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Re-Evaluating the Assistant Practitioner Role in NHS England: Survey Findings

Abstract

Aim and background: In the absence of data providing an overview on the state of the assistant practitioner (AP) workforce, this study surveys trusts in NHS England with the aim of establishing how the role is viewed, used and managed.

Methods: Based on an earlier survey undertaken around a decade ago, an online questionnaire was sent to members of an assistant practitioner network, generating a response from over fifty different trusts, drawn from different regions and healthcare settings.

Results: The survey results highlight the increased use of assistant practitioners by trusts and in a more diverse range of clinical settings. This increase has been driven more by the apparent value of the APs in addressing issues of service design and quality, than by attempts to reduce costs through substitution and skill mix dilution.

Conclusions:

The AP role has retained value to nurse managers in developing and designing services, and indeed in establishing a career pathway for healthcare assistants. Most striking are future intentions to continue using APs, particularly within the context of the emerging nursing associate (NA) role. This suggests that the AP and NA are likely to be complementary rather than alternative roles.

Implications for Nursing Managers:

Nurse managers might note the continuing use and value of the AP role, although as means of improving design and quality as well as providing career opportunities for healthcare assistants, rather than as a way of saving labour costs. Clearly the AP role has a future although there is scope to review its position in relation to the newly emerging nurse associate role.

Key Words: Assistant Practitioners, Utilisation, Management, Future, Drivers

Introduction

The assistant practitioner (AP) role has been an established part of the workforce in NHS England for over a decade and a half. It emerged in 2002 as a new role developed by the Modernisation Agency, a body set-up by then Labour Government to help reform and create a more 'patient-centred' NHS. As an advanced support role, the AP was positioned between the healthcare assistant (HCA) and the registered nurse and other non-medical professions. While the HCA remained a tightly supervised 'unqualified' role undertaking a limited range of frontline tasks associated with the fundamentals of care, the AP was required to hold a formal (level 5) qualification, typically a two-year Foundation Degree. This formal training broadened and deepened AP clinical competencies, providing a knowledge-base for the performance of more complex activities including, for example, taking responsibility for a bay of patients or even administering non-controlled drugs. However, in common with the HCA, the AP role remained unregistered. It has been rooted in a broadly conceived national job description, which, in turn, underpins a designated pay band (four) within a national (nine band) grading structure.

The sector skills council for healthcare, Skills for Health (2011:4), has described the AP role as:

> Requiring a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The assistant practitioner (is) 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.

However, within the context of such a general description, the substantive form assumed by the AP role remains loosely defined. A scoping review of the role noted, 'There is no universally accepted definition of the assistant practitioner' (Mackinnon and Kearney, 2009:2). Weakly regulated and unregistered, the AP role has raised debate about professional accountability, patient risk and care quality (Griffiths and Robinson, 2010). At the same time, with healthcare employers retaining considerable discretion on how they use the role (Skills for Care, 2011), the AP has become a flexible resource (Wakefield, 2009) with the capacity to address local circumstances and needs (Wheeler, 2017).

Given this sensitivity to local factors, employer approaches to the AP role have been diverse and our understanding of them uneven. Self-selecting case studies have explored aspects of the role in different trusts and healthcare settings (Harrison and Virden, 2011; Mathews, 2015). Indeed, attention

has been drawn to the tasks performed by APs in specific clinical contexts, for example administering local anaesthetics for minor surgical procedures in a dermatology department, (Kessler et al, 2017) and close support for children with gastronomies in a community children's team (Kessler and Nolan, 2018). However, a broader evaluation of the state of the AP workforce has been lacking. Even one of the most in-depth studies of the AP role undertaken by Miller et al (2015) was based on qualitative interviews and focus group data drawn from a limited number of sites.

A study by Splisbury et al's (2009), published in this journal, provides one of the few overviews of the AP workforce, with a survey of nursing directors seeking to map the use of APs by trust and clinical setting in NHS England. A follow-up to this study, and more general re-evaluation of how the AP role is viewed, used and managed, is timely for a number for reasons. It is around ten years since the Spilsbury et al survey, and NHS England has been through major changes. These include organisational reforms introduced by the Health and Social Care Act, 2012 and 'an unprecedented slowdown in NHS spending since 2010' (Appleby et al, 2014:3), which might be expected to impact on the structure and management of the nursing and wider healthcare workforce.

More recently the introduction of the nursing associate (NA) role in the wake of a Health Education England (HEE, 2016) commissioned report on the future of education and training for registered nurses and care assistants, has brought the AP role back into sharp relief. With the phasing out of the regulated State Enrolled Nurse role from the mid-1980s as nursing became a graduate profession in the UK (Seccombe et al, 1997), the new nursing associate marks a return to a registered second tier of nursing. Around a thousand NAs are due to qualify in early 2019 (Traverse, 2018) and a further thousand soon after. These developments raise questions about how a new registered NA role will sit alongside an existing unregistered AP role.

In this article, we survey trusts in NHS England for their views on and approaches to the AP role as a support to registered nurses and other non-medical professions. In so doing, we refresh Spilsbury et al's work by presenting an updated picture of how and where APs are used. We extend their work by providing new data on the factors driving the use and management of the AP role. The article is divided into four parts: context, methods, findings and implications for management practice. We

argue that the AP role is 'alive and well', and, used to support improved service quality and design, is likely to have a future despite the emergence of the nursing associate.

2. Context

Debate has centred on four main themes related to different aspects of the AP role: use, drivers, management and future. These themes form the basis for the article's research questions.

At the outset the take-up and use of the AP role was uneven and patchy. Certainly, the role was widely deployed in the North West of England (Kigannon and Mullen, 2008), but fared less well in many other regions. Spilsbury et al's (2009) found that only three of ten regions covered by their survey had a medium number of APs in double figures. In the succeeding years the role arguably became 'squeezed' between a healthcare assistant (HCA) workforce adopting increasingly extended roles (Kessler et al, 2012) and a registered nurse workforce continuing as the main administrator of medicines and certainly the sole provider of controlled drugs. Yet, the strengths of the AP role lay in its unregistered status, ensuring its use as a flexible resource, an opportunity to develop more generic and specialist clinical support roles. Moreover, the AP role was available in a range of clinical settings and to support a variety of non-medical healthcare professions (Adams, 2008). This balance of possibilities between the increasing and decreasing use of the AP role gives rise to our first research question:

Have trusts continued to use APs, and, if so, in what clinical settings?

The take-up and use of the AP role might be driven by a variety factors, with the main distinction centring on those related to service quality and design, and those focused on cost-efficiency. The distinction is highlighted by the Royal College of Nursing (2009:6) which notes that, 'The RCN recognises the value of this (AP) role for patients and the nursing team. However, we would become concerned if (it) were to be introduced merely as a means of reducing costs.' Clearly where an advanced support role adds to quicker, more specialist, integrated, user-centred care, patients can benefit. Indeed, such a role might well relieve pressure on registered nurses, by taking on 'routine' tasks and freeing them to perform those better aligned to their professional capabilities. However,

where the introduction of the AP is used to dilute skill mix, and specifically to substitute for the nurse, the process becomes more contentious.

These drivers are complemented by a third set which relate to career progression. The AP role has been presented as part of a grow- your-own solution to nurse shortages, a stepping stone for locally embedded healthcare assistants to move into registered nursing (Malhotra, 2006). Indeed, the sole reference to APs in the HEE's recent draft workforce strategy for NHS England refers to them as a possible source for future registered nurses (HEE, 2017). At the same time, the AP role has also been seen to provide a career opportunity in its own right, a means of helping to recruit, retain and motivate support workers keen to advance their careers but not necessarily into registered nursing. Our second research question is:

> **What factors have encouraged trusts to use of APs, in particular what has been the balance between forces related to service, cost and career progression?**

NHS trusts retain considerable discretion on how they manage their APs, with their approaches often indicative of how they view and use the role. A number of management practices are significant in these respects. Thus, whether trusts rely on internal rather external recruitment to AP roles signals whether the role is seen as a career step for existing support workers and part of a grow-your-own strategy. How APs are allocated in the staff numbers for shifts will have an important impact on the role performed. Where APs are included in the unregistered numbers, they are likely to undertake the standard HCA role, limiting the scope for them to utilise their more technically complex skills. The most contentious practice relates to AP engagement in the administration of medicines (O'Flanagan, 2014), with implications for the extent to which the role overlaps with registered nursing. Our third questions asked about these different management practices:

> **How do trusts recruit APs, classify them for purposes of staff numbers, and use them, if at all, in the administration of medicines?**

The final theme, on the future of the AP role, is closely related to the development of the nursing associate (NA) role, increasingly central to HEE policy developments on the support workforce (HEE, 2017). The NA role has prompted debate in terms of its implications for the AP workforce. As a

national officer from a healthcare trade union, Unison, notes, 'We already have health care assistants, assistant practitioners and registered nurses on wards and in the community. There is real scope for further patient confusion with the introduction of a new (nursing associate) role' https://www.unison.org.uk/news/press-release/2016/01/unison-says-new-nursing-role-is-no-solution-to-the-nursing-shortage/. Such confusion might well extend to those performing in or training to become an AP: How are existing APs to be viewed and used as the NA emerges? Much will depend on whether APs and NAs are seen by trusts as alternative or complementary roles. To view them as alternatives might well be informed by the fact that while both will be found at pay band 4 role, the NA will be a registered role, arguably reducing perceived organizational risks associated with their use, and perhaps encouraging trusts to move forward exclusively with NAs. A complementary approach might reflect a view that APs are particularly well-suited to certain clinical areas: the NA role is after all a ***nurse*** support role, with the AP role still relevant and useful in supporting other non-medical professions (Winnard, 2008). Our fourth questions ask:

> **Are trusts more or less likely to take-on APs in the future, especially in the context of the emerging NA role?**

3. Methodology

In addressing these questions, we administered a survey covering healthcare providers, that is Trusts, in NHS England. The survey design drew on the questionnaire used by Spilsbury et al in their survey, providing an opportunity to plot changes in the incidence and clinical coverage of APs over the last decade or so. Thus, similar questions were asked on the number of APs employed by trusts and in the clinical areas in which they were located. The questions on the management of APs were new, as was the question on the factors driving the use of the role, which asked respondents to indicate the importance (considerable/some/little/none) they attached to various influences. A final set of new questions concentrated on the future, inquiring about trust approaches to the NA role and how they viewed the AP role in this context. Finally, respondents were provided with a space to make comments on any issue covered in the survey. Our use of much of the survey administered by Spilsbury et al ensured that many of our questions had been tried and tested, while in drafting the new questions we drew upon insights built-up during a detailed research over the years on APs and other healthcare support workers (Author et al, 2014).

In August 2017, an online version of the survey was sent to those on the mailing list of the Assistant Practitioners Network. Established some ten years ago, this network comprises 180 individuals with a stake in the AP role- senior nurse managers, department managers, trainers and developers, clinical educators. Drawn mainly from trusts in NHS England, network members voluntarily share information, debate and explore ‘good practice’ related to the role. Over a hundred members of the network accessed the survey, so around fifty six percent of the total membership. However, with our interest in building a broad picture of AP developments across and at the level of the NHS trust, we were keen to use survey returns from individual respondents able to provide this broadly-based and informed organisational overview.

To achieve this end in securing our final sample, two steps were taken.:

- In the case of multiple responses from the same trust, we reviewed the respondents’ role and selected the individual most able to provide the requisite organisational overview. This tended to be someone from a corporate function- such as education, training and development or human resource management- or from a key directorate such as nursing.

- We reviewed the remaining, single trust, returns, and again removed those respondents unable to provide the necessary organisational overview: thus, returns from those working within specific parts of trusts such as individual APs, ward and service managers, were excluded. In doing so, the number of trusts covered by the survey was reduced. However, the final data set comprising 53 trust responses, still represented around a quarter of trusts in NHS England, with those included providing the necessary informed trust-wide perspective. Indeed, in contrast to the Spilsbury et al survey covering only nursing directors, our respondents had a broader remit and often more directly engaged with APs and their development.

At the same time, it is also worth noting that our final sample might well have under-represented those trusts which did not employ any APs. Clearly such trusts were much less likely to be members of AP Network, while Network members with few APs in their trust might similarly have been disinclined to respond.

Reviewing our final sample of around fifty, around two third (66%) of the respondents worked for trusts delivering acute services, and just over a half (52.8%) delivering community services. One in ten of the respondents worked in a trust providing mental healthcare. (Many trusts provided more than one service). Table 1 below presents the regional distribution of trusts in our final sample by Health Education England area (column 1), set alongside the proportion of total trusts in NHS England located in these areas (column 2). As indicated, most areas are represented in the survey, although three relatively small regions (in terms of trusts numbers)- Wessex, the North East and South London- did not have a respondent. There are also a few regions under-represented in our sample: for example, while 9.7% or 27 trusts in NHS England are to be found in Yorkshire and Humberside, we only have one trust from this region. The South West is slightly overrepresented in our sample, comprising 28.3% of our sample. Notwithstanding these shortcomings, in general there are no glaring geographical biases in our sample. So, for example, it can be seen from Table 1 that around fifteen per cent of trusts in NHS England and in our sample are located in the North-West. Similarly, around ten percent of trusts in NHS England and in our sample are located in the East.

INSERT TABLE 1 HERE

4. Survey Findings

4.1 Use

According to Table 2 below, it is rare for a trust ***not to*** employ an AP, unsurprising given that members of the Network were likely to work for trusts with APs. More striking is the bi-polar distribution of trusts revealed by the table: a significant proportion of trusts employ less than 20 APs but a noteworthy number of trusts also have over 50 APs. More specifically, a slight majority of trusts (54.8%), employ ***20 or fewer*** APs. This represents a marked increase in the minimum number of APs employed over the last decade. Spilsbury et al found that over half of trusts employed ***10 or less APs***. Indeed, as noted above, in only three of the ten regions covered did the median number of APs in any given trust reach double figures: East Midlands- 38; North West- 12; and South Central- 14. At the same time, our survey reveals that almost a quarter of trusts (22.6%) employed over 50 APs, the role

clearly having become a key part of the workforce in a significant minority of trusts. As a respondent stated:

> Qualified assistant practitioners make a huge contribution to service delivery with great feedback from colleagues and service users.

INSERT TABLE 2 HERE

Table 3 below, presents the clinical areas re-ordered according the reported incidence of APs (which we have classified as high, medium and low). The Table suggests that APs are to be found in an increasingly broad range of clinical areas. They are most likely to be working in medical and surgical wards, with close to half of the trusts employing them in these areas. However, there is a considerable range of clinical areas where we have classified the incidence of APs as 'medium', with around a third to quarter having APs. Clinical areas at the top-end of this group include: care of the elderly, outpatient, the community, theatres and A&E. As one of our respondents noted:

> The AP role allows the flexibility that is required, allowing us to develop the role to emergent areas such as rehab, podiatry and learning disabilities.

INSERT TABLE 3 HERE

In most clinical areas, the proportion of trusts with APs has markedly increased since the Spilsbury et al survey. In some cases, this increase has been dramatic. For example, Spilsbury et al found that only around one in ten trusts had APs in 'therapies'. Our survey shows this figure is now closer to one in four trusts. In a few clinical areas, the incidence of APs has been stubbornly low. For example, Spilsbury et al found that only around 12% of trusts had APs in maternity services, with a very similar figure being revealed in our survey. While there is clearly scope for a range of clinical areas to use APs, some areas continue to be unwilling or unable to use the role. As a respondent remarked:

> (The AP) role remains ambiguous within the Trust and not all areas recognise the value that they can add to clinical areas.

The survey data on the incidence of APs should clearly not detract from ongoing unevenness and patchiness in the use of the role. Indeed, as a proportion of the total trust workforce, APs remain only a very small segment: a medium sized district general hospital will, after all, employ between 3-4,000 workers and a teaching hospital well over 10,000 workers. It is a role, however, which displays little sign of waning, indeed quite the contrary. Table 4 below indicates that almost three quarters of trusts (71.7%) had increased the number of APs over the last five years, with only around one in ten (11.3%) decreasing their numbers.

INSERT TABLE 4 HERE

4.2 Management

Table 5 below, presenting the findings on three management practices, indicates that over two thirds of trusts recruit directly to AP posts, suggesting some maturity in the external labour market for the role. It is, however, noteworthy that over a quarter of trusts (26.9%) still do not recruit directly to the role, implying that it often remains a protected career step for existing staff. Table 5 also indicates that APs continue to be largely counted in the unregistered numbers. This was the case in close to two-thirds of the trusts (61.5%), raising questions about the scope for APs to fully utilise their skills. Most striking is the even split between trusts allowing (at least in part) and not allowing their APs to administer medicines. Clearly the administration of medicines by APs is a widespread practice, with potential implications for traditional support worker-nurse job boundaries.

INSERT TABLE 5 HERE

4.3 Drivers

Table 6 below indicates that trusts attach importance to a wide range of factors as a rationale for introducing and developing the AP role. Indeed, there are few drivers listed in the Table which respondents view as being of ‘little’ or ‘no importance’. However, the emphasis placed on the respective influences does vary. The use of the AP to address issues of service design and quality figure prominently: a significant majority of respondents (81.6%) attach ‘considerably importance’ to

this reason. The AP role was also widely seen as providing career opportunities for support workers: viewed as of 'considerable importance' by close to two thirds of respondents (65.3%). It is equally striking that under a third of trusts (30.6%) use the AP role to address nurse recruitment difficulties. Particularly noteworthy is the low proportion of respondents, under a quarter (22.4%), seeing cost saving as being of 'considerable importance': clearly cost efficiency is not perceived as a major driver for the use of the AP role.

INSERT TABLE 6 HERE

4.4 Future

The survey findings on the future of the AP role assume significance given that many trusts appear keen to engage with the in-coming nursing associate role. Well over half of the respondent trusts (58.4%) were involved in either the first or second wave NA training pilots, while a large majority of trusts (83.3%) will 'definitely' or 'probably' employ NAs in the future.

Prospective engagement with the new nursing associate role has stimulated debate in some trusts on the future of the AP role. As one respondent noted:

> The nursing associate role may be used instead of the assistant practitioner role in the future, especially when the training comes under the apprenticeship standard.

Such debate is leading to a careful consideration of whether the AP and NA might be used in a complementary way across different clinical areas. As a respondent stated:

> With the new nursing associate role, we will probably develop this (NA) role more in the ward areas of the organisation and leave the AP role in more technical areas such as dialysis and theatres. In these areas, we have found the AP role to be extremely useful, but we believe that the Nursing Associate role may give more flexibility to ward areas, particularly in light of regulation and the potential for them to administer medications.

Another remarked:

> The AP has played a significant role in the last 10 years. We see the value of these members of staff alongside the nursing associate and would like to ensure they are still valued and recognised for the expertise and taken into consideration alongside the NAs in future plans.

Indeed, the survey suggests that a not insignificant minority of trusts will be taking a pause in their use of APs: around a third of trusts (34.0%) noted that the number of APs is likely to the 'stay the same' over the next two years. More noteworthy is the finding that over half of the trusts (52.8%) plan to increase the number of their APs over this period (see Table 4 above).

5. Discussion and Implications for Nursing Management

Knowledge and understanding of the assistant practitioner role in NHS England has long remained fragmentary and impressionistic, in large part a function of the role's non-registered status and sensitivity to local circumstances and needs. One of the few attempts to map the use of assistant practitioners, undertaken around a decade ago by Spilsbury et al (2009), suggested a patchy and uneven take-up. In the succeeding years, with healthcare assistants taking on more tasks and registered nurses protecting their core job boundaries (Kessler et al, 2012), it was tempting to view prospects for the take-up of the AP role as at best, uncertain.

Seeking to provide an updated overview of the assistant practitioner workforce, the survey findings presented in this article suggest that trusts have continued to take-up the AP role, indeed in increasing numbers and across a growing a range of clinical areas. This is not to detract from the ongoing organisational challenges faced in adopting the role. The bi-polar distribution in the number APs employed by trusts, suggests that 'kick-starting' the role can be problematic, our study probably understating the scale of these difficulties with trusts not taking-up the role unlikely to be members of the AP Network, and therefore to have taken part in our survey. The survey also pointed to clinical areas, for example maternity care, stubbornly resistant to the role, indicative perhaps of significant structural barriers to its adoption in certain settings. However, more striking are findings from a survey covering around one in four trusts in NHS England, highlighting the continued and widespread use and development of the AP role. They are results which suggest that notwithstanding legitimate

concerns about care quality and accountability, healthcare employers continue to see value in an unregistered advanced support role which can be shaped to meet local circumstances and needs.

Moving beyond the Spilsbury et al (2009) survey in seeking to gather data on how and why trusts have taken-up the AP role, our study has significant implications for nursing management. It is clear, for example, that the main drivers for the use of the AP role relate to service design and quality, suggesting that the role has features, perhaps in terms of its flexibility, which allow it to positively contribute to service delivery. The role's value in this respect, and indeed in administering medicines in many trusts, is noteworthy given that it often continues to be counted in the unregistered staff numbers. The role also provides development opportunities for healthcare assistants, although it is less obviously a part of grow-your-own strategies: the length of time it takes to develop HCAs into registered nurses, alongside the personal financial challenges faced in taking this route, appear to have mitigated against such approach. The use of the AP to drive cost efficiency through substitution assumed even less significance, possibly reflecting concerns about potential resistance from registered nurses and other non-medical professions to the dilution of skill mix.

Moving forward in terms of workforce planning and development, one of the most significant findings related to the continued use of and enthusiasm for the AP role, particularly with NA role emerging. This may well reflect a residual degree of uncertainty about how the NA role will develop and be used. More typically, however, trusts appeared to view AP and NA roles as complementary rather than as alternatives. This is not to overlook ongoing reviews and debates within trusts about how the roles will relate to one another. But taken-up in a wide range of clinical areas and in support of a variety of non-medical professions, the AP's position within the NHS England workforce seems to be secure.

NHS England is moving into a phase where two very different advanced support roles will co-exist: the established but unregistered AP role and the new but registered NA role. There will be considerable value in plotting how the relationship between the respective roles unfolds, with lessons to be learnt for nursing management within as well beyond NHS England, on the relative clinical and organisational worth of different types of nurse support worker.

References

Adams, C. (2008) The assistant practitioner: A professional project, *International Journal of Therapy and Rehabilitation*, 15(11),509-517.
doi: 10.12968/ijtr.2008.15.11.31547.

Appleby, J., Galea, A. and Murray, R. (2014). *The NHS Productivity Challenge*. London: King's Fund.

Griffiths, P. and Robinson, S. (2010). *Moving Forward with Healthcare Support Workforce Regulation*. London: King's College

Harrison, D. and Virden, F. (2011). Assistants practitioners lead the way. *British Journal of Healthcare Assistants*, 5(8), 409.

doi.org/10.12968/bjha.2011.5.8.409

Health Education England (2016). *Raising the Bar*. London: HEE.

Health Education England (2017) *Facing the Facts, Shaping the Future*, London: HEE.

Kessler, I. Heron, P. and Dopson, S. (2012). *The Modernisation of the Nursing Workforce: Valuing Healthcare Assistant.* Oxford: Oxford University Press.

Kessler, I., Heron, P. and Spilsbury. K. (2017) Human resource Management Human Resource Management Innovation in Healthcare. *Human Resource Management Journal*, 27(2), 228-45.

https://doi.org/10.1111/1748-8583.12114

Kessler, I. and Nolan, R. (2018) Constructing an assistant practitioner role in a children's community team. *British Journal of Healthcare Assistants* 12(8): 398-404.
https://doi.org/10.12968/bjha.2018.12.8.398

Kilgannon, H. and Mullen, C. (2008). What are assistant practitioners? *British Journal of Healthcare Assistants*, 2(10), 513-515.

doi.org/10.12968/bjha.2008.2.10.513

MacKinnon, I. and Kearney, J (2009) *Assistant Practitioners: A Scoping Exercise*. London: MacKinnon Partnership.

Mathews, D. Assistant practitioner: An essential support in a climate of austerity, *British Journal of Healthcare Assistants*. 2015; 9(4): 188-193.

Malhotra G (2006). *Grow Your Own*. London: King's Fund.

Miller L, Williams J, Marvell R, Tassinari A (2015*). Assistant practitioners in the NHS in England.* Bristol: Skills for Health.

O'Flanagan, C. (2014) Should assistant practitioners be allowed to administer medicine? *British Journal of Healthcare Assistants,* 8(12)594-599

Royal College of Nursing (2009). *The Assistant Practitioner Role: A Policy Discussion Paper.* London: RCN.

Skills for Health (2011). *The Role of Assistant Practitioners in the NHS: Factors Affecting Evolution and Development of the Role*. London: Skills for Health.

Seccombe, I., Smith, I., Buchan. J. and Ball, J. (1997) *Enrolled Nurses: A Study for the UKCC*, Brighton: Institute of Employment Studies.

Spilsbury, K. et al, (2009). Mapping the introduction of assistant practitioner roles in acute trusts in England. *Journal of Nursing Management*, 17(5), 615-626. DOI:10.1111/j.1365-2834.2008.00943.x

Thurgate, C., MacGregor, J. and O'Keefe, H. (2010). Meeting changing service need through role development: A case for band 4 assistant practitioners. *Journal of Nursing Management*, 18(6), 654-661. September 2010

doi.org/10.1111/j.1365-2834.2010.01142.x

Traverse (2018) *Evaluation of the Introduction of Nursing Associates*, London: Traverse.

Wakefield, A., Spilsbury, K., Atkin, K., McKenna, H., Borglin, G. and Studdard, L. (2009). Assistant or substitute: Exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions, *Health Policy*, 90, 286-295.
doi: 10.1016/j.healthpol.2008.10.011

Wheeler, I. (2017) Driver and barriers to the continued development of assistant practitioner roles, *British Journal of Healthcare Assistants*, 11(2), 56-60. https://doi.org/10.12968/bjha.2017.11.2.83

Table 1: Which HEE area does your organisation fall?	Column 1 Trusts in final sample % (N=53)	Column 2 Trust NHS England % (N=277)
East Midlands	7.5 (4)	5.7 (16)
East of England	9.4 (5)	11.9 (33)
York & Humber	1.9 (1)	9.7 (27)
Thames Valley	3.8 (2)	3.2 (9)
North West London	3.8 (2)	3.6 (10)
North Central and East London	9.4 (5)	5.4 (15)
Kent, Surrey and Sussex	3.8 (2)	7.5 (21)
North West	15.1 (8)	14.8 (41)
West Midlands	13.2 (7)	10.4 (29)
South West	28.3 (15)	15.2 (42)
Wessex	0.0	3.9 (11)
North East	0.0	3.9 (11)
South London	0.0	4.3 (12)
No answer	3.8 (2)	-
Total	**100 (53)**	**100 (277)**

Table 2: How many APs does your organisation employ?	**%** **(N=53)**
None	1.9
1-10	34.0
11-20	20.8
21-30	5.7
31-40	7.5
41-50	7.5
51 or over	22.6
Total	**100**

Table 3: In which clinical areas do your APs work?		
Clinical Area:	% (N=50)	
Medical wards	45.3	High incidence
Surgical wards	45.3	
Care of the Elderly (In patients)	35.8	
Outpatients	35.8	
Community	34.0	
Theatres	34.0	
Accident and Emergency	32.1	Medium Incidence
Occupational Therapy	30.2	
Physiotherapy	29.3	
Endoscopy	26.4	
Intensive Care	17.0	
Renal	17.0	
Radiography	13.2	
Radiotherapy	13.2	Low Incidence
Maternity	11.3	
Mental healthcare wards	5.7	
Other	35.8	

Table 4: Trend in use of APs		
	Over the last five years has the number of APs % (N=53)	**In the next two years do you see the number of Assistant Practitioners in your organisation** **%** **(N=51)**
Increase	71.7	52.8
Decrease	11.3	13.2
Stay about the same	15.1	34.0
Never employed them	1.9	N/A
Total	**100**	**100**

Table 5: Managing Assistant Practitioners					
Do you recruit directly to Assistant Practitioner posts?	% (N=51)	**Are Assistant Practitioners counted in:**	**% (N=50)**	**Do Assistant Practitioners administer medication?**	**% (N-51)**
Yes, in all parts of the organisation	30.8	Registered numbers	25.0	All clinical areas	1.9
Yes, in some parts of the organisation	38.5	Unregistered numbers	61.5	Some clinical areas	44.2
Not at all	26.9	Other	7.7	Not in any clinical area	51.9
Don't know	3.0	Don't Know	5.8	Don't Know	1.9
Total	**100**	**Total**	**100**	**Total**	**100**

Table 6: How much importance do you attach to the following as a reason for introducing APs in your organisation (%) (N=52)						
	Considerable importance	Some importance	Little importance	No importance	Don't Know	**Total**
Support the provision of higher quality services	81.6	14.3	2.0	0.0	2.0	**100**
Make cost savings	22.4	42.9	22.4	6.1	6.1	**100**
Relieve registered professionals of certain (routine) tasks	55.1	38.8	2.0	2.0	2.0	**100**
Address recruitment difficulties amongst registered professionals	30.6	46.9	16.3	6.1	0	**100**

Develop new generic support roles	46.9	46.9	4.1	0	2.0	**100**
Retain support workers by providing career progression opportunities	65.3	28.6	5.7	0	0	**100**
Develop new specialist support roles	49.0	40.8	6.1	0	4.1	**100**