with that recorded in the current scoping exercise.

The following data were collected from a number of sources in order to attempt to build a picture of the spread of the nursing workforce across the UK in 2009 (Table 1).

<table>
<thead>
<tr>
<th>2009 survey</th>
<th>Registered nursing &amp; midwifery staff</th>
<th>Second level nurses</th>
<th>Support staff total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>353,570</td>
<td>7,892</td>
<td>278,390</td>
<td>Many different titles for the roles, including Nursing Assistant (103,255), HCAs (50,542), Support Worker (31,585)</td>
</tr>
<tr>
<td>Wales</td>
<td>33,021</td>
<td>172</td>
<td>15,000 approx</td>
<td>(Welsh Assembly Government 2010)</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>16,336</td>
<td></td>
<td>4,715</td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td>68,681</td>
<td></td>
<td></td>
<td>Band 2 (12,774), Band 3 (5,151), Band 4 (480)</td>
</tr>
</tbody>
</table>
Skills for Health conducted a scoping exercise in 2009 to explore the numbers of APs in a sample of regions in England. Information about the numbers of APs employed by health regions was provided by regional directors through their local contacts. The following APs were identified in these regions:

London: 101
South Central: 41
East Midlands: 227
North West: 21
South West: 302

*Numbers of APs across the UK – independent sector:* there is limited data to identify the numbers of APs working in the independent sector.

*General practice:* the Royal College of General Practitioners confirms that little information is gathered in relation to workforce data in general practice. Identifying APs who are employed in general practice would therefore rely on surveying individual GP practices.

*Care homes:* although there is no pooled data relating to the number of APs working in care homes, a number of foundation degrees relevant to social care are currently offered.

*Educational systems training assistant practitioners*

The development of AP level roles within the health services is increasingly focused on formal educational pathways. Different methods of training of APs have been described; however the most common route to AP qualification has been shown to be the foundation degree (Ferry et al., 2010). Foundation degrees are not currently delivered in Scotland, where the usual preparation route for AP status is the HND.

Foundation degrees may be generic (for example Health and Social Care), or highly specific (for example Mental Health or Learning Disabilities). There is currently no comprehensive data available to show the numbers of people enrolled on foundation degrees in subjects related to health and social care. However, a recent scoping exercise by Skills for Health (2010) explored level four educational provision in the UK. Findings showed that:

- for core health-related subjects, health and social care has the widest provision with 90 courses available and comprehensive coverage across England
- by region, the highest proportion of foundation degrees relevant to health can be found in the North West (72), London (43) and the East of England (36).

Foundation Degree Forward (fdf) provided a list of health related foundation degrees by region. In addition to the regions highlighted in the Skills for Health scoping report, numbers of foundation degrees by region were: East Midlands (9), North East (9), South East (20), South West (15), West Midlands (32) and Yorkshire (20). The Open University also provides four relevant courses. It is, however, unclear how many of these courses are running this academic year (2010/11).

*Range of job titles and job descriptions for assistant practitioners*

There is no consistent job description for the role of an AP. Job titles and descriptions vary from region to region. The terms ‘assistant’ and ‘associate’ practitioner are reported to have been used interchangeably throughout England (DH, 2006; Wakefield et al., 2009). Ferry et al. (2010) identified a number of job descriptions used to describe the AP role. These descriptions vary as a result of the wide range of roles given to APs across different trusts and different areas of health. However, Wakefield et al. (2009, p. 288) highlight the need for careful consideration when creating job descriptions for APs, stating ‘an ill-defined job
description creates difficulties in ensuring accountability and responsibility. Alternatively a too tightly defined job description stifles creativity and flexibility, which undermines the reasons for introducing APs in the first place.

An analysis of AP job descriptions by Skills for Health (2009) identified two themes to the range of job descriptions given to AP roles. These were:

- supporting the work of a registered professional, usually in ways determined by that professional at that time, rather than codified in advance
- undertaking particular tasks identified in advance, always under the supervision of a registered professional, but with a good deal of autonomy. (Cited from Ferry et al., 2010).

A previous analysis of 16 AP job descriptions within one health region by Wakefield et al. (2009) showed wide variation in the tasks or roles that APs are expected to assist with or substitute for as part of their work. Five categories of job description were described. These ranged from ‘fully assistive’ to ‘fully autonomous/independent practitioner’. These categories were described as follows (numbers in brackets represent number of job descriptions out of the 16 analysed that fitted this category):

- **fully assistive** – post holder who worker in assistive roles and did not take on tasks that fell outside this remit. In reality this postholder was expected to do little more than an HCA (1/16)
- **supportive assistive** – post-holder who undertook tasks which were largely supportive of the work of the registered practitioner and predominantly assistive in their orientation (7/16)
- **blended supportive assistive/substitutive** – post-holder that took on largely supportive assistive tasks but who on occasions was expected to take the place of or substitute for the registered practitioner so as to act more independently (4/16)
- **substitutive/autonomous** – post-holder who predominantly substituted for the registered practitioner. However, there were occasions when the post-holder was expected to act more independently and not require any form of supervision (3/16)
- **fully autonomous/independent practitioner** – post-holder that functioned as a fully independent practitioner. (1/16)

(Wakefield et al., 2009, pp.5)

For a selection of sample job titles and job descriptions used to describe APs in the East of England see Ferry et al. (2010).

**Range of tasks and professional boundaries that assistant practitioners work across**

The wide range of tasks that APs perform and the professional boundaries that they work across have been well documented in the literature for example see Ferry et al. (2010) for a range of AP job descriptions, McGowan and Campbell (2010) for a description of the tasks of an AP in a chemotherapy unit, or Kilgannon (2008) for a description of key functions of a range of AP roles.

**Aspirations of health care assistants to become assistant practitioners**

Selfe et al. (2008) note that completion of an AP training course increased future career expectations of newly qualified APs, and therefore aspirations of HCAs at the start of AP training may not match their aspirations at the end. One respondent reported that the course is very demanding and that it transforms individuals. There has been little if any research which explores this issue.
4. Scoping exercise report

**Numbers of assistant practitioners across the UK - NHS**

The current scoping exercise also sought to gather information on the numbers and spread of APs in the UK through regional contacts. This exercise yielded a sample of responses, which are not comprehensive but instead contribute to a picture of the growing development of the role of APs in England (Appendix 1).

**England**

In England, responses were given by four regions and seven trusts including one mental health trust and one community health service. The first region to develop the role of the AP was the North West, and since 2002 over 2,500 APs have qualified, working across a range of professions. Annually 300-400 APs are trained in this region. From the other respondents, approximately 955 APs in total have been trained, with an annual expectation of around 31 trainee APs. Two of the trusts were in the planning stages of a development programme, and workforce planning was in place across the remaining trusts for approximately 890 new APs. This is all contributes to a picture of the growing development of the AP role in England.

**Northern Ireland**

Requests for information on current numbers of APs were sent to each of the five Health and Social Care (HSC) Trusts in Northern Ireland. Responses have been received from three trusts to date. Two of these trusts do not employ any APs, but one trust employs 10 band four staff, with an additional 20 band three ‘practitioners assistants’ working on Hospital at Night (HaN).

**Wales**

Requests for information on current numbers of APs were sent to each of the seven Welsh local health boards. Responses have been received from four health boards to date. Two of the boards employ significant numbers of level four staff, one at 143, the other 162. One further board employs 17 APs, with a current cohort of 20 to start training in November 2010. A greater number is planned for 2011. One of the boards has no AP posts or plans for training in place.

**Scotland**

Requests for information on current numbers of APs were sent to each of the 14 Scottish health boards. Two responses have been received to date. One health board that responded has no APs and no plans to implement the role, and the other has four band four ‘advanced perioperative assistants’.

**Numbers of assistant practitioners across the UK – independent sector**

**General Practice:** One source contacted for the current exercise reported that GP surgeries in the North West found it difficult to obtain insurance for APs as insurance companies have very set parameters for their cover. One primary care trust (PCT) took one year to obtain appropriate insurance for the employment of band fours.

**Care homes:** Friends of the Elderly (FoE) developed a foundation degree to train five ‘lead carers’ (working at a level equivalent to band four) within their care homes. Due to the financial burden (£3000 per student), it was reported by a source for FoE that there were currently no plans to fund any further places unless funding became available from the government:
Hospices: three hospice sites (Help the Hospices) have developed roles for APs, with 10-20 APs per site created in conjunction with a foundation degree in palliative and end of life care. 10 APs have already qualified in Leicester and Rutland and are in the process of training another small group.

BUPA: Anecdotal reports from key contacts in this scoping exercise suggest that BUPA have not moved towards APs at all. BUPA were contacted in the course of this scoping exercise but have yet to respond.

Educational systems training assistant practitioners

Attempts were made to verify which courses were running this year and to identify numbers of students enrolled in a sample of these courses for 2010.

NHS: Five universities in England responded, all running foundation degrees with a range of titles including ‘Health Care Practice’ and ‘Health and Social Care’. One trust delivers their own programme through one of the universities. Several of the universities were waiting funding decisions before confirming numbers and courses.

Independent sector: A number of foundation degrees relevant to the development of assistant practitioners in the independent sector indicate a presence of APs. Examples include:

primary care: London South Bank University - foundation degree in Primary Care Assistant Practitioner. This course has been offered for a number of years and has a group of 17 this year.

care homes: Foundation Degree Forward funded the development of a foundation degree in Skills for Care (University of Gloucestershire). Much of the focus of this foundation degree was on gerontology. FotE funded five health care support workers (HCSW) to undertake the programme at a cost of £3000 per HCSW per year over two years, a total cost of £30,000. This qualification leads to a new position within the organisation as a ‘lead carer’ similar to band four, with a corresponding pay increase. A source within FotE maintained that this training cannot continue without government funding.

hospices: a foundation degree in palliative and supportive care has recently been developed by the Leicestershire & Rutland Hospice (LOROS), supported by fdf and Help the Hospices, with the University of Northampton. The programme was designed to meet the End of Life Care Strategy. Three sites are piloting the programme – St Margaret’s Hospice (South West region), St Nicholas Hospice (East of England region), St Ann’s Hospice (North West region). Each site aims to develop 10-20 APs through this training. Ten APs have already been trained in Leicester and Rutland. A recent scoping report (Skills for Health, 2010) highlights scope to develop level four palliative care and end of life care qualifications as priority areas.

Continuing development of foundation degrees

The continued development of foundation degrees in health and social care suggests an increasing trend toward the development of the assistant practitioner role. Examples include:

Skills for Care have been working in partnership with fdf to explore the potential to develop foundation degrees to support the adult social care workforce. UK consortia are developing foundation degrees in social care with a range of specialist focuses including: dementia (North West Consortium); commissioning and procurement (Northampton Consortium); visual impairment (York St John University Consortium); long-term conditions and learning disabilities (Staffordshire and Worcester Consortium).

The West Midlands foundation degree scheme for Health and Social Care aimed to ‘develop a collaborative working model for the development of foundation degree programmes within
the health and social care sector across the region’ (Tatum et al. 2010). The scheme emphasises a need for a generic approach to the content of foundation degrees with specialist focus, and recognises the importance of consistent financial commitment from employers. The West Midlands strategic health authority (SHA) includes the development of the AP role through foundation degrees as one of four work strands within its Widening Participation programme.

Demographic information from the current scoping exercise

Some of those who responded to the request for information for the current scoping exercise reported demographic information for their APs.

The information given confirms that previously reported, for example the majority of APs were found to be female and between the ages of 30 and 50. All reported previous health care experience, and education levels varied from NVQs to degree level.

Range of tasks and professional boundaries that assistant practitioners work across

Task descriptions given by those who contributed to the current scoping exercise show a wide range of tasks performed by the APs.

In the community some APs work across nursing and allied health professional boundaries. Their work includes some degree of podiatry, tissue viability, diabetes care, speech and language therapy, dietetics and health promotion.

In mental health, duties include core planning, liaison work, physical health care and psychological competencies.

In some trusts the APs perform standard tasks including wound care, administration of medications and administrative tasks. Several trusts report that APs perform assessments of patients in own work area, working within limits of competence and authority, management of a group of patients, early identification of acutely ill patients, discharge and transfer of patients with complex needs. In some areas less experienced nurses refer patients to the APs who have more specialised skills in their areas.

More specific competencies include cannulation and flushing of cannulae, urinary catheterisation, naso gastric tube insertion and management, management of fluids, ordering of routine bloods/investigations, monitoring mechanical infusion pump devices, tracheostomy care and suctioning, undertake vacuum assisted closure dressings.

In one trust, APs in oncology administer chemotherapy drugs to patients.

Aspirations of health care assistants to become assistant practitioners

Many of the respondents to the current scoping exercise reported that frequently HCAs wished to undertake AP training. This sometimes meant that there was more demand than there were places to offer. Two main aspirations were reported. Some HCAs saw AP training as a route to becoming a registered nurse. Others had no intention of undertaking registered nurse training but wanted more challenge than was offered in their current roles as support workers.

One trust studied the expectations of the AP role by those embarking on the course. All participants reported a desire to improve their own job satisfaction by furthering their practice, gaining confidence, taking on more responsibilities and receiving more professional recognition.

Consequences of the role of assistant practitioner to the patient, the nursing team and the AP
Evaluation of AP programmes have highlighted a number of impacts to the AP, the nursing team and to the patient. The following costs and benefits are taken from both the existing literature (Selfe et al., 2008; Mullen., 2010; Benson and Smith, 2006; Dean, 2010; Huston, 1996; Warne et al., 2002; Scott, 2010; Balls, 2010) and from those who responded to requests for information for the current scoping exercise. Benefits are shown in Table 2 below.

Table 2: Benefits of assistant practitioner role

<table>
<thead>
<tr>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To AP</strong></td>
</tr>
<tr>
<td>Career escalation/progression</td>
</tr>
<tr>
<td>Job satisfaction</td>
</tr>
<tr>
<td>Gaining confidence</td>
</tr>
<tr>
<td>Salary increase</td>
</tr>
<tr>
<td>Increased professional recognition</td>
</tr>
<tr>
<td>Working more independently</td>
</tr>
<tr>
<td><strong>To nursing team</strong></td>
</tr>
<tr>
<td>Increased capacity of registered professionals</td>
</tr>
<tr>
<td>Frees up registered nurses’ (RN) time</td>
</tr>
<tr>
<td>Increased productivity</td>
</tr>
<tr>
<td>Organisational performance and targets</td>
</tr>
<tr>
<td>Breadth of roles</td>
</tr>
<tr>
<td>Skills and knowledge transfer</td>
</tr>
<tr>
<td>Enhanced integration of interagency working</td>
</tr>
<tr>
<td>Effective communication role across different clinical staff</td>
</tr>
<tr>
<td><strong>To patient</strong></td>
</tr>
<tr>
<td>Quality of care</td>
</tr>
<tr>
<td>Development of stronger relationships with patients</td>
</tr>
<tr>
<td>Improved access to services</td>
</tr>
<tr>
<td>AP seen as more approachable</td>
</tr>
<tr>
<td>Continuity of care</td>
</tr>
<tr>
<td>More extended time to spend with users</td>
</tr>
</tbody>
</table>

Potential costs are shown in Table 3 below.

Table 3: Potential costs of assistant practitioner role

<table>
<thead>
<tr>
<th>Potential costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To AP</strong></td>
</tr>
<tr>
<td>Limited career choice in some settings</td>
</tr>
<tr>
<td>Academically tough</td>
</tr>
<tr>
<td>Financial burden to trainee AP</td>
</tr>
<tr>
<td><strong>To nursing team</strong></td>
</tr>
<tr>
<td>Overburdening of supervision and training resources</td>
</tr>
<tr>
<td>Dilution of registered nurse (RN) role</td>
</tr>
<tr>
<td>Lack of accountability, no code of conduct</td>
</tr>
<tr>
<td><strong>To patient</strong></td>
</tr>
<tr>
<td>Patients with greatest needs often cared for by those with least skill and experience</td>
</tr>
<tr>
<td>Compromise patient safety and quality of care</td>
</tr>
</tbody>
</table>
5. Conclusions

The role of AP appears to be growing, with an increasing number of foundation degrees being developed and a continuing commitment from several trusts to expand the number of APs in their workforces. Those respondents who had experience of the development of AP programmes within their organisations reported predominantly positive experiences.

Regulation
A key issue to have been raised by respondents concerns the need for regulation for APs. McKenna et al. (2004) highlight concerns for patient safety and standards of care with lack of regulation. One source for the current scoping exercise noted that this lack of regulation has implications for APs too. It was reported that registration is perceived as recognition. Registration was perceived not only to boost confidence for APs, but also that work was limited due to lack of regulation. This was leading to some APs being trained in some of the same skills as registered nurses but being unable to use those skills in practice. It is important to note that in research commissioned by the Nursing & Midwifery Council (NMC) (Griffiths et al., 2010) the status of APs in nursing is seen to raise urgent questions for the NMC. The report notes a potential risk to public safety by the kind of nursing tasks being undertaken by an unregulated AP workforce and in the absence of guaranteed supervision by registered staff and recognises that there is a clear case for regulation of AP in nursing.

Accountability
The report also highlighted the confusion around accountability as the APs perform extended skills and in some cases have patients referred to them by the registered nurses. Anecdotally there remains confusion around the AP role, in particular from registered staff.

Workforce planning
Respondents reported a number of drivers to develop AP programmes within their trusts. A shortage of registered nurses within the workforce was prompting some trusts to develop more AP roles. Conversely, some trusts reported that they were preparing to develop an AP programme in order to up-skill health care support workers who were keen for more responsibility and greater challenge in their work practice. Concern was raised that the development of AP roles should not be simply a cost-cutting exercise by trusts.

Consistency of standards of education
A lack of formal definitions for APs has meant that there has been little consensus as to their roles, functions, standards, competencies and funding of the AP position across different trusts and health regions. Although foundation degrees are the most prevalent educational route for AP training, many trusts offer their own in-house training programmes or accept different educational qualifications. This has led to concern among some respondents that skills gained during AP training may not be transferable between trusts and regions. There is a perceived need for an education framework that is consistent not only within but between regions. In-house training is perceived as less transferable than formal qualifications such as foundation degrees.

Funding commitment
Developing an educational programme to train APs was seen as being easier than obtaining a consistent commitment to funding by employers. This was highlighted by the uncertainty over the delivery of some of this year’s foundation degrees whilst education providers and potential trainees wait for confirmation that their course will go ahead. Funding was also an issue for the charity sector, where no new employees could embark on one particular AP training programme due to a lack of funds within the organisation. Spilsbury et al. (2008) found that a lack of funds within some trusts was preventing the development of more AP roles.

Coding
A number of respondents raised the issue of the difficulty obtaining data regarding the numbers and spread of APs across the UK due to the lack of coding for the different bandings within the health services. Centralised coding of the different bandings would enable easier
tracking of APs on a year by year basis across the UK. This is being revised in March 2011 as previously noted to include codes for AP roles.

*Further research*

The apparent growth in the numbers of APs across the UK has been shown to offer a range of benefits to both staff and patients. Further study addressing some of the concerns raised by those involved with the development of the AP role and exploring the aspirations of those who choose to undertake AP training would contribute to the continued success of the role of the AP in nursing.
6. References


Huston C (1996). Unlicensed assistive personnel: a solution to dwindling health care resources or the precursor to the apocalypse of registered nursing, Nursing Outlook 44 (2) pp.66-73.


Wakefield et al. (2009) Assistant or substitute: Exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions, Health Policy, 90 (2) pp.286-295.


7. Further reading

Skills for Health (2011) The role of assistant practitioners in the NHS: factors affecting evolution and development of the role, Bristol: SfH.

Skills for Health (2009) Core standards for assistant practitioners, Bristol: SfH.
### Appendix 1: Numbers of APs across the UK – NHS

<table>
<thead>
<tr>
<th>Area/Board</th>
<th>Total numbers of APs trained</th>
<th>Annual numbers of APs in training</th>
<th>2010/11 cohort</th>
<th>Workforce plans for APs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 1</td>
<td>over 2,500</td>
<td>300-400</td>
<td>340</td>
<td></td>
<td>APs work across many professions and roles range from generic to specific.</td>
</tr>
<tr>
<td>Region 2</td>
<td>111</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 4</td>
<td>805 Full Time Equivalent*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust A</td>
<td>16</td>
<td>20</td>
<td>21</td>
<td>20 per annum</td>
<td></td>
</tr>
<tr>
<td>Trust B</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Currently looking to develop the HCA role, currently doing scoping work into APs. No decisions made yet into numbers.</td>
</tr>
<tr>
<td>Trust D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Are in the planning stages of a programme of AP development. No decisions have currently been made on numbers of AP roles to be developed.</td>
</tr>
<tr>
<td>Trust E</td>
<td></td>
<td></td>
<td>8</td>
<td></td>
<td>4 personality disorder (2 female, 2 male), 2 autism, 2 independent life skills (to be linked with occupational therapy).</td>
</tr>
<tr>
<td>Mental Health Trust 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Has developed roles for 7 APs, with expanding utilisation.</td>
</tr>
<tr>
<td>Community Health Services 1</td>
<td>13</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Requests for information on current numbers of APs were sent to each of the 5 Health and Social Care (HSC) Trusts in Northern Ireland. Responses have been received from 3 Trusts to date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Wales

Requests for information on current numbers of APs were sent to each of the 7 Welsh Local Health Boards. Responses have been received from 4 Health Boards to date.

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Number of APs</th>
<th>Development/Role</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Board 1</td>
<td>143</td>
<td>Offer a level 4 certificate that forms the basis for any AP development.</td>
<td></td>
</tr>
<tr>
<td>Health Board 2</td>
<td></td>
<td>No specific nursing AP posts and no educational programmes to support their development.</td>
<td></td>
</tr>
<tr>
<td>Health Board 3</td>
<td>162</td>
<td>The term ‘Assistant Practitioner’ is not used within the organisation. These Band 4s cover all hospital, mental health and community services within the health board.</td>
<td></td>
</tr>
</tbody>
</table>

### Scotland

Requests for information on current numbers of APs were sent to each of the 14 Scottish Health Boards. 2 responses have been received to date.

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Number of APs</th>
<th>Development/Role</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Board 5</td>
<td>4</td>
<td>Undertook new SVQ level 3 in surgical support, to become advanced perioperative assistants. This role was evaluated by Agenda for Change and returned as Band 4</td>
<td></td>
</tr>
<tr>
<td>Health Board 6</td>
<td></td>
<td>No APs at band 4 and no plans to implement them.</td>
<td></td>
</tr>
</tbody>
</table>
The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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