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Evaluation of the Development and Impact of Assistant Practitioners Supporting the Work of Ward-Based Registered Nurses in Acute NHS (Hospital) Trusts in England

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Glossary of terms/abbreviations

AfC	Agenda for Change
AP	Assistant Practitioner
CPD	Continuing Professional Development
CWI	Centre for Workforce Intelligence
FD	Foundation Degree
HCA	Health Care Assistant
HCSW	Health Care Support Worker
MEE	Medical Education England
NA	Nursing Auxiliary
NHS	National Health Service
NMC	Nursing and Midwifery Council for Nursing and Midwifery
NVQ	National Vocational Qualification
Qualpac	Quality of Patient Care Scale
RCN	Royal College of Nursing
RN	Registered Nurse
SEN	State Enrolled Nurse
TAP	Trainee Assistant Practitioner

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1 Introduction

The skills of registered nurses and their support staff are much in demand to meet the National Health Service (NHS) agenda and constitute a limited resource that needs to be deployed in the most efficient and cost effective way. The NHS is seeking to make better use of the staff resource and skills through role expansion and role redesign (Modernisation Agenda). An important role development for nurse support staff is the assistant practitioner role and this study is concerned with understanding this innovative role and the way it is enacted in practice.

1.1 What is an assistant practitioner?

Assistant practitioners (APs) are 'higher level' support workers who complement the work of registered professionals and work across professional groups (1). The role is graded at level 4 under the Agenda for Change Framework (2), requires formal training (for example national vocational qualification or foundation degree) and is being developed alongside pay structures that reflect their levels of preparation and practice for healthcare work. These characteristics distinguish assistant practitioners from healthcare assistants (HCAs) who are graded at level 3 and 2 and generally not required to hold formal educational qualifications. HCAs were first introduced in the UK in the late 1980s as part of the reforms for nurse education and training to support RNs' work, under their direct supervision, because of the abolition of enrolled nurse training and supernumerary status granted to student nurses (3). Essentially, HCAs replaced nursing auxiliaries. Introduction of the HCA grade was accompanied by plans for formal national vocational training of this group of workers; this was to be the distinguishing factor between the 'old' style nursing auxiliary and 'new' HCA role. However, the uptake of vocational training by HCAs and employers has been poor. Currently, HCAs in the NHS are not regulated and are not required to have any formal training or to hold a recognised qualification. This has raised concerns about patient safety and quality of care (4). However, *The Career Framework for the* NHS (5) emphasises a more structured approach to training and role competence for the *entire* healthcare workforce, including workers supporting the roles of RNs. In addition, a recent policy review has highlighted the need for support staff regulation, particularly for 'enhanced' support roles such as the assistant practitioner, because of their increasing responsibilities (6). In theory, the more structured approach of the modernisation agenda should mean that registered nurses (graded at level 5 and above) are supported by assistant practitioners (level 4), Senior HCAs (level 3) and HCAs (level 2). However, it is currently unclear

how these different levels of worker will be deployed and what aspects of nursing work they will each perform.

1.2 Our study

This study explores the deployment of the AP (level 4) and evaluates how the role affects RNs (level 5 and above) and HCAs (level 3 and 2) within the existing nursing team structures in acute hospital wards. Importantly, the study seeks to establish whether assistant practitioners free up time of registered nurses (and possibly other health care professionals such as therapists) to perform activities requiring their level of skill (substitution), or are there simply more workers carrying out similar activities (complementing) and therefore not improving efficiency or effectiveness in the nursing (and wider) workforce? The national and international context of a shortage of registered nurses and the incremental growth in numbers and types of nurse support staff makes this study timely. As the numbers of support staff increase they are 'taking over' (substituting for) a number of activities previously the domain of registered nurses, particularly direct care activities at the bedside (7). Workload studies indicate that professionally trained staff spend a high proportion of their time undertaking tasks which do not require their level of expertise or experience, in particular administrative and housekeeping duties (8). Professionals should therefore be delegating a proportion of their tasks to support staff, freeing their time to manage patients with more complex needs that require advanced/ specialist skills (9, 10). Skill mix initiatives, including changes in the numbers and types of support staff, have been associated with greater organisational effectiveness (9). In particular, the performance of support staff improves when the support worker is supported and supervised by a professional and integrated into existing team structures, rather than working independently (11, 12). Reviews of nursing skill mix indicate that there is a gap in knowledge, and poorly developed methods, in respect of skill mix changes, role development, acceptability and effectiveness, and cross-boundary and team working (9, 13, 14). This study evaluates how changes in the structure of the UK nursing workforce and the activities performed by different levels of registered nurses and support staff (APs, Senior HCAs and HCAs) might impact on service delivery and quality of care for in-patients in acute hospital wards.

Anecdotally, the development of assistant practitioner roles in acute NHS (hospital) Trusts across England has varied in terms of numbers, job remit and preparation for practice. However, the roles of APs and their impact on service delivery and patient care have not been widely evaluated. The focus of this study is to understand AP role development, and the organisation and management of these roles to better understand how they complement, or substitute, the existing nursing workforce and their impact on service delivery and patient care.

1.3 The report

First, the report presents the policy and literature context for the study (Chapter 2), highlighting the theoretical definitions for the AP role but the limited evidence base. The focus of Chapter 3 is to outline our research approach and methods which occur in three sequential stages: (i) multiple case study design (three NHS Trusts provide the context for fieldwork) using mixed quantitative and qualitative methods; (ii) a survey of APs to gain understanding of the national picture; and (iii) synthesis of findings with relevant literature and policy to develop clear guidance for future development of these roles. The study findings are presented in Chapters 4 to 6: Chapter 4 presents the interpretations of national policy by the three participating organisations in the case study fieldwork, highlighting their visions for the AP roles; Chapter 5 explores the AP role in practice, building on how the vision is operationalised in practice by various stakeholders and the potential impacts of the AP role on service delivery and patient care and existing team structures; and Chapter 6 explores the wider introduction and development of AP roles in acute hospitals in England, highlighting perceived opportunities and challenges for the role from the perspective of a national sample of APs. Chapter 7 draws together the findings of the study, presenting main headlines and conclusions about the tensions associated with AP role introduction into ward-based nursing teams, highlighting the need for ongoing consideration and debate of this relatively new occupational role.

We recognise that the AP role is not exclusive to acute hospital wards, nor do APs exclusively support the work of RNs: AP roles are being developed across a range of health and social care settings to support a variety of registered practitioners. However, the focus of this report is ward-based APs supporting the work of RNs in acute NHS (hospital) Trusts. The report provides rich description of the settings for readers to judge the relevance of these findings for their own contexts. We consider some of our findings to have wider transferability to other settings and contexts. We highlight here our recognition that the title assistant practitioner is not always used for this band of worker; a variety of other titles are in use. However, for consistency throughout the report (and to protect the identity of one of our case sites where these workers have a unique title) we will use the term assistant practitioner, or AP.

2 Context: Understanding development of the assistant practitioner role

The number and mix of staff in the health service is a major determinant of the volume and quality of care, its efficiency and total cost. A health service without the right number of people, with the right skills, in the right locations will not deliver high quality, comprehensive service to patients over the next two decades. Sir Derek Wanless (15: p.184)

The quality of experiences and outcomes of the people who use our services are almost entirely due to their interactions with our staff. Lord Warner (16: p.1)

2.1 Introduction

Nursing care is delivered by both registered nurses and assistant staff. The Royal College of Nursing (RCN) introduced the term 'nursing family' to indicate an inclusive model of the nursing workforce; recognising that nursing care is delivered by nursing teams that encompass a continuum of roles from junior health care assistants (HCAs) to Registered Nurses (RNs) at advanced and specialist levels of practice (17). Securing a sufficient number of nursing staff with the appropriate skills, across these levels, and deploying them effectively is a highly complex challenge, but an increasingly important priority given the current economic climate and financial constraints in the NHS. The skills of both registered nurses and assistant staff need to be used appropriately and efficiently (18). Indeed the concerns of current government policy emphasise the importance of productivity, efficiency and quality, highlighted in the above quotation from the Wanless Report (15).

An international focus on more flexible working practices has led to changes in roles for the *entire* UK nursing workforce through role extension, expansion and redesign (19). Such changes have potentially important implications for patient care and outcomes, as well as service delivery and nursing teamwork. It is important, therefore, to evaluate such changes. This study was specifically concerned with the introduction and development of a new type of worker: the *assistant practitioner*. However, as we shall see, understanding the introduction of their role requires us to discuss a wide range of policy initiatives, which provide the broader context for these changes. These debates are much wider than the AP role *per se* and attempt to juggle many different policy concerns. With this in mind this chapter will:

- explore broader factors influencing nursing workforce planning and their influence on the development of new assistant roles in nursing;

- consider the roles of assistant staff in the nursing workforce and locate the role of the assistant practitioner in the nursing (and wider clinical) team;
- understand the existing evidence-base on assistant practitioner roles in nursing.

In doing so, we highlight main political and professional concerns about the assistant practitioner role and reflect on the complex influences informing the role of the AP.

2.2 Factors influencing nursing workforce planning and their influence on the development of new assistant roles in nursing

The NHS spends 70% of its funding on staffing costs (20) and more than £4 billion is spent annually on training (21). As such, the effectiveness of the health service is largely dependent on the effectiveness of the workforce (highlighted in the quote by Lord Warner, p.14). There are a number of key factors that influence the demand and supply of the nursing, and more broadly, the healthcare workforce. These include:

- *Demographic trends* and the impact of an ageing UK population on future demand for health and social services;
- *Technological changes* that have a subsequent impact on training and staffing requirements;
- *Changing public expectations* of the health service, particularly given recent substantial increases in NHS expenditure;
- *Health and social care trends* and *population health concerns*, such as improved population health status, improved quality of life for chronically ill and disabled, increasing rates of obesity;
- *Evidence-based practice* that has improved practices such as appropriate antibiotic use, call and recall screening, compliance with best practice protocols;
- *Legal changes to working practices*, such as Working Time Directive regulations;
- *UK and international labour market* due to numbers entering health care workforce training and subsequently being employed in UK or abroad, and migration of the health workforce within the European Union and around the world;
- *Key policy changes and central targets* which influence the type and numbers of staff required to meet policy agendas and targets.

Over the last decade, there have been a number of key policies influencing changes to the healthcare workforce. The introduction of the European Working Time Directive in 1998 played a significant

role in national workforce policies (22). Restrictions to working hours for medical staff necessitated review of staffing arrangements and alternative staffing options, such as new non-medical roles supporting or substituting for doctors in training and new service models (23). Alongside this, in 2000, the UK Government set out plans for modernisation of the NHS (24). This referred to a range of initiatives aimed at restructuring and reorganising the health service at national and operational levels. The healthcare workforce was recognised in these plans as playing a key role in the modernisation agenda. Crucially, policy has aimed to:

- *Increase staff numbers:* more training places, recruitment drives to attract new staff and encourage immigration of health care workers and return to practice (24-26);
- *Improve staff retention:* establish career pathways, improve pay systems and working lives standard (2, 25, 27-31);
- *Introduce new roles:* such as assistant practitioners (24, 32, 33);
- *Develop new ways of working:* role sharing and blurring of professional boundaries (24, 25, 33, 34);
- *Improve workforce planning:* through the activities of education bodies, Workforce Development Confederations, Care Group Workforce Teams, Workforce Review Teams (24, 28, 34-36);
- *Improve quality of the workforce:* increase access to education, training and continuing professional development, clinical governance and regulation of professions and support staff (24, 37-43).

It is important to highlight here that despite increasing staff numbers and opportunities for continuing professional development (CPD) over the past decade, financial restraints in Strategic Health Authorities (at the time of writing this report) have led to a reduction in the number of available training places for health care professionals and a cut in CPD.

The 'modernisation' of working practices, originating from the NHS Plan (24) was set out and realised in *A Health Service of all the Talents* (34). This emphasised the need for workforce flexibility and productivity, through (i) new ways of working for existing staff and (ii) new clinical roles. The assistant practitioner was one of the 'new' role developments.

2.2.1 Changing roles for registered nurses and recognising the contribution of assistants

The *Wanless Report* (44) claimed to be the first evidence-based assessment of the long-term resource requirements for the NHS and highlighted the need to address use of the healthcare workforce. The review pointed to the changing roles of RNs as they took on a wider range of tasks and complex roles. This has led to increasing debates

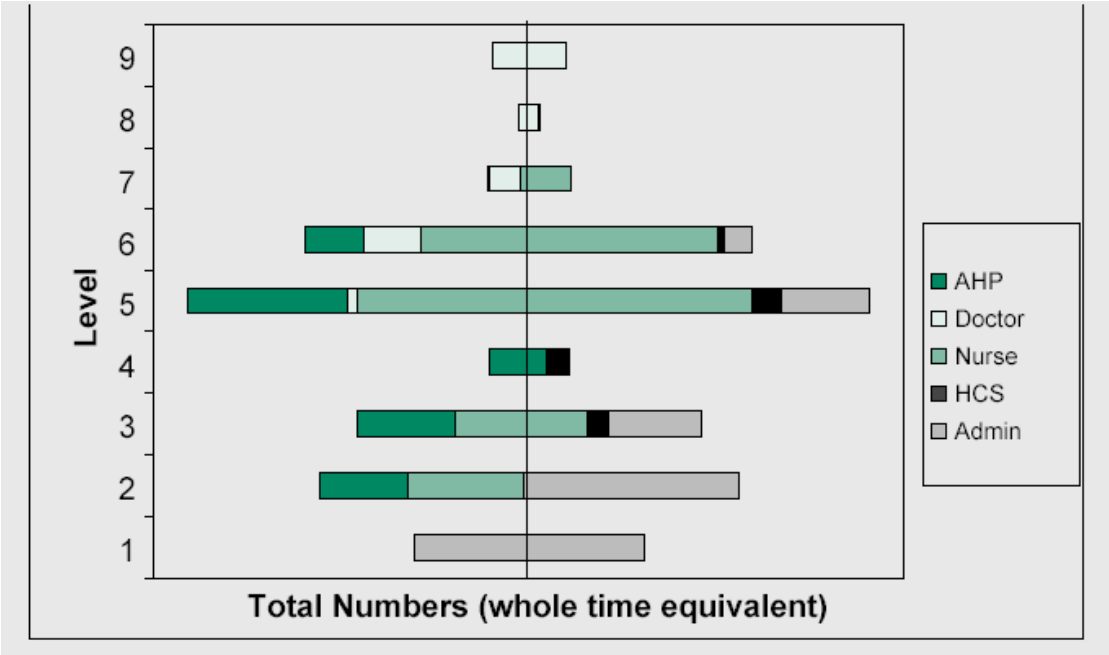
about the work of RNs and the potential to delegate parts of their work to assistant workers. The report indicated that over a 20-year period there would be increasing recognition of an extended role for assistant workers (p.58), but the detail associated with this increased role for assistants was not addressed in this report. This detail was provided elsewhere. The *Third Future Healthcare Workforce* report (45) more explicitly described a vision for the future role of healthcare assistants, outlining the types of activities that these workers should be able to perform in health and social care settings. This included: personal care; monitoring a patient's condition; implementing the care planned by a registered practitioner (such as wound management); undertaking investigations (such as blood tests); education and support of patients and carers; and liaison with other agencies and services. The vision was an assistant working with a level of responsibility, accountability and skill that extended well beyond delivery of fundamental care. It could be argued that, to a certain degree, these proposals for role development of assistant staff are now being realised. Despite the Government's vision of an expanding role for HCAs (including new types of assistant role, such as the AP) and their plans for investment in this workforce, critics have highlighted a lack of commitment to development of these workers because there have been no clear recommendations for the provision of training to develop the workforce (46) and no decisions regarding regulation of assistant workers, a matter which has recently been highlighted as requiring urgent attention (47). These issues will be returned to in subsequent sections of the report.

The *Changing Workforce Programme* (CWP) was introduced specifically to encourage and realise the modernisation agenda through: (a) the redesign of staff roles either by combining tasks differently, expanding roles or moving tasks up or down a traditional unidisciplinary ladder and (b) removing any obstacles to change so as to ensure that new ways of working became embedded as a new way of life within the NHS (33). A *Career Framework* was proposed to describe the roles of all healthcare staff in terms of level of competence (31). There are nine levels of competence and assistant staff occupy levels 2, 3 and 4.

The main outcome of changes to the NHS workforce during the past decade has been a significant increase in the numbers of staff, but this has not been consistent across all occupations and specialities. The number of health care assistants has almost doubled in the period 1997-2004, whilst the number of managerial staff has grown by two-thirds, and nurses, allied health professionals and medics have all grown by a quarter (48). However, examination of the structure of the healthcare workforce (Figure 1) revealed that the largest number of staff are employed in Agenda for Change pay bands 5 and 6 (the level of registered nurse), with fewer staff at band 4 (the level of assistant staff) (20). The result of this workforce structure is that the majority of work is being carried out by registered nurses. An important question has to be whether some of this work could be carried out by assistant practitioners and health

care assistants of lower grades to promote more effective working practices. If the NHS is to be able to increase flexibility and capacity within the system then staff at all levels will need to be developed.

Figure 1. The 'shape' of the health service workforce by nine Agenda for Change pay bands produced by the Department of Health and the NHS Workforce Review Team [cited by (20)]



In 2008, the *NHS Next Stage Review* (49) reiterated the vision for the NHS workforce: recognising talent and capability, and empowering staff to take responsibility for improving services and delivering consistent, sustainable, high-quality patient care. This review also set out new approaches to workforce planning, education and training, with new national bodies announced: NHS Medical Education England (MEE) (50, 51) and the Centre for Workforce Intelligence (CWI) (52, 53). Workforce planning is identified as a core part of the productivity and quality improvement agenda for the NHS (21). In particular, the emphasis for workforce planning is not solely on 'new' recruits but on how the health care system can develop new skills for those already employed in the service. This approach suggests enabling the existing workforce to evolve and adapt to the changing, and unpredictable nature, of the health care environment. Workforce planning can be summarised as having three main elements (54: p4):

1. assessing how many, and what type, of staff are required (demand side)
2. identifying how these staff will be supplied (supply side)
3. determining how a balance between demand and supply can be achieved.

Further, workforce planning is also about ensuring the workforce has the right skills and that there is clarity of workforce roles and responsibilities to resolve any gaps and overlap in activities (21).

Key drivers for changes to workforce configuration include: managing and responding to skills shortages; managing labour costs; and enhancing organisational effectiveness (13, 55, 56). However, establishing new ways of working and challenging workforce boundaries are identified as major organisational challenges (57, 58). Professional role demarcations, conventional team structures and hierarchies, existing care processes and established divides between health and social care all come under scrutiny (59). How these tensions are worked out, will equally inform how future roles are defined, as much as formal policy initiatives. We return to this below, but as Vaughan (60) argued:

'The division of labour... has developed through time and practice rather than any more logical reason but is deemed by practitioners and managers to be unalterable.' (60: p.44)

2.2.2 Understanding the introduction of assistant practitioners

Examining health care roles and the skill mix required to deliver healthcare is an important, but complex, issue. Buchan and Dal Poz (9) highlight key considerations for examination of the workforce including skill shortages, cost containment, quality improvement, technological innovation, new medical interventions, new health sector programmes or initiatives, health sector reform and changes in the legislative or regulatory environment. These considerations are not mutually exclusive; more than one driver will often be acting on a health system at any one time and this is part of the complexity involved in understanding the role of APs. However, Buchan and Dal Poz also suggest possible interventions (or solutions) for addressing each of these drivers and maximising use of human resources (Table 1) and this is a useful way of starting to think about the AP contribution to health care.

Table 1. Health care roles and skill mix: determinants, requirements and possible interventions [adapted from (9: p.576)]

Determinant	Requirement	Possible intervention
Skill shortages	Response to shortages of staff in particular occupations or professions	Undertake skill substitution; improve use of available skills
Cost containment	Improved management of organizational costs, specifically labour costs	Reduce unit labour costs or improve productivity by altering staff mix or level
Quality improvement	Improved quality of care	Improve use and deployment of staff skills to achieve best mix
Technological innovation, new medical interventions	Cost-effective use of new medical technology and interventions	Re-train staff in new skills; introduce different mix or new types of worker
New health sector	Maximum health benefits of	Determine the cost-effective

programmes or initiatives	programme implementation, by having appropriately skilled workers in place	mix of staff required; enhance skills of current staff; introduce new types of worker
Health sector reform	Cost containment, improvements in quality of care and performance, and responsiveness of health sector organizations	Adjust staff roles; introduce new roles and new types of worker
Changes in the legislative or regulatory environment	Scope for changes in (or constraints on) role for different occupations, professions	Adjust staff roles; introduce new skills and new types of worker

To summarise, nursing (and healthcare) role boundaries are being challenged through role *enhancement* (increasing the depth of a job, such as nurse-led primary care clinics), *delegation* (moving a task up or down a traditional uni-disciplinary ladder, such as specialist to non-specialist nurse or physician), *substitution* (expanding the breadth of a job, in particular by working across professional divides or exchanging one type of worker for another, such as nurse practitioners substituting for doctors) and *innovation* (introduction of 'new' roles, such as assistant practitioners) (61). Nancarrow and Borthwick (10: p.30) also provided a framework for understanding changing roles in healthcare, suggesting movement of the work force in four directions:

a. *Diversification:* new work or new ways of performing work

b. *Specialisation:* adoption of increasing levels of expertise;

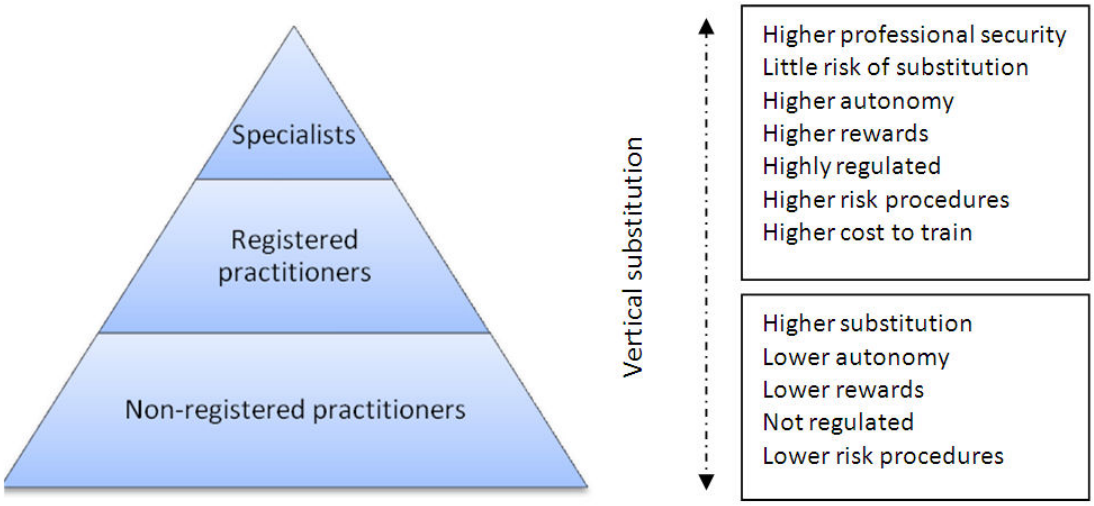
c. *Horizontal substitution:* undertaking roles of another discipline by workers of similar level of training and expertise

d. Vertical substitution: delegation or adoption of tasks across disciplinary boundaries.

Within this framework the AP role most closely fits vertical substitution and diversification. The consequences of substitution from registered practitioners to assistant staff are that lower risk work is performed by unregulated staff with less autonomy and lower financial rewards for the work (Figure 2).

Moving work 'vertically' across registered and non-registered practitioners, in this case between the registered proportion of the nursing workforce and assistants, raises a number of important issues. These include the delegation of work to assistants, boundaries and responsibilities of assistants, level of supervision, and regulation. These issues are considered further in the following sections.

Figure 2. The influence of vertical substitution [adapted from Nancarrow and Borthwick (10)]



2.3 Roles of assistant staff in the nursing workforce and locating the assistant practitioner role in the nursing team

The processes by which the nursing workforce segregated itself into registered nurses and non-registered workers (or assistants) has been well documented (62-65) and is therefore not considered in any detail here. However, it is important to highlight that the shape of nursing practice today is the result of varied and complex socio-political interactions occurring over time, in a variety of social arena and at differing policy levels (66). The Registration Act, implemented in 1919 (64), provided: (i) an autonomous professional body to centralise the control of the nursing labour force; (ii) a self-governing body with a majority representation of nurses; and (iii) a one-portal system of entry to nursing to establish standards and duration of training (65). Despite introduction of the nursing register, nursing work has continued to be provided by a variety of workers, including State Enrolled Nurses (SENs), nursing auxiliaries (NAs), health care assistants (HCAs) and more recently the role of assistant practitioner (AP). Thornley's study (67) of nursing highlighted how nurses lost social closure[2] of the profession following nursing shortages and described how government challenges of *'the nebulous character of*

[2] 'Social closure' refers to the boundaries a profession draws around their knowledge and the subsequent monopoly on certification and credentials required, which excludes 'outsiders' (68). For these strategies to succeed they must be accepted and endorsed by the government through legislation and licensure (69). Interprofessional competition is a fundamental feature of professionalism and leads to 'jurisdictional disputes': conflict over the content, control of, and differentiation of work (70). The rise of specialisation also raises the possibility that social closure can occur within professional groupings, as each specialism attempts to justify its focus of interest and the skills required to realise this interest. APs could be perceived as a specific 'threat' among other nursing specialists.

'skill' in nursing' (67: p.165) have succeeded and maintained a role for assistant workers within the nursing workforce. In 2009 there were over 625,000 registrants on the NMC register in England (71) and over 286,000 support staff to nurses, midwives and doctors in the NHS (72).

Throughout history there have been ongoing tensions between the professional vision for nursing, where all aspects of nursing are carried out by RNs, and the management perspective which aims for cost effective services and ways of deploying professional skills more efficiently (73). In a health service climate with finite resources, policy encourages the rethinking of human resource use and flexible working. Bold statements have been made about cost savings that could be made if doctors were replaced by nurses (74) and registered nurses replaced by health care assistants (75). In the past, the RCN has recommended that a skill mix of 65% registered nurses to 35% health care assistants is regarded as the benchmark for the general ward nurse staffing establishment (76). However, at time of reporting there are two key areas of concern in relation to the future nursing workforce and the role of assistants within this workforce:

1. Skills shortage due to retirement: it is reported that 180,000 nurses are due to retire in the next decade (77); and
2. Changes in nurse education: the move to degree-level registration for nurses is likely to lead to an increased use of assistants and the assistant practitioner role in the future (47, 78)

Despite an unprecedented increase in numbers of assistants in nursing over the past decade, there are still wide ranging debates about role boundaries between the registered nurses and assistant staff: what is acceptable or appropriate work for assistants; concepts of accountability and responsibility; patient safety; and how work should be delegated (4, 79). There is recognition of the 'role drift' between RNs and assistants and a call for assistant staff to better educated, better paid, regulated and registered, *'It would be comforting to the public and to the nursing profession if [assistants] became autonomous and accountable second level nurses rather than merely assistants'* (80: p.2).

Knibb et al. (81) highlight that the nursing support workforce delivers a substantial proportion of 'essential' nursing care and has expanded to take on clinical tasks such as wound care, venepuncture and screening. This is supported by a number of other studies (7, 82-85). Specifically, Kessler et al. (84) define four main objectives underpinning assistant use: (i) a relief; (ii) a substitute; (iii) an apprentice; and (iv) a co-producer.

A full understanding of these objectives requires practical realisation and it is to this we now turn.

2.3.1 Defining the assistant practitioner role

Assistant practitioner roles are aligned to level 4 on the Skills for Health Career Framework (31). The introduction of the AP role represents an important UK workforce policy initiative and offers a potentially important career development for assistant workers (86). There has been considerable policy discussion about their actual role and various definitions have emerged. In the first instance, APs were described as 'higher level' assistant workers, introduced to complement the work of registered professionals and work across professional groups (in both hospital and community settings), under the supervision of registered practitioners (87). The role is considered to require formal training - national vocation qualification (NVQ) or foundation degree (FD) and is being developed alongside pay structures that reflect the level of preparation and practice for healthcare work (2). An assistant practitioner has been defined as:

'A healthcare worker who delivers healthcare to patients and who has a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker.' (Workforce Development Confederation Standing Conference, cited in 88: p. 1)

A more recent definition has been offered by Skills for Health (89: p.1):

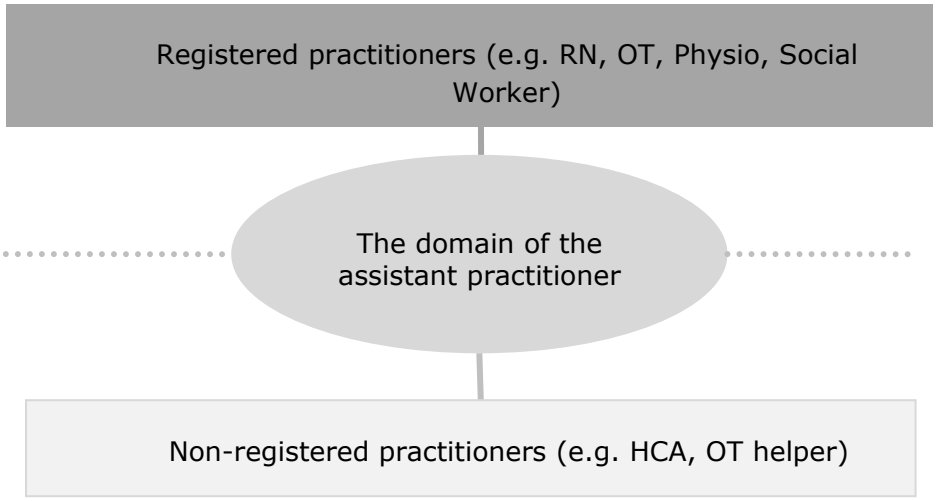
'An Assistant Practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve.'

Alongside this definition, Skills for Health (89) have developed core national standards for the AP role in response to healthcare employers' requests for standardisation (Figure 3). The AP role has also been visually represented as below (Figure 4), reflecting the domain of APs as being clearly defined between the work of registered and non-registered practitioners (87).

Figure 3. Core standards for the AP (89)

1. The role of the Assistant Practitioner should be recognised and valued in its own right;
2. Candidates who have the capability to undertake the job should be recruited to an appropriate post of employment and training programme;
3. The education and training of Assistant Practitioners should support the development of a practice focused, competent individual;
4. The Assistant Practitioner should be acting at the appropriate level on the career framework;
5. The Assistant Practitioner should be competent in a number of core domains and other appropriate areas if in a clinical role (these are listed in the Skills for Health document); and
6. The Assistant Practitioner should be enabled to develop within their role and progression routes should be available

Figure 4. The domain of the AP (87)



Whilst the role may vary depending on the service in which the role is based, core characteristics of the role have been presented (87), including:

- Provide direct health and social care; and treatment;
- Where relevant, provide day to day management of a group of patients;
- Assist in the assessment of patient needs;
- Undertake a variety of clinical skills – e.g. catheterisation, insertion of a PEG tube, swallowing assessment, mobility exercises, assist in ADL assessment, venepuncture, immunisation, ECGs;
- Undertake health promotion work;
- Undertake clinical work and the essence of care;
- Possess communication skills;
- Act on authority of a Registered Healthcare Practitioner;
- Work in a way that ensures the scope of practice is constrained to protocol or a prescribed plan of care determined by a Registered Healthcare Practitioner;
- Is subject to clinical supervision;
- Engages in Continuous Professional Development;
- Takes responsibility for own actions;
- Supervises other support workers;
- Undertake A1 Award to support colleagues working towards NVQ Levels 2 and 3.

2.3.2 Education and training for AP role

Formal educational training for this worker was envisaged to be transferable, credible and work based. Currently, the education and training required for the AP role has not been standardised resulting in APs being prepared in a variety of ways for their roles. The key areas of knowledge and development to be acquired for the AP role are summarised in Figure 5. Concerns have grown over recent years that APs will replace RNs and recreate the 'SEN'[3] position in the nursing workforce: these concerns have been heightened by the current economic climate and financial constraints. There have been reassurances from Skills for Health (90) that this is unlikely. However, conflicting reports suggest that there will not be 'enough' RNs in the future to meet the demands for nursing care and that APs and support workers with appropriate qualifications will have a much larger role in nursing care provision (91, 92). In addition, it is been voiced that APs will be expected to have a supervisory role for Senior HCAs at Band 3 and HCAs at Band 2 (79).

Figure 5. Areas of AP knowledge and development (87)

- Awareness of confidentiality issues for service users;
- Increased confidence and abilities to challenge;
- Familiarity with legislation relevant to caring for service users;
- Accountability of the caring professional;
- Legislation issues relating to record keeping, data protection and freedom of information;
- Knowledge and application of the principles of equality and diversity;
- Information technology skills;
- Reading and digesting evidence of clinical and care practice;
- Reflection on practice with theory;
- Written and oral presentation skills;
- Time management (managing competing demands of work, study and home);
- Psychology and mental health (to differing levels depending upon the service);
- Care planning and a focus on processes related to admission and discharge;
- Team working; and
- Health, safety and risk management

2.3.3 Regulation of the AP role

There have been wide ranging discussions with regard to regulation of assistants supporting the work of RNs. When an assistant (HCA or AP) assumes responsibility for a patient related activity they:

- assume a legal duty of care;
- declare themselves having the qualifications, skills and competence to undertake the care;

[3] A State Enrolled Nurse (SEN) (in the UK) was a nurse who completed a two-year programme of nursing education and was entered on to the second-level part of the nursing register. This grade of nurse was largely abolished with introduction of Project 2000 (3); existing SENs were offered conversion courses leading to RN status.

- are legally accountable under civil (or even criminal) law for their actions;
- are accountable to their employer through employment law.

However, it is only those on a professional register and who are professionally regulated that also hold professional accountability (93): assistants are not 'professionally accountable.' The RN assumes accountability for delegating work to assistant staff and must ensure the person has the necessary knowledge, skills and competence to undertake such work. The intimate work carried out by assistant staff with patients who are vulnerable has raised significant issues for patient safety and public protection. In addition, the increased responsibilities associated with APs have led to requests for urgent policy attention of the regulation of these staff (43). Regulation has several different functions (which are not mutually exclusive) and can be categorised as: professionally-led regulation, public protection, education, safety of individuals, competence, performance management, quality assurance and setting standards (17, 94). Professional regulation requires standards of entry to a register, education standards, a code of ethical conduct, titles that are clearly understood by all and agreed definition of a role and its functions. The Nursing and Midwifery Council (NMC) have recently announced plans to analyse the risks and issues presented to public protection by unregulated assistant staff (95). The Prime Minister's Commission on the future of nursing and midwifery in England has recommended that:

'To ensure they deliver care that is effective, safe, patient-centred and compassionate, some form of regulation must be introduced for the support staff to whom registered nurses and midwives delegate tasks.' (47: p.5)

A recent review suggests that full-scale statutory regulation of health care support workers based on the historic regulatory model was likely to prove disproportionate to the risks involved, with the risk of *'overly constraining roles and functions that are often designed to meet the needs of the patients and the public'* (96: p.35). The Working Group considered two options to develop a 'lighter-touch' approach to regulation of these staff: (i) employer-led regulation and (ii) licensing. Employer-led regulation would require the following key elements (96: p.36):

- A set of induction standards that focus on public protection;
- A code of conduct for assistant staff;
- A code of conduct for employers; and
- A centrally held list of names of those who meet the standards required.

A licensing regime would predominantly focus on three core aims (96: p.38):

1. To ensure appropriate standards based training/ qualifications for the role;
2. To help secure adherence to a code of conduct; and
3. To ensure those whose conduct does not meet the required standard are barred from carrying out these roles in the future.

In 2009, NHS Scotland published a Code of Conduct for Healthcare Support Workers (HCSW) (97) and alongside this, there is a Code of Practice for Employers of Healthcare Support Workers (98) to support HCSWs to work to the standards required in their code. In particular, employers are expected to have procedures in place to enable HCSWs to protect confidentiality, carry out risk assessments, record and report information, communicate effectively and ensure HCSWs understand their responsibilities and management structures.

2.3.4 Delegation of nursing work to assistant staff

The NMC (99) have issued clear guidance relating to delegation of nursing work to assistant staff, including HCAs and APs. Delegation is the process by which a registered practitioner allocates work to an assistant worker who is deemed competent to undertake that task (94). 'Competence' is a term used to describe the skills or qualities against which a staff member's performance can be assessed. In the NHS, the Knowledge and Skills Framework is concerned with identifying the relevant competency levels required for job roles and is used as a tool for individual review and development (30). Delegating care 'requires defined standards of practice to ensure patient safety and the delivery of high quality care' (100: p.3-4). Whilst courses aimed at training assistant workers demonstrate their competence to practice, the RCN indicates that decisions about 'who should do what' remain with the RN and are determined by needs of patients and the organisation (100). Recent articles have addressed whether assistant staff should be delegated responsibility to administer medications to patients (101). The Society of Chiropodists and Podiatrists (SCP) (102) have developed guidelines for the appropriate level of supervision to be given to assistant practitioners depending on the knowledge and skills of the assistant for the delegated task (Figure 6).

Employers have an obligation to ensure that all their employees are given a job description and person specification detailing their roles and responsibilities (100). Lines of responsibility should be clearly articulated in job descriptions: that is what the assistant is responsible for and who they are responsible to. This helps minimise risks of confusion and promotes clear lines of accountability.

Figure 6. Guidelines on supervision of assistant practitioners (AP) by registered practitioners (RP) [adapted from SCP (102)]

Level	Description of theoretical knowledge	Description of technical and operative skills	Appropriate supervision
A	Having to ask or be told what to do	RP showing: AP helping	Direct supervision
B	Aware of what to do, but not really knowing what to do	AP undertaking the work: RP helping	
C	Confident in their underpinning knowledge but not able to demonstrate that knowledge in the clinical setting	AP doing the work: RP overseeing their work	Indirect supervision
D	Understands what to do and able to do it	AP doing: RP available within clinical environment	
E	Able to develop their knowledge and build on it during practice	AP doing: RP available for advice	Proximal supervision

2.4 Existing evidence-base on assistant practitioner roles in nursing

Much of the above discussion is at a policy level, offering theoretical definitions of the AP role. Some points of consensus do emerge and these include having a defined assistant role, in which practitioners are qualified to do the tasks required of them within the context of explicit supervisory relationships. As with other nursing posts, however, role enactment of APs also becomes defined through actual practice and there is little literature exploring this. We, therefore, have little sense of the realities of working as an AP and given some of the tensions outlined above, this is an important omission. Key questions include:

- Who decides how and why APs are deployed?
- How is the role of APs defined and negotiated in practice?
- How does the work of APs relate to that of other nurses and assistants?
- How are they managed, supervised and held accountable for their tasks?

We have limited evidence on assistant practitioner roles that enables us to answer these questions. Our literature search revealed a report

on the introduction of occupational therapy APs (103), a review of studies of skill mix in radiography (104), studies of the training of APs in one geographical area (105) and small scale, local evaluations of the perceived benefits of AP roles to service delivery and patient care (106, 107). There are also descriptive articles on processes associated with introducing AP roles into services generally (86, 108), and also into areas such as radiography (109) and critical care (110). There are numerous personal accounts of developing as an assistant practitioner (111). Selfe et al. (105) reported perceived positive effects of APs undertaking a foundation degree, the positive impact of APs on team working and skill mix, improved inter-agency working and enhancing care for patients and clients. Local evaluations also demonstrate positive perceptions, optimism and satisfaction with APs in their role, perceived value of the role among managers and other practitioners and opportunities for the role to improve continuity of care (106). Anecdotal reports highlight the potential benefits of AP roles, such as freeing up registered practitioners' time to enable them to focus on more complex activities. However, organisational, cultural and professional concerns associated with their introduction have also been raised (103, 105, 108, 112, 113, 114).

To summarise, very little is currently known about how the AP role is enacted 'on the ground' and in relation to the day to day delivery of patient care. The gaps identified in the current literature, coupled with an understanding of the policy context, have informed the research objectives of this evaluation. Our research objectives were:

i. To explain the antecedents, impact and consequences of changes in the structure and delivery of nursing care in settings with assistant practitioners;

ii. To investigate the scale and scope of introduction of the assistant practitioner roles where the main remit is to support the work of ward-based registered nurses in acute NHS (hospital) Trusts;

iii. To explore how introduction of assistant practitioners in acute NHS (hospital) Trusts in England are having an impact on staff practice, patient experience and service delivery and performance; and

iv. To synthesise findings and recommendations from the study for policy makers, commissioners, providers, practitioners, patients and researchers.

We now turn to the research approach and methods deployed to address these objectives.

3 Research approach and methods

3.1 Introduction

To address the research objectives, and develop the knowledge-base of assistant practitioner (AP) roles supporting the work of ward-based registered nurses (RNs), our study required a mixed methods approach. Our research was designed specifically to develop an understanding of the:

- major social, political, historical, environmental and economic influences informing changes in the nursing workforce in acute NHS (Hospital) Trusts in England , which facilitated the development of the AP role to support RNs;
- tasks and activities that APs are undertaking in the ward setting;
- organisation, management and supervision of AP roles in wards;
- influence of introduction of AP roles on the practice, activities and workload of RNs, existing nurse support workers (e.g. healthcare assistants) and roles in the wider clinical setting (e.g. therapists, managers);
- relationships between formal policy (national and local) expectations of AP roles and local practice in a hospital and ward;
- factors that facilitate or act as barriers for development of the AP role; and
- potential impacts of the introduction of APs on quality of patient care, staff recruitment and retention, career development for support staff, staff well-being and staffing costs.

Three distinct sequential stages, using a range of methods, were deployed to gain both an appreciation of the role within organisations and its wider national development. These stages can be summarised as:

- Stage 1: case studies, incorporating mixed quantitative and qualitative methods, for in-depth study of the assistant practitioner role;
- Stage 2: survey methods to gain understanding of the national picture; and
- Stage 3: setting the study findings within the wider literature and policy context.

Appendix 1 provides an overview of the study.

This chapter outlines rationale for these stages and the methods used. We have approached the study using methods detailed in the original protocol. Any deviations from the protocol are explained, with consideration of the rationale for any changes.

3.2 Theoretical framework

Understanding the role of APs requires exploration of their work, the social meaning attached to their work and their position within the nursing division of labour and in relation to other members of the nursing team, including RNs and HCAs. Importantly, this understanding needs to be located within the context of nursing care delivery, health services and the wider social and policy arenas; these contexts were introduced in Chapter 2. It also requires a theoretical starting point; one which provides an analytical device through which to scrutinise and make sense of the AP role.

Donabedian's (115) approach to quality is used to frame this study to understand how organisational structures (such as the organisation and management of nursing workforce and policies), influence processes (such as the activities undertaken by different team members of the nursing workforce) and impact on outcomes (such as the quality of service delivery or staff satisfaction). In addition, the study interprets findings using an interactionist theoretical lens. Interactionist theory regards societal structures as being socially constructed and constantly reshaped through human interpretation and social actions and reactions (116). This approach concentrates on the micro-social processes of negotiating role and function, and societal value of an occupation's workforce but also links these interactions with wider organisational structures, as they impose themselves on the individual (117). Individuals, therefore, are both constitutive and constituted. The study therefore seeks to gain understanding of the work of assistant practitioners by examining the social system of which they are part (118, 119). Thus, the study was planned to gain an in-depth exploration of the integration and impact of the role in practice settings as well as an understanding of the national development of the role.

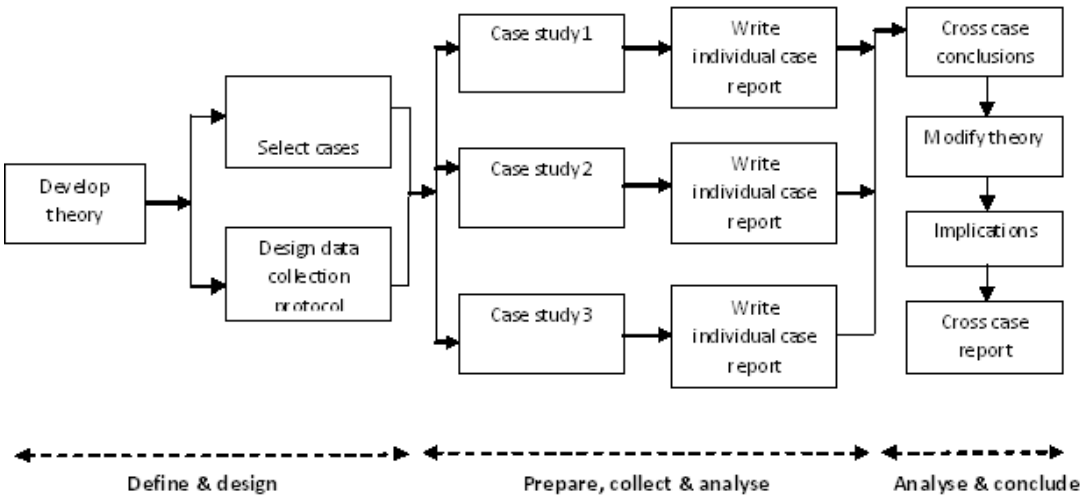
3.3 Stage One Case Studies (October 2007 to January 2009)

Case studies, although having a variety of different meanings, have a long and distinguished history within social science (120, 121). The strengths of case study design lies in its ability to deal with, and provide insights into, complex 'real world' developments that emerge through day-to-day practice (122, 123). This is what interested us. Healthcare work involves social interactions and, as such, healthcare roles can only be understood within the social matrices in which they occur or the social system of which they are part (118). This study is

concerned with the role of APs supporting the work of ward-based RNs in Acute NHS (Hospital) Trusts. The case study approach adopted, focused on these workers in their natural work setting and generated naturally occurring data. Case studies are appropriate for researching issues of social action and provide detailed insights into how national workforce policy initiatives are being implemented in practice (120, 124).

Stage 1 of the study aimed to explore: the perceived impact of introducing assistant practitioners on a range of staff (including RNs, HCAs, therapists and managers); the impact of the role on nursing workload and activity; the quality of process of nursing care delivered by different levels of nurses (RNs, APs and HCAs); and the impact on organisations. In doing so, the study examined relationships between both 'planned' formal policy (espoused strategy) and 'actual' informal negotiation of policy by staff in practice (emergent strategy) (124, 125). It is important to outline the application of the case study approach and data collection methods for this study.

Figure 7. Multiple case (embedded) design for studying APs [adapted from (120)]



A multiple-case (embedded) design has been used (Figure 7) (120). The rationale for using a multiple case design was for theoretical replication. Each individual case study consisted of a 'whole' study and generated descriptive accounts of the development and impact of the AP role located within its physical, social, temporal, organisational and economic context. In addition, findings from each case study were compared across the case studies to determine both convergent findings (regardless of context) and divergent issues (dependent on context). The case studies have more than one unit of analysis because there was more than one individual studied within the organisation and more than one method used; therefore, the case studies have embedded units (120). The following sections describe sampling of case studies and the mixed quantitative and

qualitative methods used for in-depth study of the assistant practitioner role.

3.3.1 Sampling of case sites

An important first stage for this national study of the AP role was to establish which acute NHS (hospital) Trusts in England employed APs to support the work of ward-based RNs and to identify in which types of clinical areas they were being deployed. This information was essential to inform the sampling frame for in-depth case study data collection for the study. However, no national data were available to fulfil these requirements. We therefore had to carry out some preliminary scoping work (not detailed in the study protocol) to establish these data. In April 2007, a national census of the AP role in acute NHS (hospital) trusts in England was carried out through email distribution of a brief, descriptive, cross-sectional questionnaire. The questionnaire was sent to all Directors of Nursing (DoNs) in acute English NHS Trusts (n=168) to gather relevant existing data to describe current (or planned):

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

The findings of this scoping study have been reported in detail elsewhere (126). The survey highlighted a range of diverse practices and contexts which were used to inform sampling for the study. From the survey data, three Acute NHS (Hospital) Trusts were purposively sampled to include NHS organisations where:

- the assistant practitioner role was well established, as well as areas where the role had recently been introduced;
- there was variability of clinical ward areas where role has been introduced (such as rehabilitation, medical, intensive care);
- there were differences in numbers employed;
- differences in geographical characteristics (rural and urban); and
- where the co-operation and support of local key stakeholders could be established.

It was our original intention to sample five case sites. However, following completion of the scoping study and discussions with Trust staff we reduced the number of case sites to 3 but increased the depth of work that we would carry out in each case site: we had originally proposed observation in two wards per site but we increased this to four in each. Our rationale for this was that the APs existed in very small numbers within the ward-based nursing teams

(this could be one AP to a maximum of four within a ward). To gain understanding of the role within each case site, it made methodological sense to increase the number of wards (and reduce the number of case sites); otherwise we believed we would not have been able to adequately capture a valuable understanding of the role and its variation within the case sites. This change in protocol was approved by SDO.

The case sites are summarised below. First, a description is provided of the Acute Trust and the nursing structures within each organisation. Secondly, the AP role is described in each organisation and the wards sampled for closer scrutiny are also briefly described. The point of these descriptions is to offer context to our findings.

Throughout the report these sites are referred to as Case Sites 1, 2 and 3 and the wards sampled for in-depth scrutiny as 1-13. Therefore, when reporting in-depth findings in subsequent sections of the report, these will be labelled as case site and then ward number. For example, 1:1 refers to Case Site 1, Ward 1 and 2:3 refers to Case Site 2, Ward 3 and so on.

3.3.2 Description of case sites

Case Site 1

The first case site is an Acute Trust located in the North West of England. It is a major acute teaching hospital, providing services for children and adults across two hospital sites, one of which is a community hospital managed by the Primary Care Trust (not included in the study). The Trust gained NHS Foundation Trust status in November 2006. It provides district general hospital services and specialist tertiary services to a local socially diverse community of 250,000. Specialist tertiary services are also provided to patients from further afield. There are approximately 900 patient beds. During 2006/7 approximately 430,000 patients attended the Trust. The Trust employs a total of 5,200 staff. Almost half of these (44%; n=2294) are nursing staff: 1,736 registered nurses and 558 assistant staff (including HCAs and APs).

There are four clinical divisions: Surgery (General and Specialist), Medicine, Heart and Lung and Clinical Support Services (Appendix 2 lists clinical areas included in each of these Divisions). Each of these divisions has a General Manager or Associate Director, Divisional Medical Directors, Finance Managers, HR Manager, Planning Manager and Head of Nursing. There have been considerable changes in the nursing management structures over recent years, and in the year preceding the commencement of data collection. The Chief Nurse was newly appointed in 2007 and one Assistant Chief Nurse left the organisation in 2007. This Assistant Chief Nurse had led on developments associated with the assistant practitioner role including negotiation of funding and educational preparation with the SHA and

higher education institutes, establishing where the AP role should be developed with Trust staff and developing job descriptions. In addition, there have been many changes at the (Divisional) Head of Nursing level. Initial funding for the AP role was accompanied by funding from the SHA for a 'Champion' of the AP role. Following withdrawal of the Champion funding, this individual was appointed as a Modern Matron (Medicine). Many of the senior nurse managers currently in post have not been involved in development of the AP role in the organisation; only the Modern Matron, and to some extent the remaining Assistant Chief Nurse, have understanding of the historical context of the role.

In 2003, the first cohort of assistants commenced training for the AP role. However, the organisation indicated that they had been preparing for the role since 2000, investing in assistants to undertake NVQ level 3 to prepare them for the 2-year foundation degree. The Chief Nurse had undertaken this planning because of anticipated problems with recruiting to RN posts and a need to bridge a skills gap in the organisation. Assistants were selected for training as an AP, developed within their clinical area and were then secured a position as an AP upon qualification. (A similar approach to recruitment was adopted in Case Site 3 but Case Site 2 was different).

The emphasis for development of the role in Case Site 1 focused on supporting the patient journey. In the ward areas (the focus for this study), this led to the development of a role for APs to deliver both nursing care and therapies, such as physiotherapy and occupational therapy. As a result the majority of support for initial development of the AP role was in rehabilitation wards, with subsequent developments of the role in other medical wards and, to a lesser extent, the surgical division.

At the outset of data collection in Case Site 1, it was not possible to locate a list of APs within the organisation. The research team 'scoped' the role with key stakeholders and informants, and through promotion of the study within the organisation to facilitate a process for APs to 'present themselves' to the research team. Table 2 presents an overview of assistant practitioners (APs) and trainee APs (TAPs) identified in Case Site 1 in December 2007. The majority of APs were employed by wards in the Division of Medicine (n=27); this included five Therapy Assistant Practitioners, some of whom were based on the rehabilitation wards. In the Division of Surgery, APs worked in wards (n=6) and in the operating theatres (n=3). In the Division of Heart and Lung, APs worked in wards (n=2) and Cardiac Laboratories (n=2). In Clinical Support, they were based in radiology (n=8), pathology (n=7) and outpatients departments (n=2).

Table 2. APs and TAPs employed in Case Site 1 (December 2007)

Division	Number of APs	Number of TAPs	Total
Surgery Specialist / General	**8**	**1**	**9**
Medicine	**23**	**4**	**27**
Heart & Lung	**4**	**0**	**4**
Clinical Support	**8**	**9**	**17**
Trust total	43	14	57

For in-depth study, four wards were sampled from within this case site. Selection of the wards was based on an understanding of numbers of APs, clinical speciality, perceptions of how the role was being integrated and permission from Divisional and Ward Managers for ward staff to engage with the study data collection. Figure 8 presents detail of these wards and other sampled staff. We included wards:

- with a maximum and minimum number of APs;
- where the AP was utilised for delivering nursing and therapy;
- that represented both surgical and medical divisions;
- that had different patient populations in terms of dependency and length of stay; and
- that had different configurations of assistant staff (including AfC Bands 2 and 3).

In addition to focusing the study specifically and solely on the sampled wards, questionnaires were distributed to all APs employed by the trust and they were offered an opportunity to participate in a focus group discussion about the role. These mechanisms enabled us to identify whether there were any differences between wards studied in-depth and the wider population of wards and APs in the organisation.

During the periods of observation (December 2007 to March 2008), the researchers familiarised themselves with the AP role within the organisation and in particular how it was utilised within the four ward settings. It is useful to summarise these field note observations to provide contextual detail and understanding of the role in different settings. These descriptions are provided in Appendix 3.

Figure 8. Case site 1 ward sample

Ward 1: Short Stay Surgical Ward (covering orthopaedics, plastic, gynaecology, urology and oral and maxilla facial procedures) with rapid turnover of (mainly) low dependency patients on admission. The ward has 16 beds (3 x 4-bed bay areas + 4 single rooms). Total nurse staffing = 20: 1 WM (Band 7), 1 CN (Band 6), 12 RN (Band 5), 2 AP (Band 4), 2 HCA (Band 3) and 2 HCA (Band 2).	**Ward 2:** General rehabilitation ward with low turnover of highly dependent patients requiring mainly physical/rehabilitative care. The ward has 28 beds which are divided into 2 areas. One area has 12 beds (2 x 4-bed bays and 4 single rooms) and the other 16 beds (3 x 4-bed bays and 4 single rooms). Total nurse staffing = 25: 1 WM (Band 7), 1 CN (Band 6), 13 RN (Band 5), 3 AP (Band 4), 2 HCA (Band 3) and 6 HCA (Band 2).
Ward 3: General medical ward providing care (predominantly) for the elderly, with low turnover of highly physically dependent patients, some with cognitive difficulties. The ward has 28 beds (5 x 4-bed bays and 8 single rooms). Total nurse staffing = 30: 1 WM (Band 7), 1 CN (Band 6), 16 RN (Band 5), 1 AP (Band 4), 1 HCA (Band 3) and 10 HCA (Band 2).	**Ward 4:** Acute stroke unit and stroke rehabilitation ward, with low turnover of high dependency patients. Many of the patients have problems with communication following their stroke and cognitive difficulties. The ward has 26 beds divided into 10-bed acute unit (2 x 4-bed bays and 2 single rooms) and 16-bed rehabilitation ward (3 x 4-bed bays and 4 single rooms). Total nurse staffing = 26: 1 WM (Band 7), 1 CN (Band 6), 13 RN (Band 5), 3 AP (Band 4), 1 HCA (Band 3) and 7 HCA (Band 2).
• AfC Band 4 APs other wards and clinical areas	• Ward Managers without AP role • Senior nursing management (organisational and divisional)

Key: WM = Ward Manager; CN = Charge Nurse; RN = Registered Nurse; AP = Assistant Practitioner; HCA = Health Care Assistant

Case Site 2

The second case site is an Acute Trust in the North East of England. It provided services for children and adults across two hospital sites, one of which has a major trauma centre and the other a district general hospital site. Both sites were included in the study. The Trust gained Foundation status in May 2009 (after data collection had been completed). It provides a wide range of district general hospital services and specialist (tertiary) services to a local community of 570 000. There are approximately 1,254 patient beds. During 2006/7 approximately 780,071 patients attended the Trust. The Trust employs a total of 6,675 staff. Of these, just under 3,000 are nursing staff: 2146 registered nurses and 738 assistant staff.

There are seven clinical divisions: Surgical, Medicine (Acute), Medicine (Speciality), Neurosciences, Cardiothoracic services, Women and Children, Trauma, and Anaesthesia and Theatres (Appendix 2 lists clinical areas included in each of these Divisions). Each of these divisions has a Chief of Service, Divisional Manager, Clinical Director,

Senior Nurse, Modern Matron, and Clinical Managers. Nursing management structures at the executive level have remained fairly stable. The Director of Nursing had been in post since 2004 and the Assistant Director of Nursing since 2003, although the ADN had been associated with the organisation for many years prior to taking up their current position. However, at the divisional and directorate levels, a number of changes had occurred with Senior Nurses, with many expressing that they did not understand the historical context and development of the AP role in the organisation.

The first cohort of assistants commenced their training for the AP role in 2004. The organisation was keen to ensure that any potential future shortages of registered practitioners could be covered by an assistant group with the appropriate competencies to ensure service delivery for patients. The role was initially developed within Division of Cardiothoracic services and subsequently within the Divisions of Surgery and Medicine. These APs work with registered nurses in the delivery of care and services to patients. A number of AP roles have also been developed in radiology, radiotherapy and occupational therapy to work alongside registered practitioners in these clinical areas. Numbers of APs in the organisation were initially difficult to establish; lack of an occupational code for this worker made it difficult for the Trust's HR department to provide an accurate list of these staff. Numbers of APs were identified by the research team (Table 3): no TAPs were located in the organisation at the time of data collection.

Table 3. **APs and TAPs employed in Case Site 2 (April 2008)**

Division	Number of APs	Number of TAPs	TOTAL
Medicine Acute / Speciality)	**6**	**-**	**6**
Neurosciences	**8**	**-**	**8**
Women & Children	**-**	**-**	**-**
Cardiothoracic Services	**9**	**-**	**9**
Surgical	**10**	**-**	**10**
Trauma	**-**	**-**	**-**
Anaesthesia & Theatres	**1**	**-**	**1**
Trust total	34	0	34

The clinical areas within each Division where APs worked included:

- Medicine: wards (n=3), radiotherapy (n=2), occupational therapy (n=1);
- Neurosciences: radiology (n=8);
- Cardiothoracic: wards (n=5), catheter labs (n=3), cardiac investigation unit (n=1);
- Surgical: wards (n=10);
- Anaesthesia and Theatres: ICU (n=1)

Following initial discussion, four wards were sampled from within the organisation. However, upon further discussion with ward teams we established that one of these wards actually operated as two distinct units working within the one ward area, with two ward managers and

two separate nursing teams. Therefore, this ward was subsequently classified as two distinct wards. Five wards were therefore included in the sample for case site 2. A breakdown of selected wards is provided below (Figure 9), with a description of the AP role as observed by researchers in Appendix 3.

Figure 9. Case site 2 ward sample

Ward 5: Cardiac care unit with rapid turnover of acutely and critically ill patients. The ward has 14 beds across two 4-bed bay areas and 6 single rooms. Total nurse staffing = 44: 1 WM (Band 7), 7 CS (Band 7), 9 RN (Band 6), 24 RN (Band 5), 1 AP (Band 4), 2 HCA (Band 3).	**Ward 6:** Colorectal surgical ward with mixed rates of turnover of medium to high dependency patients. The ward has 31 beds: 4 x 6-bed bays, 1 x 3-bed bay and 4 single rooms. Total nurse staffing = 42: 1 WM (Band 7), 2 CS (Band 6), 25 RN (Band 5), 4 AP (Band 4), 6 HCA(Band 3) and 4 HCA (Band 2).
Ward 7: Upper Gastrointestinal surgical Ward, with rapid turnover of medium to highly dependent patients. The ward has 17 beds: 2 x 6-bed bay, 1 x 3-bed bay (+ 3 beds of another speciality) and 2 single rooms. Total nurse staffing = 24: 1 WM (Band 7), 3 CS (Band 6), 10 RN (Band 5), 1 AP (Band 4), 3 HCA (Band 3) and 4 HCA (Band 2).	**Ward 8:** ENT surgical ward, with with rapid turnover of medium to highly dependent patients. The ward has 13 beds: 1 x 6-bed bay, 1 x 3-bed bay (+ 3 beds of another speciality) and 4 single rooms. Total nurse staffing = 18: 1 WM (Band 7), 10 RN (Band 5), 1 AP (Band 4), 1 HCA (Band 3) and 5 HCA (Band 2).
Ward 9: Medical assessment unit, with rapid turnover of medium to highly dependent patients. The ward has 27 beds divided into an acute side (2 x 6-bed bays and 1 single room) and a short stay side (2 x 6-bed bay and 2 single rooms). Total nurse staffing = 32: 1 WM (Band 7), 1 CN (Band 6), 17 RN (Band 5), 2 AP (Band 4), 11 HCA (Band 2 and 3 – detail not provided).	• AfC Band 4 APs other wards and clinical areas
• Ward Managers *without* AP role • Senior nursing management (organisational and divisional)	

Key: WM = Ward Manager; CS = Clinical Specialist; CN = Charge Nurse; RN = Registered Nurse; AP = Assistant Practitioner; HCA = Health Care Assistant

Case Site 3

The third case site is an Acute Trust in the South West of England. It provides services for children and adults across five sites – two general hospital sites that were included in this study, plus three sites not included in the study (a rehabilitation and assessment hospital plus two community hospitals managed by the PCT). The Trust gained NHS Foundation Trust status in July 2004. It provides district general hospital services and specialist tertiary services to a local community of around 500,000. Specialist tertiary services are also provided to patients from further afield. There are approximately 1,100 patient beds and during a year the average activity for the

Trust is: 17,000+ planned inpatients admissions; 62,000 emergency inpatient admissions; 74,000 day case admissions; 430,000 outpatient attendances; and 100,000 A&E attendances. The Trust employs about 6,000 staff and of these 2,438 are registered nurses and 426 are assistant staff such as HCAs and APs.

There are four clinical divisions in the organisation: Surgical, Medical, Women and Children and Diagnostic and Specialist (Appendix 2 lists clinical areas included in each of these Divisions). Each of these divisions has a Head of Staff/ Divisional Medical Director, Nursing Director (Assistant), Director of Service Delivery, HR Lead, Finance Lead, Information Lead and General Managers. There is also an Assistant Director of Professional Education (appointed during the study period) who has a responsibility for the APs. The Nursing Director had been associated with the hospital since 1995 and had been in their current post for 1 year, following 2-years as an Assistant Director. The nursing management structures have remained fairly stable since introduction of the AP role and consequently, there was some historical continuity: something lacking with the other two case study sites.

The first cohort of assistants commenced training for the AP role in 2005. Key drivers for introduction of the AP role in this organisation identified by senior managers include: (i) ensuring fundamental care is delivered to patients, with APs taking a lead on Essence of Care clinical benchmarks[4] (127); (ii) planning for the future RN shortage; and (iii) changes in educational preparation for RNs (to all graduate) which will change the shape of the nursing workforce: fewer RNs and more assistant staff. Like Case Site 1, assistants were chosen for the AP role and training, developed within their clinical area and had a Band 4 position secured upon qualification. The first cohort of APs to train for the Band 4 role completed year 1 of pre-registration nurse training at a local university. This initial course of preparation for the Assistant Practitioner (AP) role was later considered to be misguided: the course did not prepare the APs for their role. This has subsequently been addressed for later cohorts who still complete a one year certificate level course but the content is more specifically designed to prepare the APs for their role.

The main focus of the AP role in this case site is supporting the delivery of Essence of Care to patients and being a 'lead' for the health care assistant workforce. It is a nursing role, rather than one that crosses a number of professional roles or boundaries. As such, development of the AP role to date (in this case site) has been concentrated in ward areas and outpatient clinics. As with the other

[4]Essence of Care clinical benchmarks include: (1) Bladder and Bowel Care, (2) Care Environment, (3) Communication, (4) Food and Drink, (5) Personal Hygiene, (6) Pressure ulcers, (7) Promoting Health and Well-being, (8) Record Keeping, (9) Respect, (10) Safety and (11) Self-Care.

case sites it was not possible to get a comprehensive list of where the role was deployed. At the start of data collection at this case site (August 2008), 40 APs were identified within the organisation who were either qualified or were in training (Table 4). The majority are employed within wards in Surgical and Medical divisions (n=34) and out patient departments in these Divisions (n=3), with very small numbers of APs in the Divisions of Women and Children and Diagnostic and Specialist.

Table 4. APs and TAPs employed in Case Site 3 (August 2008)

Division	Number of APs	Number of TAPs	TOTAL
Surgical	**14**	**5**	**19**
Medical	**15**	**3**	**18**
Women & Children	**1**	**0**	**1**
Diagnostic & Specialist	**2**	**0**	**2**
Trust total	32	8	40

Four wards were purposively sampled (using similar criteria as per first case site) from both hospital sites within the Trust; 3 from one site and 1 from the other. The sampled wards represented both medical and surgical environments. A breakdown of selected wards is provided below (Figure 10), with a description of the AP role as observed by researchers in Appendix 3.

Figure 10. Case site 3 ward sample

Ward 10: Mixed surgical ward with rapid turnover of (mainly) highly dependent patients requiring acute or elective surgery and/or recovery after surgery. The ward has 25 beds across two bay areas. Total nurse staffing = 36: 1 SS (Band 7), 2 WS (Band 6), 21 RN (Band 5), 1 AP (Band 4), 11 HCA (Band 2).	**Ward 11:** Medical ward receiving medical admissions with extremely high turnover of mixed dependency patients. The ward has 18 beds (3 bays and a single room) and a triage area with 4 beds. Total nurse staffing = 38: 1 SS (Band 7), 4 WS (Band 6), 20 RN (Band 5), 2 AP (Band 4), 3 technicians (Band 3) and 8 HCA (Band 2).
Ward 12: Medical ward providing rehabilitation and care for the elderly, with low turnover of highly physically dependent patients. The ward has 28 beds (4 bays and 4 single rooms). Total nurse staffing = 25 (with 2 staff on long-term leave): 1 SS (Band 7), 2 WS (Band 6), 10 RN (Band 5, 1 AP (Band 4), 11 HCA (Band 2).	**Ward 13:** Mixed surgical ward with high turnover of high dependency patients. The ward has 28 beds divided into 3 bays (including 1 high dependency bay) and 4 single rooms. Total nurse staffing = 55 (with 3 staff on long-term leave): 1 SS (Band 7), 4 WS (Band 6), 32 RN (Band 5), 1 AP (Band 4), 3 HCA (Band 3), 14 HCA (Band 2).
• AfC Band 4 APs other wards and clinical areas	• Ward Managers *without* AP role • Senior nursing management (organisational and divisional)

Key: SS = Senior Sister; WS = Ward Sister; RN = Registered Nurse; AP = Assistant Practitioner; HCA = Health Care Assistant

3.3.3 Case study methods

Both quantitative and qualitative data have been collected in each case site. Stage 1 deployed the methods detailed in Figure 11. These are described in further detail in subsequent sections below.

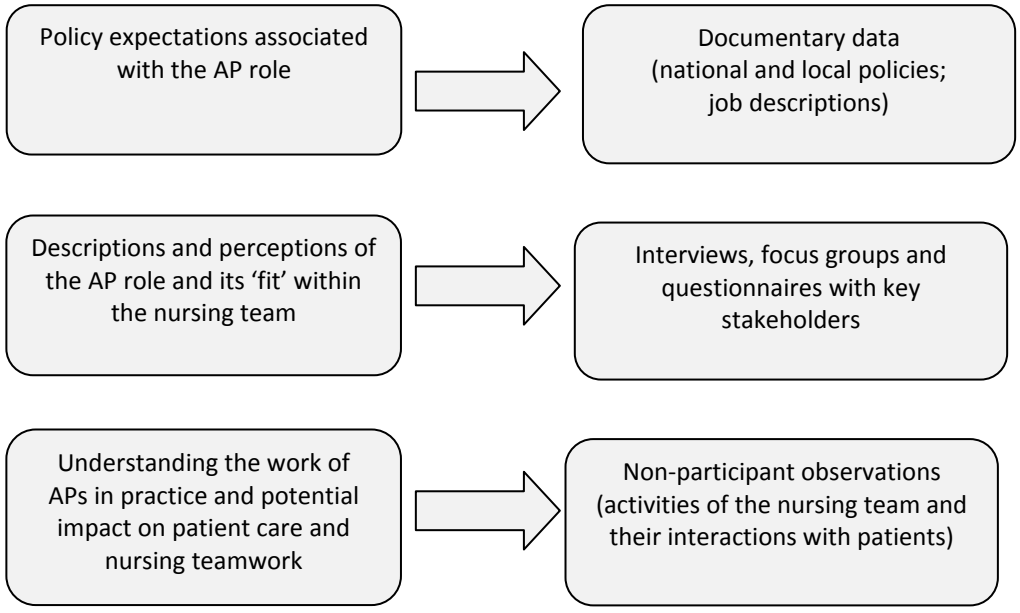
For each sampled case site, the co-operation and support of local key stakeholders was sought. This was essential for the success of the study and the research team spent time ensuring that access and co-operation were fully negotiated at the following levels:

- **Trust level**: Trust's Director and Assistant Director of Nursing and meetings with individuals occupying positions of 'social significance' in the organisation at Trust-wide meetings (such as senior nurse meetings, 'staff-side' meetings and assistant forums);
- **Ward level**: Directorate Managers, Ward Managers and Charge Nurses; and
- **Individual level**: Ward nursing staff, including APs, RNs and HCAs.

We were also aware that such contacts would be equally valuable in developing our dissemination strategies.

Ethical considerations associated with the study are considered in a subsequent section (3.6).

Figure 11. Case study methods



The subsequent sections provide further detail of the methods used to gain in-depth understanding of APs work within the context of the nursing teams, ward speciality and organisation of which they are part. A sequential mixed method design was deployed (128), using

the methods detailed in Figure 11. Essentially, we were aiming to gather accounts of the expectations associated with the AP roles, descriptions and perceptions of the role and descriptions of how the role was enacted in practice and potentially impacted on service delivery and patient care. The order of data collection ensured that each strand emerged from or was dependent on the previous strand, evolving as the study progressed. Methodological triangulation (129, 130) enabled the use of these multiple methods to study the AP role within context. This is a particular strength of this study: we were studying a role that was developing within organisational contexts and the complexities associated with these developments.

Documentary data

Documents are a useful source of data in case study research to:

- corroborate and augment data from other sources; and
- prompt further investigation where there are contradictions (120).

Organisational documents relating to the AP role (such as job descriptions, minutes from meetings about the AP role, or progress reports) were requested in each case site. We were able to collect job descriptions but due to staff turnover it was difficult to establish an audit trail of other documentary sources that would provide useful data for the purposes of this study. In addition, the lack of an occupational code for these staff also made it difficult to collect human resource data. These data were not available and so we were not able to address one of our objectives: the potential impacts of APs on staffing costs.

Job descriptions were requested from the Human Resource Department and from all Divisional and Ward Managers in each of the case sites. Gathering these documents required considerable time and effort. Our final sample comprised job descriptions relating specifically to tertiary adult oriented clinical care areas where the AP worked alongside nurses and undertook nursing related tasks. Hence, job descriptions relating to acute general medical, rehabilitation, surgical and high dependency clinical care areas were included in analysis for the purposes of this report. Despite having access to a small number of job descriptions from clinical areas allied to medicine and nursing, namely, those related to midwifery and radiology, these have been excluded (n=7): the focus of this study was ward-based APs providing care to adults. The total number of job descriptions included in the study is 22: 13 from case site 1; 2 from case site 2; and 7 from case site 3 (Table 5).

Table 5. AP Job Descriptions and the Representative Clinical Specialities from which they were drawn across 3 case sites

Clinical Speciality	Number of job descriptions
CASE SITE 1	
Medicine and rehabilitation services	n= 5
Surgical care services	n= 4
Critical care services	n= 3
Dermatology	n= 1
Maternity care services	*n= 2*
Radiology	*n= 1*
Total number obtained	**n= 16**
Number excluded	n= 3
Total number of job descriptions case site 1	**n= 13**
CASE SITE 2	
Radiology	*n=4*
Critical Care Services	n=2
Total number obtained	**n=6**
Number excluded	*n=4*
Total number of job descriptions case site 2	**n=2**
CASE SITE 3	
Surgical Care Services	n=3
Critical Care Services	n=1
Medicine and rehabilitation services	n=3
Total number obtained	**n=7**
Number excluded	*n=0*
Total number of job descriptions case site 3	**n=7**
Total number obtained	**n=29**
Total number excluded	n=7
Total number of job descriptions included in the study	**n=22**

Questionnaires, interviews and focus groups were then used to generate data to explore the impact of workforce changes on the nursing team structure. Each of these methods is considered below.

Questionnaires

The structured questionnaire aimed to explore organisational climate, management, team working and also staff knowledge, skills, motivation and satisfaction with their role. By administering the questionnaire to all nursing staff (including RNs, APs and HCAs) in the sampled wards (n=13), we anticipated being able to understand how the AP role was 'fitting in' to existing teams structures and the subsequent impacts this had on the work of other members of the team. At the request of the participating organisations, the questionnaire was also administered to a wider population than the sampled wards to include all APs (nursing and non-nursing) working in the organisation and these data are reported for comparative purposes.

The questionnaire combined sections of the NHS National Staff Survey (131) and the Survey on Working in the NHS developed by

the NHS Workforce Initiative (132).[5] The questionnaire (presented in Appendix 4) had 2 main sections to gather information on:

A. Background details and the work undertaken by the respondent. These data were important for analysis so that we could distinguish between different members of the nursing team, or assistant practitioners working in different clinical areas;

B. Respondent views about their job and opportunities for development in their role.

The questionnaire had both closed and open questions. It was piloted in case site 1 with RNs and HCAs in two wards without APs (and therefore not included in the planned data collection) prior to administration in the main study.

Administration of the questionnaire (and a cover letter) in each case site was undertaken when researchers were in the organisation gathering all case site data. In Case Sites 1 and 2, questionnaires could be personally addressed to staff members on the sampled wards and APs across the organisations. An identifier was attached to each of these questionnaires for the purpose of being able to send reminders to people who had not responded. In Case Site 3, we were not provided with lists of staff names (a decision by the Research Governance Department in this case site) and so questionnaires were distributed by Ward Managers in the sampled wards and to APs across the organisation by a Practice Trainer. As a result, we were not able to attach any identifiers to questionnaires in case site 3 and so reminders were sent to all staff. We did colour code the questionnaires for the different clinical areas in case site 3 so that we could establish return rates by each of the wards and other APs. We consider the different approach in case site 3 did lower response rates. At each site, reminders cards were sent out 1-week after initial distribution and then reminder letters sent at 4-weeks and 6-weeks, with the questionnaire being re-administered at final reminder stage. Staff were asked to return the questionnaire to the research team.

The numbers of questionnaires distributed by case site were: case site 1 = 148; case site 2 = 184; case site 3 = 188. The number of questionnaires returned in total was 270 (52%). Recruitment for questionnaire data collection progressed well in case site 1 (58%) and case site 2 (56%). However, as indicated above the response rate in case site 3 was less (44%), despite efforts by the research team to increase recruitment. Further detail of the sample is provided in the findings (and in Appendix 11; Table 1).

[5] In the original proposal we considered using the NHS National Staff Survey (131) and the Job Content questionnaire (133). However, upon further scrutiny the research team decided the Job Content Questionnaire was not suitable. Therefore, the final questionnaire included items from the NHS Staff Survey and the Survey on Working in the NHS (132).

Interviews and focus groups

Interviews and focus groups were carried out with staff from the sampled wards, namely, the APs and a range of nursing staff working with them (including RNs, HCAs and their managers) and other health care professionals who were supported by the APs (e.g. therapists). In addition, a sample of staff from Senior Management (for example Directors of Nursing, Human Resource Manager, Heads of Clinical Divisions and Modern Matrons) and Ward Managers who did not utilise the AP role in their clinical areas were also invited to take part in the study. At the request of the organisations, APs working in wards out with those sampled for the in-depth study, or other clinical settings, were also invited to participate in an interview or focus group discussion. The aim of these qualitative data collection methods were to explore in detail:

- the tasks and activities of assistant practitioners in different ward settings;
- how introduction of the assistant practitioner roles is perceived to impact on roles, practice, activities and workload of the nursing team (and relevant others);
- how introduction of the assistant practitioner roles is perceived to impact on patient care;
- the ways that the role is perceived to be integrating within existing working structures and the key factors facilitating or acting as barriers to development and integration of the role; and
- how the role is organised, managed and supervised.

Focus groups were the preferred method for eliciting the views of ward-based staff. It was anticipated that these group discussions would help facilitate RNs, APs and HCAs to explore and clarify their views on the introduction of the assistant practitioner role through group processes and in ways that would be less easily accessible in a one-to-one interview (134). However, focus groups were not always practical due to ward staff commitments and when this was the case, individual interviews were conducted instead. In all, a total of 105 participants were interviewed and 31 participants participated in 7 focus group discussions (Table 6). The sample includes a range of participants that could represent the views of stakeholders of interest for this study.

Non-participant observation

Observational data collection was an important part of this study because it enabled detailed exploration of the tasks and activities of APs and how their role affects the practice, activities and workload of the nursing team (RNs and HCAs) and potentially impacts on patient care. The observational work provided the opportunity to move beyond perceived roles (data generated by questionnaires and

interviews): often what people *say they do* and what they *actually do* in practice do not coincide. This desirable attribute made observation an ideal approach for examining the provision of nursing care by a team that had introduced the Band 4 AP role. Two approaches to observation data collection were undertaken:

i. activity analysis of the nursing ward team; and

ii. scrutiny of interactions between patients and members of the nursing team.

In addition, when observing interactions between nursing staff and patients, we collected data on patient dependency so that we could understand whether there were any differences in types of patients allocated to APs. Observation encompassed all members of the nursing team because APs do not work in isolation and so it is important to understand their role within the context of the team structures. Observation data collection across the three case sites occurred sequentially: case site 1 - January to May 2008 case site 2 – May to June 2008; and case site 3 - September to November 2008.

Table 6. Summary of interviews and focus groups in 3 case sites

Case site	Method	Participants	Total by case site
1	Interviews	*Wards:* 5 Ward Managers (Band 7) with APs 2 Ward Managers (Band 7) without APs 3 RNs (Band 5 and 6) 4 APs (Band 4) 5 HCAs (Band 2 and 3) 2 Therapists *Divisional/ Organisational/ Managerial level:* 5 Organisational Manager 4 Divisional Manager 2 Organisational role	**32 interviews**
	Focus groups	*Wards:* 1 with APs (n=5) 1 with RNs (n=3) *Wider organisation:* 1 with APs (n=9)	**3 focus groups (17 participants)**
2	Interviews	*Wards:* 6 Ward Managers (Band 7) with APs 3 Ward Managers (Band 7) without APs 5 RNs (Band 5 and 6) 9 APs (Band 4) 4 HCAs (Band 2 and 3) *Wider organisation:* 1 AP (Band 4) *Divisional/ Organisational/ Managerial:* 4 Organisational Manager	**39 interviews**

		5 Divisional Manager 2 Organisational role	
	Focus groups	*Wards:* 1 with Ward Managers (n=3) *Wider organisation:* 1 with APs (n=4)	**2 focus groups (7 participants)**
3	Interviews	*Wards:* 6 Ward Managers (Band 7) with APs 1 Ward Manager (Band 7) without APs 4 RNs (Band 5 and 6) 6 APs (Band 4) 4 HCAs (Band 2 and 3) *Wider organisation:* 1 AP (Band 4) *Divisional/ Organisational/ Managerial:* 6 Organisational Manager 5 Divisional Manager 1 Organisational role	**34 interviews**
	Focus groups	*Wards:* 1 with APs (n=4) *Wider organisation:* 1 with APs (n=3)	**2 focus groups (7 participants)**
		Total participants (3 case sites)	**105 participants interviews** **31 participants (7 focus groups)**

It is important to note two deviations from the protocol for the observation data collection. First, we had planned to gather 'intermediate' care outcomes data using methods similar to Carr-Hill et al. (11). The small numbers of APs employed within a clinical setting revealed that these data would not provide useful findings about the impact of the AP role. Secondly, we had planned (if possible) to recruit and train Trust nurses to assist with observation data collection; our rationale being that this might help to diminish any potential sense of threat within organisations of being 'judged' by 'outsiders'. However, it proved impossible to recruit Trust nurses due to pressures of their other work commitments.

Observation of AP activity

Activities of the APs and ward nursing team were observed using a structured observation instrument (135). This instrument (which has been regularly updated), has been used in a number of studies to observe nursing activity including examining efficiency and effectiveness of different ward designs (136), comparing activities undertaken by enrolled and registered nurses on medical wards in Australia (137) looking at the relationship between patient dependency, nursing workload and quality (135) and nursing

effectiveness and skill mix (11). It provides an efficient and simple way to generate a snapshot of nursing activity on a ward.

Following a pilot study, some minor modifications were made to the instrument. We removed the item referring to outpatients because our observations were all ward based. We also added an item 'direct, unseen' so that if care was being delivered behind closed curtains or in a side room area it could be recorded that a member of staff was at the patient bedside but that it was not possible to determine the exact nature of the activity because it would be too intrusive.

Based on the instrument, activities of the nursing team were recorded in four main categories, each containing a number of items. A copy of the instrument is provided in Appendix 5 and a description of the items in Appendix 6. The four main categories were:

1. ***Direct care***: care that typically took place at the bedside, such as medication administration or personal hygiene (15 items);
2. ***Indirect care***: care that was patient related but did not directly involve the patient, such as handover of patient information at staff changeover or speaking to patient's relatives (5 items);
3. ***Associated work***: tasks such as cleaning and administrative communication (8 items); and
4. ***Non-productive time***: this included breaks and any 'personal' activities (4 items).

All nursing staff on duty for the sampled time periods were approached to participate in the study's activity observations and asked to provide written consent. The researchers attended handover so that staff on a particular shift could be provided with an information sheet and consent obtained. The majority of staff agreed to participate in this part of the study. Where a staff member declined to give consent their activities were simply not recorded; there was never more than one staff member who declined to participate in an observation period. A total of 248 members of nursing teams (including RNs and assistant staff) were recruited across the three case sites to this part of the study.

Sampling different time periods was an important aspect of this observation work. Nursing staff patterns of work and activity may vary according to time of day and day of week. The nature of patient demands also may vary according to the time of day and reflects the changing shifts and availability of staff. We therefore ensured coverage of observation of staff activity during the early and late shifts and throughout the week (including weekends) to ensure we collected data that represented nursing work across these time periods and when an AP was on duty. Night shift activity was not observed because this was felt to be too disruptive and intrusive to patient care. The number of sessions for observing ward nursing team activity was related to the number of observations of

interactions with patients: these were carried out simultaneously (see below and Appendix 7). Observations took place over a 2-hour period with the activities of all members of the nursing team being recorded at 10-minute intervals. Data were inputted and managed in a database (Microsoft Access, 2007) and exported to a statistical programme (Stata SE Version 9.1) for analysis.

Observation of AP activity

The quality of interactions between RNs, APs and HCAs and patients were collected using the Quality Patient Care Scale (Qualpacs) (138), an established instrument for measuring the quality of the process of nursing care in a ward. The Qualpacs instrument is *patient-focused:* all observations are based on who comes to the patient's bedside to provide care and how frequently. The basic principle of Qualpacs is that the nurse observer watches nurses and assistant staff caring for selected patients and rates the nurse/assistant-patient interaction based on pre-specified instrument criteria: there are five areas of care including psychosocial, physical, general, communication on behalf of patient and professional implications (Figure 12). These interactions could be anything from a casual greeting to a procedure (such as assisting the patient to wash). Each distinct nurse-patient interaction is recorded in a column, assigned a rating, and the grade of nurse recorded.

The instrument consists of 60-items (grouped into five main categories described above and in Figure 12) which delineate actions by members of the nursing team when providing care for an individual patient (Appendix 8). We used the same version of the instrument adapted by Carr-Hill et al. (11) which does not include items 16-23 of the original instrument (138): these items refer to psychological aspects of care which are rarely appropriate to care delivery in acute hospital wards.

Figure 12. Subsections of Qualpacs instrument (11)

Subsection	Category of care	Number of items
1	**Psychosocial: Individual** Actions directed toward meeting psychosocial needs of individual patients	15
2	**Physical** Actions directed toward meeting the physical needs of individual patients	15
3	**General** Actions that may be directed toward meeting either psychosocial or physical needs of the patient or both at the same time	15
4	**Communication** Communication on behalf of the patient	8
5	**Professional implications** Care given to patients reflects initiative	7

and responsibility indicative of professional expectations

A condition of ethical approval was that any patient included in these observations had to give written consent for observation of their care to be undertaken. In previous research (for example 11), verbal consent from patients had been deemed sufficient. This raised a number of methodological issues which are addressed in the final chapter when reflecting on methods. Patients were selected in consultation with the RN responsible for patient care on the ward during the sampled shift. The researcher sat in the ward area for a two-hour period and simultaneously observed two patients (occasionally three) in close proximity. The researcher observed who came up to the patient's bedside (i.e. members of the nursing team) and rated the quality of interaction on the relevant sections of the instrument. The items on the instrument were scored with reference to the standard of 'care expected of a first level staff nurse', in accordance with guidance from original developers of the instrument (138). Measurements were made of all nursing care provided to a patient, regardless of qualifications or job categories of personnel providing the care; therefore including RNs, APs and HCAs. Scores ranged on an ordinal scale from 1 (poorest care) to 5 (best care) and items that were not observed, or not applicable were recorded as such and were not scored. The researcher also attended verbal reports of patient care at shift handover periods and consulted the patients' nursing notes to gather further information about patient care to enable comprehensive completion of the instrument.

Observations were conducted when an AP was on duty: these staff were the focus of the study. We originally proposed to carry out a total of 180 observational sessions (360 patients): the sample size is recommended to be 15% of the total population (138). The number of observations for each participating ward was based on the numbers of APs that were employed by the ward (Appendix 7). A summary of the number of observations is provided below in Table 7.

Table 7. Number of observation sessions of nursing activity and interactions with patients

Ward	Qualpac observations (patients)	Activity sessions
Case site 1		
1	30 (27)	13
2	35 (19)	15
3	19 (12)	10
4	38 (8)	17
Total case site 1	**122 (66)**	**55**
Case site 2		
5	20 (11)	10
6	35 (15)	16
7	20 (8)	10
8	20 (7)	9
9	25 (12)	12
Total case site 2	**120 (53)**	**57**

Case site 3			
10	27 (6)		12
11	38 (19)		15
12	27 (11)		12
13	27 (7)		12
Total Cases site 3		**119 (43)**	**51**
TOTAL	**361 observations (162 patients)**		**163 x 2-hour sessions**

Data on patient dependency were collected using the Nurse Dependency Scoring Scale, developed by St George's Health Care NHS Trust (personal correspondence with Sue Cooper, 2007). This instrument was based on the work of Ball and Goldstone (139) to establish nurse staffing and skill mix from analysis of nursing activities. Patient care needs are rated in four categories: personal care and hygiene; feeding, nutrition and elimination; mobility; and nursing attention (Appendix 9). Patient dependency is a cumulative score of each of these care categories, which are then translated into a dependency score ranging from 1 to 4, with a lower score indicating lower dependency.

3.3.4 Data analysis

Our strategy for analysing data generated by these methods was using parallel mixed data analysis (140, 141). This involved separate processes for analysing quantitative and qualitative data, using appropriate analytical methods (as described below). Although analyses of these data were independent, each provided understanding of the AP role and then these understandings were integrated.

Quantitative data

The approach for analysing questionnaire and observation data were as follows.

Structured questionnaires and the observations of nursing activity were described by professional group (registered nurses, health care assistants and assistant practitioners). For the structured questionnaire, the assistant practitioner group included not only those who were part of the observation data collection (referred to as 'ward-based band 4 workers') but also any other assistant practitioners in the organisation – both in ward settings (referred to as 'assistant practitioners (nursing)') and in other settings (referred to as 'assistant practitioners (other)').

Data structured in this hierarchical form (staff within wards, within case sites) mean that the observations are clustered so that the standard assumptions of Ordinary Least Squares Regression are not met and that the standard errors of the coefficients are under-estimated. Typically, there are two solutions: either the use of a multi-level modelling approach or a fixed effects model using robust standard errors. However, given the relatively small number of

wards, that this data was to be integrated with the qualitative findings and the questions we were attempting to address, we did not feel that using either of these techniques would give us any greater insight than providing descriptive data alone.

For the Qualpacs data, the situation is typically more complex than for the other data types, because observations are based on patients who are being cared for by multiple members of staff in different shifts. The situation is therefore more complicated than that envisaged in either fixed or random effects modelling of a straightforward hierarchical data structure. The solution developed is based on the multi-level modelling approach, but taking into account the fact that each patient may have been seen by more than one of the nurses in the same ward. In principle, the analysis of the Qualpacs data would therefore have involved what is called a multi-level multiple member approach (142). However, we are still concerned with disentangling and controlling for the higher level effects of particular nurses in the hierarchy. The question arises as to how we might model these effects for observations where more than one of these nurses' effects might be making contributions:

$$Y = (X\beta)_i + u_{nurse(i)}^{(2)} + u_{patient(i)}^{(1)}$$

where nurse(i) $\in(1,2,\ldots S)$; patient (i)) $\in(1,2,\ldots S)$;

and $u_{nurse(i)}^{(2)} \sim N(0, \sigma^2_{u(2)})$, $u_{patient(i)}^{(1)} \sim (N(0,\sigma^2_{u(1)})$

However, further development of this model was seen as unnecessary given the lack of variation in the Qualpacs scores.

Qualitative data

The main aim of analysing the job descriptions, interviews and focus groups was to establish similarities and differences related to the AP role both within and across the case sites. The ways in which this was achieved are detailed below.

Job descriptions

The job descriptions were analysed for key themes and comparisons made within and across clinical settings in a case site and also across case sites. First, the job descriptions were analysed at the macro-level for broad similarities and differences (143). Broad similarities equated to 'tasks' that the job descriptions focused on and whether these were the same for each of the AP roles within and across case sites or different. Differences represented tasks not considered the 'norm' (in this sample) for an AP to do; for example taking responsibility for running a clinic, or being asked to manage patients rather than care for them under the supervision of the RN. Each of the documents identified very similar role expectations under the headings related to *Policy*, *Education and Training* and *Clinical Governance*. However, wide variations were noted between the job

descriptions at each of the sites under the heading that specifically related to *Clinical Responsibilities*. It was therefore the Clinical Responsibilities section of the job descriptions that formed the basis of our analysis. A grid was drawn up (Figure 13) and each role identifier individually micro-analysed in terms of the language used in the role statement descriptor.

An in-depth scrutiny of each individual document and each role descriptor was conducted. In this context, each statement listed under the clinically oriented task on the job description document was examined in order to identify precisely what the AP was expected to do in relation to their job title and clinical speciality. Hence, when analysing the documents we took into consideration each of the items outlined in Figure 13. In this way, we were able to adopt a clear and consistent strategy, on which to base our search for role categories and from this, locate the necessary evidence to support why a particular job description was eventually assigned to a specific category. In practice, the job descriptions highlighted a multiplicity of tasks that could be categorised in several ways. The categorisation process formed part of a pragmatic decision-making procedure: if there were more assistive statements present in the job description they were assigned a more assistive category.

Once each clinical task statement had been examined, each job description was then re-examined on a macro level to identify the key orientation of the clinical task statements and assign a final definitive overarching role category assignable to each job description (Figure 14). This enabled us to identify if the job description was predominantly assistive or autonomous, or more reflective of one of the intermediate categories. Further detail of method and analysis of job descriptions has been published (144, 145).

Figure 13. Headings used to analyse the job descriptions and organise the data

Job description	Role summary statement orientation	Clinical task	Clinical task Orientation	Comments: Evidence for conclusions drawn

Figure 14. Categories for AP job descriptions

Fully Assistive

Post-holder who worked in assistive roles and did not take on tasks that fell outside this remit. In reality this post-holder was expected to do little more than an HCA

Supportive Assistive

Post-holder who undertook tasks which were largely supportive of the work of the registered practitioner and predominantly assistive in their orientation.

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.

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.
Fully Autonomous / Independent Practitioner
Post-holder that functioned as a fully independent practitioner.

Interviews and focus groups

Qualitative data (generated by focus groups and interviews) were analysed for thematic content (146). This approach is both inductive (data interrogated to answer research questions but themes allowed to 'emerge' from the data) and iterative (data collection and analysis occurring simultaneously). Initially we understood each case site and then we explored similarities and differences across the case sites. Throughout this process, comparative analysis was carried out; this method allowed data from different participants to be compared and contrasted, such as APs from different clinical areas within case sites, as well as comparisons of what APs say about their role compared with managers and other ward-based nursing staff. This understanding was then used to explore differences and similarities across the three different case study cites. Deviant cases were actively sought throughout the analysis and emerging ideas and themes modified in response (147). The focus groups were also analysed for process to explore data generated depending on group composition.

All of the interviews and focus groups were audio recorded (with participants' permission) and transcribed verbatim. Data analysis involved a process of organising the data, descriptive coding, interpretive coding, writing and theorising. Data were managed using a qualitative computer software package (ATLAS.ti 5.0). To promote quality, the following strategies were used: description of the participants to provide context (credibility and transferability), transparency of the research process and use of theory (transferability), evidence of consistency using multiple examples from data (dependability), involvement of two members of the research team in data analysis, and engagement of the wider research team, informants and participants with interim findings (confirmability) (148).

3.4 Stage Two National Survey of Assistant Practitioners (September 2009 to February 2010)

Wider national development of the AP role was studied using survey methods (Stage 2). We wanted to investigate how the role was being developed, organised, managed and supervised. This stage of the study extended beyond in-depth description to explore the wider implementation of the assistant practitioner role in acute NHS (Hospital) Trusts across England. The national survey was designed

using findings from the case study work (Stage 1) and gathered assistant practitioner's demographic and biographical data (including age, gender, ethnicity, qualifications and clinical experience), data on actual roles and responsibilities in practice, factors that have helped or hindered integration into existing ward-based nursing teams, supervision of the role and lines of responsibility, career opportunities and organisational support of the role. The questionnaire had both closed and open questions (Appendix 10). It was piloted with APs who participated in case study work, prior to wider administration.

Administration of the survey built on the scoping study of the AP role, carried out prior to case study work (126). Trusts that had indicated employing APs in their organisation in April 2007, or planned to introduce the role within 3 years, were re-contacted. The three trusts that had participated in the case study work were excluded from this stage because of their extensive involvement in Stage 1 of the study. The sample therefore comprised APs working in the 40 Trusts who replied to the research team indicating that they currently employ APs (Table 8). Twenty-six organisations (39%) who identified having APs in 2007, or who indicated they had plans to introduce the role in the next 3-years, did not respond to our request for information about the AP role in their organisations in 2009. For those organisations who did respond (n=40), the research team established the name of a key contact in each of these organisations: that is an individual whom the Director of Nursing identified as having some responsibility for the AP role in the organisation and who would be able to assist with administration of the questionnaire. These key contacts included the following types of staff, Clinical Practice Development Lead, Assistant Director of Nursing, Practice Educator and Organisational Development Manager. With the help of the key contact, we established numbers of APs employed in each organisation and then provided envelopes containing study information and questionnaires for distribution in the organisations by the key contact. This was determined the most appropriate method of administration of the questionnaires to the APs. The questionnaire pack also contained a pre-paid envelope so that APs could return the questionnaire direct to the research team. Two further reminders were sent out at 4 and 6-weeks, with another copy of the questionnaire at final reminder stage. To raise the profile of the study and inform APs directly about the national survey we also published a short article (149) and created bulletins in the following web resources: the forum on www.ukaps.info and three AP groups on *Facebook*.

A total of 1090 questionnaires were distributed to 40 Acute Trusts by post, as well as the questionnaire being made available via the web. The total number of completed questionnaires was 381 (approximate response rate of 35%); the majority of these were returned by post (n=347), 5 electronic returns stated the name of their organisation and could be assigned to an SHA, 29 did not provide detail of their

employing organisation. The research team used a range of strategies to promote the survey and improve recruitment. However, whilst the response rate may appear low, this is comparable with other studies that have used survey methods with assistant staff groups (for example referenced studies 81, 105). Further detail of the sample is provided in the findings presented in Chapter 6.

Analysis of the questionnaires was similar to the approach detailed above for analysis of case site questionnaires. In principle, descriptive summary statistics and cross tabulations have been used to present the quantitative findings and open (qualitative) responses have been thematically coded.

Table 8. Overview of sample and responses for national survey of APs

Strategic Health Authority	Number of Trusts receiving questionnaire in 2009/ number of Trusts who identified having APs in 2007	Number of questionnaires distributed	Number (%) of questionnaires returned
1. East of England	4/7	92	38 (41.3%)
2. East Midlands	2/3	155	40 (25.8%)
3. London	4/8	39	4 (10.3%)
4. North East	1/4	27	8 (29.6%)
5. North West	16/21	519	174 (33.5%)
6. South Central	2/4	18	3 (16.7%)
7. South East Coast	2/3	13	4 (30.8%)
8. South West	4/9	139	46 (33.1%)
9. West Midlands	4/4	58	22 (37.9%)
10. Yorkshire & The Humber	1/3	30	13 (43.3%)
Electronic questionnaires	-	-	29
Total	**40/66**	**1090**	**381 (35%)**

3.5 Stage Three Synthesis of findings (duration of study)

The final stage of this study has involved synthesis of findings from Stages 1 and 2 and consideration of the case study and national findings within the context of the literature and policy reviewed for the study so that we have been able to draw out key lessons. The literature and policy review has been ongoing throughout the study period. Analysis of individual case study data occurred during October 2007 to January 2009, followed by a period of cross case analysis and synthesis leading up to administration of the national survey. We experienced severe delays in being able to commence Stage 2 of our study due to an administrative error at the Ethics Committee. Analysis of Stage 2 data was completed February to March 2010. Synthesis of findings from both stages with literature and policy has

been undertaken during February to April 2010. Our conclusions and main headlines from the study are presented in the final chapter and are are located within the 'realities' of service delivery.

3.6 Ethical considerations

The study was reviewed by a Multi-centre Research Ethics Committee (REC reference number: 07/MRE04/20). Stage 1 in May 2007 and Stage 2 in August 2009. Research Governance Approval was obtained in the three Acute Trusts participating in Stage 1. Our main ethical considerations included:

- the handling and storage of personal identifiable data;
- ensuring informed consent was obtained from participants;
- maintaining confidentiality and anonymity;
- disclosure or observation of activity which may threaten patient safety;
- disclosure of sensitive or upsetting information during interviews or focus groups; and
- use of participant quotes from interviews and focus groups.

Our approach to managing these was negotiated and approved by the ethics committees and research governance departments. Here we make particular note of the strategies used in the report for ensuring we maintain anonymity for participating organisations and individuals. The steps we have taken include:

1. general (*not* specific) descriptions of wards that participated in observation data collection;
2. case site and ward identifiers (*not* names) used throughout this report;
3. participants have been given a study ID; this is particularly important for the qualitative data where participants may exist in small numbers, for example the APs;
4. senior managers have been grouped in to 2 main categories (organisational or divisional managers) and given a study ID; this is particularly important for the qualitative data where participants may exist in small numbers, for example Directors of Nursing;
5. the questionnaire has been analysed by worker group rather than ward;
6. the description of the organisation, and hence the context for these case study findings, has been checked with the organisation prior to submission of the report.

3.7 Summary

This chapter outlined our broader methodological approach in addition to describing the specific methods we used, in meeting the study aims and objectives. We chose a mixed methods approach, sequential in design, to:

1. generate an in-depth description of the AP role in three organisations;
2. explore national introduction and development of the AP role; and
3. synthesise our empirical material in relation to relevant research and policy literature.

Subsequent chapters present our findings. Chapters 4 and 5 focus on findings generated by the case studies: separated into organisational vision of the AP role and then the practice realities. The national survey findings form Chapter 6.

4 Findings: the organisational vision

4.1 Introduction

This chapter is concerned with understanding how national policy of the AP role has been understood within organisations and developed to meet local priorities and needs. The policy review highlighted the vision of the AP role and the most recent definition of an AP (Skills for Health 2009). The national vision for the role is one where the AP:

- delivers competent care;
- has knowledge and skill beyond that of 'traditional' healthcare assistants;
- undertakes care and work that has previously been the within the remit of registered professionals only;
- might cross professional boundaries;
- is accountable to themselves, their employer, and the people they serve.

In the next two chapters, and drawing on a range of material, we explore the extent to which this national 'vision' has been translated and implemented into organisational structures (Chapter 4) and practices (Chapter 5) in our three fieldwork sites. In this chapter, we specifically draw on a mix of documentary and qualitative case study data to explore the organisational vision of the AP role and its introduction into existing nursing team structures reporting on:

1. the extent to which the AP role was introduced due to external pressures or perceived organisational need;
2. organisational interpretation of the AP role through job descriptions and the extent to which the role is envisaged as an assistant or substitute;
3. communication of the vision for the AP role across the organisations; and
4. progression of HCAs from within the organisation to train as APs, making the role 'home-grown' and rewarding 'stars' of the assistant workforce.

The subsequent chapter then goes on to explore implementation and impact of the role in practice.

4.2 External pressure or perceived need for the AP role

The extent to which AP roles were introduced in organisations because of perceived local need was questionable; although this did vary across case sites. Senior Managers from case site 1 and 2 described financial support from the SHA as having driven the introduction of AP roles within their organisations. There was a suggestion that the organisations may not have had the opportunity to fully consider the roles prior to their introduction: steerage for the role coming from outside the organisation rather than being a perceived organisational or local need (Box 1). Whist the role was originally introduced in case site 1 to address potential staff shortages (a priority area for the SHA), the organisational vision was to develop the role in relation to supporting patient journeys; a role that would cross professional boundaries and be suitable for all clinical areas and specialities. In case site 2, where the role was less well established concerns were expressed about the expectations of the role: what these practitioners should do and in which clinical areas and specialities they would best fit. The role was developed largely at a divisional level, rather than an organisational initiative as in case site 1, to 'fit' within nursing teams (Box 2).

Senior managers from case site 3 indicated that their motivations for introducing the AP role was more about perceived organisational need rather than external drivers or financial support. Expectations of the role were about ensuring delivery of fundamental aspects of nursing care, with APs taking a lead for *Essence of Care* (127). As such, the AP role was perceived by senior managers to cover aspects of care that were considered as being neglected (Box 3). The organisation supported their APs to undertake different training to the APs in the other case sites and this was deemed to be more focused on preparing the APs for their specific organisational role. It is important to highlight here, that deficiencies in courses were identified by all case sites in relation to how well they prepared the APs for their roles. Some organisations had successfully renegotiated content with training and education providers and in case site 2 the APs completed extra competencies for working in high dependency care units.

Box 1: External support for the AP role

It was something that, as a Trust, we were being involved in. The Strategic Health Authority were pushing it as a workforce issue… There won't be enough trained nurses, so we're going to have to think of alternative… I'm not sure that the ward managers, and even the matrons and possibly directorate managers, I don't think they were quite sold on why we were doing it. But it was free and there was a Champion role to help you do all the paperwork to push it all through… (1: Divisional Managerial: 2)

Just because there's a bit of money there we'll jump on the band wagon, you know, without thinking it through. I think we were probably a year too early. We should have thought the role through, exactly what does it mean. But we didn't, we just went for it. (2: Divisional Clinical: 2)

Box 2: Divisional versus organisational development of AP roles in case site 2

That was a little bit the culture of [name Trust] because it was a very divisionally focused culture and the divisions developed a lot of the things themselves. (2: Organisational Manager: 2)

(Q: How do you think it came about that the role was implemented in this Trust?) I think in the Trust probably ad hoc really… From my interpretation of it, it did depend on the individual areas and whether or not they thought that would be helpful for their role rather than a sort of, this is a Trust wide approach that we're going to adopt for this (2: Divisional Clinical: 6)

In terms of our approach to assistant practitioners at the moment or certainly up until now, we've kind of encouraged the people that have enthused the most about them and I think what we need to do maybe is to start and sell the virtues of assistant practitioners to other parts of the organisation that could probably use them as well. (2: Organisational Manager: 3)

Box 3: Organisational versus general need for the AP role to fill a service gap

I think the way that assistant practitioners have generally been developed is about trying to look at how, in the future when we have possible shortages of registered practitioners, what is the opportunity to be able to develop roles flexibly and ensure that we can still provide a service to the people that obviously need that care. (2: Organisational Manager: 2)

We were losing the essence of nursing… So we always had this very kind of strong desire for making sure that the role was about essence of care, [the] fundamentals of care. (3: Organisational Manager: 49)

Regardless of perceived drivers for introduction of the AP role, the role had not been adopted across the organisation in any of the case sites at time of data collection. In each case site, there were a majority of clinical areas that were not considering, and in some cases actively refusing to introduce the AP role. Reasons provided for resistance to the role included:

- lack of suitability of the role for the clinical speciality and patient population;
- lack of requirement for a role that crosses professional boundaries;
- lack of distinction between Band 3 and Band 4 role descriptions;
- reluctance to replace Band 5 positions with a Band 4 worker; and
- financial restraints.

Views were expressed about the most appropriate environments for introducing the AP role. Senior managers felt the role could be suited to most clinical areas but ward-level staff were more likely to indicate the type of clinical specialities suited to the role, which varied across the case sites. The ward level view of the AP role was often based on local exposure and experience of the role and there were disparities in perceptions across staff groups about where the AP role was best suited. In addition, senior ward nursing staff expressed that some clinical environments would lead to role dissatisfaction for APs

because the roles and activities they would be too permitted to undertake could potentially be too limited due to patient characteristics and the type of work carried out in some specialities. Where financial restraints were cited there were some ward managers who contested this rationale and emphasised the gains associated with Band 4 positions, rather than what would be 'lost' from the nursing team (Box 4).

Box 4: Accommodating AP role in nursing teams

I mean I've got 10 nursing auxiliaries, with 1 [AP]. I would say another 2 or 3 [APs] in an ideal world… I don't think they need to take away the numbers of qualified staff against [APs] that I need… If I needed another 2 [APs], certainly with the pay-scale, my budget would have to be increased… to make that level. Because if I was increasing my [APs] by some, I think my nursing auxiliary quantity would go down. (3: 10: SS21)

I'm the budget holder and I had to use a staff nurse's pay for [name] band 4 but I thought it was an absolute asset and I've gone to many a meeting, for other wards who haven't got it, to sell her role really and I just think it's great value because I don't think you need everybody at the top… You've got to have a leader. All the girls in the green do like to have somebody who's in charge of them or somebody at their level perhaps that they can go to about basic things and everybody then takes pride in their work. (3: Medical ward with AP: SS33)

She's cost more money than an ordinary health care assistant and that's one of the reasons why the other sister probably on the fifth floor were a bit reluctant to have her because they kept seeing it that you're basically trading a band 5 nurse, you're losing a band 5 and replacing with a band 4 but I didn't see it like that… I just saw it rather than losing a band 5, I saw it as gaining – changing a band 2 to a band 4. I didn't see it as one of my members of staff in the skill mix stepping down, I saw it as one of them stepping up. (3: Surgical ward with AP: SS32)

It is important to note, however, that actual numbers of APs in each of the organisations were relatively small when compared to the number of RNs and HCAs in each of the case sites: APs comprised 10.2% of the assistant workforce in case site 1, 4.6% in case site 2 and 9.3% in case site 3. The way in which the introduction of the AP role was communicated varied across the 3 case sites. It is important to observe the organisational expectations of the AP role as outlined in job descriptions in each of the case sites, which provided mixed descriptions of the roles within and across case sites.

4.3 Assistant or substitute: defining the AP role through job descriptions

Job descriptions provided a useful way of understanding expectations of the AP roles within the case sites. These documents embodied many of the dilemmas outlined above and reflect the tensions identified in the subsequent chapter. As such, their analysis provides further contextual material from which to understand the role of APs. According to Forchuk *et al.* (150), a job description is:

'a formally written document, which acts as the cornerstone for employers and employees to understand each person's job function, sphere of responsibility, accountability, and authority in the workplace. Job descriptions define the job and often reflect the philosophy of the organization; particularly as such documents can

help define differences and similarities between jobs that may have the same job title.' (150: p.479-480)

Job descriptions from each of the case sites were categorised and assigned a role descriptor, which reflected the main function of the roles (144, 145). The role descriptors ranged from fully assistive to fully substitutive: however, the fully substitutive descriptor was not used for any of the job descriptions. The spread of assigned role descriptors is shown in Figure 15.

The job descriptions fall into two distinct clinical areas: (i) critical or high dependency services; and (ii) general or rehabilitative services. Wards grouped in the critical care services were those where the patient's condition could change very rapidly, for example Cardiac Catheterisation Laboratory, Emergency Medical Unit, Acute Admissions Unit, and Acute Vascular/Urological Surgery. In contrast, those grouped under the general or rehabilitative services were the general medical, short stay surgical and rehabilitation wards. APs located in critical care or high patient dependency areas, tended to have job descriptions oriented towards the substitutive/autonomous end of the occupational spectrum (italicised in Figure 15). Examples of this notion of autonomy for APs working in critical care services are provided in Box 5 and 6. The words 'support' and 'teach' (used in these examples) indicated that the AP was expected to initiate action; the AP was not expected to consult the RN but to independently arrange and complete the tasks. Similarly, in the example provided in Box 7, the AP is expected undertake a specific set of actions without referring to the RN. Verbs used in the job descriptor statements indicated the level of autonomy or supervision the AP was afforded within the respective clinical task domain. The verbs used in these job descriptions suggest that the AP is expected to make decisions and take actions based on their own 'professional' judgement.

Figure 15. Categorisation of the job descriptions using role descriptors

Role descriptor	Job descriptions by clinical area (n=22)	Case study site
Assistive Role	Cardiac High Dependency Unit	1
Supportive Assistive	Medicine	1
	Surgical Admissions Unit	1
	Short Stay Surgery	1
	Surgery (General)	1
	Stroke Rehabilitation	1
Supportive / Substitutive	Rehabilitation 1	1
	Rehabilitation 2	1
	Heart and Lung Unit	1
	Orthopaedic Outpatients	3
	Trauma and Orthopaedics	3
	Rehabilitation 1	3
	Rehabilitation 2	3
Substitutive / Autonomous	Orthopaedics	1
	Cardiac Catheterisation Unit	*1*
	Burns Unit	*1*
	Coronary Care Unit	*2*
	Acute Admissions Unit	*2*
	Respiratory Medicine	*3*
	Emergency Medicine Unit	*3*
	Vascular/Urological and Intermediate Surgery Unit	3
Autonomous	Lymphoedema Services	1

Box 5: Substitutive-autonomous clinical task orientation

Job description	Role summary statement orientation	Clinical task	Clinical task orientation	Comments: Evidence for conclusions drawn
AP Orthopaedics Case site 1	Substitutive/ Autonomous	Teaching post-op exercise regimes and provide with appropriate walking aids	Substitutive/ Autonomous	Teaching is a high order skill and the AP is clearly expected to take on this role re post op exercises as part of an independent activity. So too in this context the AP is expected to assess for the appropriateness of the walking aid if s/he is to provide the patient with the right tool. This again is a role that was previously

				undertaken by the AHP and as such it encroaches on more traditional role demarcations generating an upward role boundary transgression

Box 6: Substitutive-autonomous clinical task orientation				
Job description	**Role summary statement orientation**	**Clinical task**	**Clinical task orientation**	**Comments: Evidence for conclusions drawn**
AP CCU Case site 2	Substitutive/ Autonomous	Support and teach junior staff in delivering care	Substitutive/ Autonomous	This action would previously have been the sole domain of the RN and not an assistant member of the healthcare team. Here the term support clearly implies the AP is expected to take a lead in this activity rather than the RN doing this in partnership with the AP

Box 7: Substitutive clinical task orientation				
Job description	**Role summary statement orientation**	**Clinical task**	**Clinical task Orientation**	**Comments: Evidence for conclusions drawn**
AP Vascular / Urology and Intermediate Surgery Case site 3	Substitutive/ Autonomous	Undertake specific clinical skills appropriate to area of practice as agreed by the Trust. i.e. simple wound dressings, wound assessment in line with Trust policy, venepuncture, bladder scanning, ECG, blood glucose monitoring, removal of catheters	Substitutive	The substitutive element of the role is that the tasks are being delegated from the RN to the AP and as such they are having work passed down to them from a position of higher occupational social space

Despite many of the job descriptions having a largely substitutive/autonomous element to them, they also had a considerable number of duties identifiable as assistive in nature as

the following examples from each of the case sites demonstrate (Boxes 8 to 10). In addition, many of the job descriptions for APs, across all case study sites, had duties listed which were supportive of the work of the ward, unit or hospital, rather than being specifically supportive of the work of the registered practitioner *per se*. As indicated by the type of role descriptors used in the documents in the following example (Box 11).

Box 8: Assistive clinical task orientation

Job description	Role summary statement orientation	Clinical task	Clinical task orientation	Comments: Evidence for conclusions drawn
AP Case site 1	Substitutive/ Autonomous	Assist in splint making and the altering of simple splints under the supervision of the OT	Assistive	The term assist is indicative that this role is undertaken as part of a supportive function. Also the alteration of simple splints under supervision strengthens this notion of assistant and support for the registered practitioner.

Box 9: Assistive clinical task orientation

Job description	Role summary statement orientation	Clinical task	Clinical task orientation	Comments: Evidence for conclusions drawn
AP AAU Case site 2	Substitutive/ Autonomous	The practitioner will be able to assist in a limited range of clinical activities as outlined in the Scope of Practice document, following policies and protocols.	Assistive	The term assist clearly indicates the orientation of the role in that the AP is to be given a limited repertoire of actions to undertake on their own

Box 10: Assistive clinical task orientation

Job description	Role summary statement orientation	Clinical task	Clinical task orientation	Comments: Evidence for conclusions drawn
AP Orthopaedic Outpatients Case site 3	Supportive/ Substitutive	Assist the registered nurse in the admission, discharge and transfer of patients and the evaluation of specific programmes of care, by completing approved areas of documentation ie	Assistive	This role definition is designated by the verb and the start of the sentence in that the AP is expected to assist in these actions rather

		front sheet of admission, areas of the GPP, discharge/transfer documents, plaster request forms and plaster register.		than take responsibility for them.

Box 11: Supportive clinical task orientation				
Job description	**Role summary statement orientation**	**Clinical task**	**Clinical task orientation**	**Comments: Evidence for conclusions drawn**
AP Medicine Respiratory Medicine Case site 3	Substitutive/ Autonomous	Understand and adhere to Trust policies, procedures and guidelines	Supportive	This is a role/activity that is supportive of the smooth running of the organisation rather than a specific role or task specifically related to the clinical area

APs reported that they did not always have a clear job description and this was viewed as contributing to the uncertainty surrounding what they could and could not do (Box 12); an issue picked up in the next chapter in more detail.

Box 12: Lack of job description and job clarity

If you had a clear job description to tell you what you were doing in your role then you'd be able to understand... But because there's not a [clear] job description and the job description that we've got is such a wide, and it covers everything, it's left up to yourself to develop your job description or up to the line manager to tell you what to do. (1: Medicine: AP61)

[*Name] was interviewed and given a post on [name ward] and we didn't even have a job description or a role*. (2:Medicine: WM233)

I think it was very important that they had a job description that we knew what the job description was, so that everybody was going down the same line, you know… I think since we've got that job description and we know what they can do, it's better, they benefit definitely from it. So maybe just the fact, you know, getting that job description at the beginning rather than sort of months down the line. (2:Medicine: RN324)

Despite a clear vision for the role at organisational managerial level, and sometimes at the divisional manager level, it was apparent that staff across the organisation perceived the AP role to be poorly articulated and communicated, despite some organisations also employing a 'Champion' for the AP role. The champion had responsibility for supporting the APs and promoting the role within the organisations and whilst staff perceived these roles as offering support for the development of the individuals undertaking AP training they were not observed to offer organisational support. Indeed, problems in identifying a source of ongoing support about the AP role were cited in organisations and particularly in case site 1

and 2 (Box 13). The high turnover of staff in management positions led to confusion about whom staff should go to should they wish to discuss ongoing support and management of AP roles. The lack of clear job descriptions further reinforced staff perceptions of the lack of clarity about the roles. These issues are covered in more detail below.

Box 13: Ongoing support and management in relation to AP roles

I rang a certain person who said, no so and so was doing it now, so I rang them and they said, "oh well I've stopped doing that, I've moved on to this, and I think so and so might be doing it," and before I knew it, I'd rung round all of these people and no-one was dealing with it. So there was no-one, at senior level, leading in the Trust with assistant practitioners. I don't know what had happened there. (2: Medicine: WM234)

I think more of corporate approach to it really. A more clearly defined job description, outcomes and supporting that role and probably somebody at Trust level supporting that role as well because they just kind of did the course, went back into their areas and some of them were doing extended role and had job satisfaction and others didn't and there was nobody really there, a voice for them really… [The AP role] needs the support from Trust level to make sure that they're effective and cost-effective as well really. (2: Divisional Clinical: 6)

4.4 Blurred vision

There was recognition by staff across the organisations - at both organisational and ward level - that initially at least, there were very confused messages about the AP role and its purpose within the organisations. This has led to continued confusion of ward level expectations of the role and for APs undertaking training. The lack of a clear vision about the role, or at least lack of communication of that vision, led some clinical areas to feel the role was not suitable for their area (discussed above). This - as we shall see - also contributed to some residual confusion even after the role had been established. This is why understanding some of these historical tensions have implications for how the role developed within the three fieldwork sites.

Staff criticised senior managers for not preparing the organisations to engage with the AP roles. Few senior managers were charged with responsibility for promoting and engaging staff with the role and as a result staff felt unprepared for the introduction and development of the role. In addition, there was a perceived lack of discussion and engagement of staff in developing the AP role to suit their clinical environment. Indeed, there was an indication that our research had prompted interest and engagement with the AP role by some staff in the organisation for the first time (Box 14).

Turnover of staff in senior positions was also perceived as having created a lack of senior management awareness and engagement with the role. Ward managers indicated that they would appreciate an opportunity to discuss the AP role at an organisational level because since being introduced there have been no discussions about the role's contribution to organisational goals and its value.

Operationalisation of the AP role within organisations was not well understood by ward managers (Box 15). The AP role was largely defined and negotiated in practice (an issue picked up in the next chapter) (Box 16); and something that is fundamental in understanding their role. In addition, the lack of role clarity for APs also created misguided expectations for HCAs who wanted to undertake the AP role and training. Upon qualification, this led to decreased satisfaction in the role for some APs (Box 17). Particularly of note is the fact that a number of tensions appeared to have arisen due to inconsistencies in AP roles both within and across organisations because of a lack of clear organisational policy on why some decisions had been taken regarding what APs could and could not do. There were perceptions among ward-based staff that APs were being prevented from developing in areas of practice that were sometimes undertaken by more junior HCAs, technicians or that student nurses could undertake. Areas of tension offered as examples included: intravenous cannulation, catheterisation and some wound care. Discussions between managers at organisational and ward level were rare, which resulted in a lack of consensus and decision-making about the AP role and the contribution it could make to the clinical environment.

In case site 3, three years into development of the AP role, the organisation set about developing an organisational strategy for the role. The strategy outlined a need for APs to be employed in every clinical area and has started to addresses more formally, what they consider their APs 'should' and 'should not' be doing. Senior managers in all organisations were keen to point out that they had experienced a lack of national policy guidance and support for the development of Band 4 roles in their organisation and this had affected how the organisations adopted, or not, these higher-level assistant positions.

Box 14: Lack of organisational engagement with the AP role

So this should have been more in place when we qualified and management should have stipulated and said, this is the role, this is what they do, they are qualified up to a Band 4, they are APs, they're not Band 2 auxiliaries and let's treat them as that and give them the space. And they should have adhered, like [name manager] said, they should adhere to what they promised us. You're in a bay, you look after 4 patients, so literally if they needed a doctor, you get the doctor, their observations, whatever they needed, the full care expect for the pharmaceutical side, we should have been giving. (1: Medicine: AP62)

Let's face it. Before you people [research team] came in and took an interest in this [role], it was only left with two people as far as I was concerned: [name] and the practice trainers [name] and [name] to actually sell it to the ward managers to see what we can do and how we can do and what it is. So there's no awareness in the Trust to say what we can do, how we fit in. (1: Medicine: AP61)

You have to first be sure about what the role is about, what you're trying to achieve with the role and be very clear across all the team what that role means. So if you're designing it, that it's not just designed in isolation, that it's designed with the whole clinical team that are going to then house this person and that it's clear about what that difference would make to the other nurses who are in the skills escalator as well because you don't want the role to just be adding in another person who repeats what the registered nurse does, it's got to

complement that really and allow them to free up their time to do more important things in their perspective really, in their day to day role. (2: Divisional Manager: 4)
Once we got [name], it was - what do we do with [them] now? What do we allow [them] to do? (2: Medicine: WM234)

Box 15: Lack of opportunity for ward managers to discuss AP role and developments
I'd be interested to know how the Trust feels about them because I've not had any, I know [name senior manager] very strongly supported them but I don't know what the Trust thinks of the assistant practitioner role. I've not really had any feedback on that. (1: Medicine: WM47)
I don't know how the APs are viewed or utilised on other wards. I don't know what the senior manager's opinion is here. (1: Medicine: WM72A)
It's interesting to find out how it's developed or utilised in other areas because we don't get that feedback. (1: Medicine: WM21)

Box 16: Poor AP role definition at outset
I think it was quite loose at the beginning. It became more specific once the first ones had started their training and it became a little bit more defined as to what the reins were and the objectives and through that how they would fit into the ward team. (1: Medicine: WM21)
(Q: So would you say they knew what they wanted you to be?) No, no. I'd say they didn't in all honesty. I don't think anybody knew where we were going, what we would be or what we'd be doing at the time and I think that's more for the fact that it was just a new thing. (2: Surgical: AP226)

Box 17: Misguided expectations and role disappointment for APs
What they sold us isn't what we got. Definitely. (1: Surgical: AP15)
We sort of employed them without thinking the role through and I think they felt let down because, my god this is rubbish, I'm doing nothing more than what I was as a health care assistant and I think that's probably true across the Trust, you know, we jumped on the band wagon and say, yeah we have to have these APs but we didn't think the role through and I think a lot of them feel unsupported. (2: Divisional Clinical: 2)
But it was just the fact that they doing like 18 months studying to get this position and then it seemed fine while they were doing that and then it was when they finished that it was like, well what are we going to be doing with them? You know, it was as if somebody thought about it afterwards, you know, when the horse has bolted after you've shut the gate type of thing. (2: Surgical: HCSW213)

The lack of organisational consistency in uniforms when integrating APs into ward based nursing teams in case site 1 and 2 was highlighted by many APs as a specific example which reflected the lack of organisational vision for AP role. This issue is clearly more wide-spread, being picked up in the national survey (Chapter 6). The AP uniforms were described as a barrier to their recognition and integration within the ward based nursing teams; an issue that was discussed by a variety of staff, not just the APs. The colour of their uniforms was completely different to RNs and HCAs and therefore made the role stand out and created confusion for other staff,

patients and their relatives, because APs did not appear to be part of the 'nursing family' (Box 18).

The ways in which confusion about the AP role translated into practice is the subject of the subsequent chapter. However, prior to understanding the work of APs in more depth it is important to highlight the means by which these staff became appointed to their positions within the organisations.

Box 18: Uniforms as barriers to integration

A15 *Not many people know in the multi-disciplinary team, they look at you and think what's that green [uniform], they've no idea what you do.*
A118 *Well, even the relatives look at you and think you're a….*
A15 *Cleaner.*
A118 *I don't know about a cleaner but they think that you're agency, you know.*
A15 *I've had that.*

(1: AP focus group discussion)

RN2: *I think the, the biggest thing that hampers them…*
RN5: *…is the uniform.*
RN2: *…is the uniform, the colour of the uniform.*
RN80: *It was vile in colour.*
RN2: *If they could be dressed the same, you know, like, if they could be dressed like us. They stand out.*
RN80: *I think, you know…*
RN2: *I don't think they have to stand out.*
RN80: *…pea green was never gonna be a winner was it really?*

(1: RN1 focus group discussion)

I think the green was the biggest mistake that they could have made to be honest. I think they should have blue with a green trim, that's my only criticism of the actual practitioner's role… They just feel as though you've shoved them out part of the team because they're so different to everybody else, they stand out when we're supposed to be integrated.. (1: Surgical: WM1B)

I think patients get confused about what [the AP] role is really because they ask, colour epaulettes and I think if they're very confused what they can do, whereas they know a health carer, they know a nurse but they do get confused. (2: Surgical: RN222)

4.5 'Home-grown' and individual assistant 'stars'

In the main, assistant staff were nominated by their ward manager to undertake training for, and promotion to, the role of AP. Once nominated for training, the HCAs in case site 1 and 3 were guaranteed a Band 4 assistant position if they successfully completed the training course: foundation degree in case site 1 and higher education certificate in case site 3. In case site 2, despite promises of an AP position upon completion of their foundation degree training, the APs had to apply for a job (Box 19). At the time of data collection, there were no APs appointed from 'outside' the organisations. The role was viewed as an opportunity for ward managers to retain and reward assistants who had worked in the organisation for a number of years and were recognised as 'stars' as well as retaining and promoting assistant staff in clinical areas where it was sometimes considered difficult to recruit RNs (Box 20). Indeed, because these staff were known to the ward and had progressed into

the AP role as 'insiders' there were questions raised by ward managers about whether, if they left the organisation, they would (or could) be replaced.

Box 19: Applying for AP positions in case site 2

Yeah but they don't necessarily get an assistant practitioners role when they've done the Foundation Degree. Now this is one of the things they were told, if they did the Foundation Degree, they would automatically become an assistant practitioner and that never happened because it's money. The Trust are not going to upgrade people just because they've done a course. (2: Medicine: WM234)

I think a problem really and I don't know if you've picked this up in [name division] but they sent several people to do this programme and when they came back there wasn't the funding to appoint them as assistant practitioners initially and I feel quite uncomfortable about that because that's not saying to somebody when they come back off a programme that we value you and, you know, what you've done. So we've got to be sure that, you know, if you send people – I don't think it's an automatic thing that you have to have a job - I think there should be the window there for them that …. (Q: To apply for ….?) Yeah. (2: Organisational Manager: 1)

Box 20: Assistant stars

The bulk of them, you retain them but you're rewarding them, if you know what I mean. So you've got these good reliable staff, sometimes their families are grown up and, you know, they've gone through all that but they've still got an active brain. So I think that the Trust has benefited because you've got more out of your staff. (1: Division Managerial 1)

[The APs] clearly had a lot more ability and they had a lot more about them; they're quite intelligent people and you could see that for them, they were using this route to gain further qualifications. (1: Division Managerial 2)

The [staff] that chose to do it already had a lot of experience and a lot of skills and I felt it could only be good for them to move on because they were a bit static and wanted to do something and so I felt it would be good for them to show what they were good at, give their experience and get some, what's the word, credit for it. (2: Surgical: WM149)

I don't think we've brought anybody in new to do that role. I think we've tried to grow our own and I think that's a good philosophy, especially if you've got a very talented health care assistant who's done a lot of things, is a very keen member of the team. (2: Organisational Manager: 1)

At the time we were struggling to recruit people into rehab... you either love it or hate it. So we were struggling actually to recruit [RNs]. So if we had [assistants] on board who were enthusiastic and wanted to progress and wanted to enhance their skills that seemed like a good idea. (1: Medicine: WM47)

Ward managers who, in the main, had responsibility for nominating assistant staff from their clinical areas for AP training had the potential to generate inequities for assistant staff in the organisations. Since significant numbers of wards had resisted the introduction of the AP role into their nursing teams, this could potentially disadvantage some HCAs in terms of their career progression (Box 21). One strategy for overcoming this inequity would be to have a central system for nominating potential AP candidates within an organisation so that those assistants wishing become APs could be trained and appointed on wards desiring to appoint an AP. This option had been considered in case site 3 but there was some reluctance among assistant staff to move to a

different speciality (Box 22). Divisional managers reported a lack of any strategic approach to identifying assistant staff who demonstrated sufficient potential to develop into the AP role coupled with a tendency for organisations to sit back and see which assistants came foreword or were noticed by their ward managers.

Box 21: Nominating assistant staff for development

There's a very good person [in the ward] and they wanted to do it and [name ward] made it quite clear that they did not want or need a [AP] and we again had that debate… It was totally inappropriate for these individuals to be compromised simply because that ward or department didn't want or feel they needed one… They could still do it under the heading of surgical division or medical division. (3: Organisational Manager: 49)

We've had the question, what about the areas like [name ward] that struggles to find a role for a [AP] in that area because it tends to be registered nurse driven and you've got a health care assistant there that's fairly keen to do the role. Do you allow them to do the role in [that ward] or move them somewhere else? So they do the role but there's nothing for them to do or do you say, well if you want to do that, you've got to move to this ward. So again, that's something that we really need to think about. (3: Organisational Manager: 57)

Box 22: Moving specialty to develop as AP

Financially, I would find it very difficult to justify it really in terms of our needs. When she found that we weren't going to be able to do that, she did look at moving elsewhere to take up the role in another department but then she said, actually I really like what I do here and I don't want to leave, so it was unfortunate. It wasn't at all that I wouldn't have supported her expanding her skills but as a manager, I've got to justify having that role within the unit. (3: Medical Divisional Manager without AP: 58)

They would need another [AP] but it doesn't mean to say it's going to be on here because of the funding and things, obviously it's got to come out of the budget but they'll probably be posts somewhere else. But would I like to go anywhere else? Personally no. (3: Medicine: HCA11)

Currently, the majority of ward-based assistant staff in the organisations were Band 2, with few Band 3 assistant positions. Therefore, the AP position provided a significant progression route for assistant staff. However, there were indications that rewarding long-standing staff may not always be the most appropriate selection criteria for the AP role. It was suggested by both senior and ward managers that in some cases, persons appointed to the role had become complacent in the role and continued to function as health care assistants rather than embracing the opportunities and challenges of their new roles (Box 23).

Management within the organisations voiced conflicting opinions and different views about who should become an AP. Some senior managers in case site 1 and 3 suggested that an assistant, who planned to go on to be an RN, or other registered practitioner, should not do their AP training. This was viewed as a waste of organisational resources and time for the individual. In case site 2, there appeared to be greater understanding of the AP role as a route to progression towards RN training. However, other managers across case sites 1 and 3 indicated that it was only when undertaking AP training that

some assistant staff developed confidence and recognised their abilities to undertake RN training. Therefore, to exclude staff from going on to develop after becoming an AP was perceived as creating inequity (Box 24). There were examples of APs who had gone on to complete their RN training. This again exaggerated feelings of inequity for APs who were considering the possibility of undertaking registered training but were then informed by their managers that they would not be supported by the organisation to do so. The experiences of this are described in the next chapter.

Box 23: AP role should be about more than rewarding long-serving assistant staff

Make sure you really need [an AP]. Do you really need it or are you trying to reward your good HCAs? Because I think that was an issue. Don't try to reward your good staff because just tell them they're good. You need to work out, do you need someone with additional skills. Make sure that all your health care support workers are skilled up to the max, trained to the max; that you have pushed them to the edge of their ability and you're comfortable that they're all singing, all dancing health care support worker. And after that, if you still feel you need more, look at an AP role. But don't use an AP training programme to train your health care support workers. That would be my message. (1: Division Managerial 2)

I'd say to think long and hard and to see whether your particular area would benefit from somebody in that role. Not to just have one for the sake of having one because everybody else has got one, which is what I think has happened here. (2: Medicine: WM234)

My take on this is that we have appointed because we wanted to reward people rather than appointing the person who wanted to take on that role… You don't choose a person because they've been in a place for a long time and, you know, they're quite good and we'll pat them on the head. You want somebody who really wants, is hungry for that role… So it's maybe that my disappointment is because it's the wrong person in the job… From what I've seen it's been a reward for long service or because they're a nice person or whatever rather than what their motivation is for wanting to do it and are they strong enough to do it? (3: Medical Divisional Manager: 19)

AP28: *I think a lot of the, not a lot, some of the APs just took the money and said, thank you very much.* (3: AP focus group discussion 1: mixed clinical areas)

Box 24: Committed AP or aspiring RN?

They wanted this new role of assistant practitioner to help support the staff nurses and the doctors in whatever area it was. So their argument is that they'll train you, they'll make you become an assistant practitioner and they'll pay you while you're doing it. All they wanted from us is to stay as assistant practitioners; not in a way to keep you as a prisoner sort of thing, but they wanted assistant practitioners. They didn't want the opportunity to be taken away from people that wanted to do this in a way to get into nursing sort of thing. And I think they are still dis-encouraging us to become staff nurses once we're APs. (1: Medicine: AP61)

It has always been made clear, you know, we've got the pathway, the career pathway and whatever and it's quite clear that the [AP] is an [AP] and it doesn't lead on to anything else. (3: Organisational Manager: 49)

We're very keen for our band 3 HCAs to go and do the training to become an [AP], if they want to. But they have to be committed to staying as an [AP]. In other words, they don't want to progress to nurse education. Okay, if they want to progress to nurse education, we're saying you should do that at NVQ level 2 or 3, okay. But there's quite a lot of HCAs who don't want to go and do their

training, so this is the next step for that category of staff. We don't want to put staff through their training to level 4 and then to lose them to go and do their training. We'd rather take the staff who are committed to staying to work at that level who don't want to do the training, if you know what I mean. (3: Organisational Manager: 52)

4.6 Summary

The chronological development of the AP role played an important part in shaping and establishing APs in hospital wards, the way APs work and their potential impact. In at least two of the case sites, there was initial confusion about the role of APs and locating the need for the role: it was not always clear whether there was an organisational need for the role or whether it was introduced in response to external pressures from SHAs. The apparent lack of focus on resolving these issues at an early stage, highlighted by poor articulation of the AP role through job descriptions, played some part in the continued confusion about the AP roles and the lack of preparedness of staff on the ground to manage the introduction and integration of APs into their ward nursing teams. Not all clinical specialities embraced the AP role and indeed some areas were actively resisting its introduction. There were noticeable differences between the accounts of senior managers with a vision for the AP role and ward-based nursing staff who would have to work along side the APs in practice. It is the recognition of the AP role in practice to which we now turn.

5 Findings: the AP role in practice

5.1 Introduction

Using case study findings – and a mix of quantitative and qualitative material from our three fieldwork sites – this chapter explores the AP role in practice; having already established the organisational vision for the roles in the previous chapter. Little is known about the AP workforce, in particular who they are, what they do and their potential impacts on patient care and nursing teamwork. We describe and understand, for the first time, the personal characteristics of APs working in ward-based nursing teams in acute care; report on perceptions of the role; and observation of their activities and interactions with patients in practice. The national picture is then considered in Chapter 6. The findings from the case studies and national survey are then integrated in the final chapter to offer main headlines about the development and potential impacts of the AP role on patient care and nursing teamwork in acute hospital wards.

5.2 Understanding the AP workforce

5.2.1 Who are APs?

APs had an average age of 42 years (standard deviation (SD) 9 years) and were most likely to be female and identify themselves as 'white British' (Appendix 11; Table 1). The wards purposively sampled for in-depth study and observation data collection (n=13) had more male APs than any of the other non-observed wards or clinical areas employing APs in the three participating organisations. The APs had a mean length of service within the NHS of 14.3 years (SD 6.5 years), ranging from 4.7 to 34 years. The majority of APs had completed a qualification for their role; this tended to be a foundation degree with a certificate of higher education the next most frequently cited qualification. None of the APs in case site 3 had completed the foundation degree because the organisation used a one-year certificate programme to train APs for their role.

The majority of APs worked full-time and in the wards were more likely to be contracted to work internal shift rotation (day and night shifts). However, in other clinical areas (such as outpatient departments or radiography) the APs were more likely to have permanent day-time shifts (Appendix 11; Table 2 and 3).

5.2.2 What do APs report that they do?

We were keen to understand and locate AP work roles and activities within the context of the ward nursing teams. The questionnaire asked respondents for their views on their roles and activities (Appendix 11; Table 4). The majority of AP respondents in the observed wards reported that their role involved delivering care to patients (100%), delivering treatments (82%), planning care delivery (82%), supervising others delivering care (71%), discussing care with patients (82%) and their relatives (65%), administrative duties (71%) and report writing (94%). They were less likely to report that their work involved carrying out physical examinations (53%), planning treatment delivery (53%), planning for patient examinations (47%), supervising others carrying out physical examinations (41%) and attending meetings (35%). The reported roles and activities tended to resemble the responses of RNs rather than the HCAs, although APs reported more meeting attendance than RNs. Interestingly, fewer APs in the wards that were not observed felt that they had a role in planning care delivery (45%), supervising others delivering care (38%) or in administrative work (35%).

5.2.3 What were APs observed doing?

Observation of activities of APs, RNs and HCAs in 13 wards across the three case sites allowed us to describe the types of activities that APs undertake in their day-to-day work, locating them within the ward-based nursing teams. Across all three case sites there were a total of 15,355 activity observations. A breakdown of number of activities recorded per ward is provided (Table 9).

Table 9. Number of activities observed by ward

Case site	Ward	Ward type	Number of observations
1	1	Short stay surgical	959
	2	General rehab	1370
	3	General medical	842
	4	Acute stroke/stroke rehab	1803
2	5	General medical	498
	6	Surgical	1677
	7	Surgical	661
	8	Surgical	400
	9	General medical	1773
3	10	Surgical	1093
	11	General medical	1833
	12	Rehabilitation	1061
	13	Surgical	1385

We categorised the workforce into three groups (RN, AP and HCA) so that we could compare activities performed by each category of staff on the observed wards. Table 10 indicates the activities observed, grouped into four categories (direct care, indirect care, associated work and non-productive activities) by staff group. All staff groups spent the greatest proportion of their time on direct care activities; however, this was higher amongst the APs compared to the RNs and highest amongst HCAs. Whilst all three staff groups spent a similar proportion of their time on associated activities, RNs were more frequently engaged with indirect care than both APs and HCAs and APs were, in turn, more likely to spend time on indirect care than HCAs. Conversely, RNs spent slightly less time on non-productive activities compared to the other two staff categories.

Table 10. Activities divided into 4 categories performed across the three staff groups

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care	4002 (44.0)	1183 (47.0)	2014 (53.7)
Indirect care	2216 (24.4)	427 (17.0)	326 (8.7)
Associated	2143 (23.6)	639 (25.4)	984 (26.3)
Non-productive	728 (8.0)	269 (10.7)	424 (11.3)

A more detailed breakdown of the activities performed by each staff group is given in Table 11. We have included only those activities performed at least 5% of the time by any of the staff groups (a complete breakdown of all activities is provided in Appendix 12). RNs spent the greatest proportion of their time on reporting activities (14.3%), followed by administration communication (12.8%) and medication (11.9%) when compared with both APs and HCAs. Both APs and HCAs spent the greatest proportion of their time on hygiene activities (although the figures for each of these groups were quite different – 14.4% and 22.4% respectively). For several activities the proportion of time spent by APs fell between the figure for RNs and HCAs, including hygiene, movement, vital signs, charting, cleaning, meals and drinks and administrative communication. However, for medication, the pattern of work for APs was more similar to HCAs. For some activities all three groups spent relatively similar proportions of their time, for example, communication with patients and nursing procedures.

Table 11. Detailed breakdown of most common activities across the three staff groups (5% or more in any of the groups)

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care			
Comm patients	407 (4.5)	140 (5.6)	174 (4.6)
Hygiene	668 (7.4)	362 (14.4)	838 (22.4)
Medication	1085 (11.9)	35 (1.4)	16 (0.4)
Movement	146 (1.6)	92 (3.7)	191 (5.1)
Vital signs	278 (3.1)	122 (4.9)	230 (6.1)
Nursing proc	461 (5.1)	151 (6.0)	194 (5.2)
Indirect care			
Charting	512 (5.6)	121 (4.8)	61 (1.6)
Reporting	1301 (14.3)	246 (9.8)	217 (5.8)
Associated			
Cleaning	223 (2.5)	113 (4.5)	192 (5.1)
Meals and drinks	104 (1.1)	99 (3.9)	250 (6.7)
Admin comm	1161 (12.8)	264 (10.5)	339 (9.0)
Non-productive			
Breaks	516 (5.7)	176 (7.0)	313 (8.4)

Activities by ward type

We were interested in examining the nature of APs' activities, in the context of the wider nursing workforce, by type of ward. We split the wards across all three case-sites into medical, surgical and rehabilitation. Table 12 shows the number of observation by category of ward. The data in Table 13 shows the proportion of time spent on the four activity types across the three staff groups, by type of ward.

Across all three ward types, all three staff groups spend the majority of their time on direct care activities. However, these proportions do vary by ward type. For example within the surgical wards, RNs, APs and HCAs all spend a very similar proportion of time on direct care. For rehabilitation wards, the HCAs spend the most time on direct care, with the RNs spending the least. For medical wards, this pattern is slightly different with the APs spending the least proportion of time on direct care activities. We were also interested in identifying differences in the AP roles across the case sites, given that the organisational vision for the roles had been so varied. Below we present a breakdown of activity analysis for each case site.

Table 12. Number of activities observed by ward type

Wards	Clinical sub-category	Number of observations
3, 5, 9 & 11	General medical	4946
1, 6, 7, 8, 10 & 13	Surgical	6175
2, 4, 12	Rehabilitation	4234

Table 13. Activities divided into 4 categories performed across the three staff groups, by type of ward

	RN - n (%)	AP - n (%)	HCA - n (%)
Medical wards			
Direct care	1345 (42.6)	253 (39.9)	598 (51.8)
Indirect care	731 (23.2)	130 (20.5)	60 (5.2)
Associated	761 (24.1)	165 (26.0)	326 (28.3)
Non-productive	321 (10.2)	86 (13.6)	170 (14.7)
Surgical wards			
Direct care	1832 (45.3)	474 (44.4)	494 (46.4)
Indirect care	998 (24.7)	180 (16.9)	119 (11.2)
Associated	886 (21.9)	304 (28.5)	313 (29.4)
Non-productive	328 (8.1)	109 (10.2)	138 (13.0)
Rehabilitative wards			
Direct care	825 (43.7)	456 (55.8)	922 (60.3)
Indirect care	487 (25.8)	117 (14.3)	147 (9.6)
Associated	496 (26.3)	170 (20.8)	345 (22.6)
Non-productive	79 (4.2)	74 (9.1)	116 (7.6)

Activities by case site

Case site 1

In case site 1, all staff groups spent the greatest proportion of their time on direct care activities, however, this was higher amongst the APs and HCAs compared to the RNs. Whilst all three staff groups spent a very similar proportion of their time on associated activities, RNs were more frequently engaged with indirect care than both APs and HCAs and conversely, RNs spending less time on non-productive activities compared to the other two staff groups (Table 14). A more detailed breakdown of the activities performed by each staff group in case site 1 is given in Table 15. As above, we have included only those activities which any of the staff groups spent at least 5% of their time conducting.

Table 14. Case site 1 - Activities divided into 4 categories performed across the three staff groups

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care	1052 (42.0)	513 (52.7)	846 (56.6)
Indirect care	739 (29.5)	153 (15.7)	155 (10.4)
Associated	629 (25.1)	240 (24.6)	356 (23.8)
Non-productive	85 (3.4)	68 (7.0)	138 (9.2)

RNs spent the greatest proportion of their time on reporting activities (16.2%), followed by medication (10.7%), when compared to both APs and HCAs who spent the greatest proportion of their time on hygiene activities (although the figures for each of these groups were quite different – 19.3% and 29.2% respectively). For some activities, all of the groups spent relatively similar proportions of their time performng, for example, communication with patients, nursing procedures, clerical work and cleaning. However, APs were more similar to HCAs for some activities – medications, movement, meals & drinks, reporting and breaks when compared to RNs and for some

activities the proportion of time spent fell in between RNs and HCAs (hygiene, charting and administration communication).

Table 15.Case site 1 - Detailed breakdown of most common activities across the three staff groups (5% or more in any of the groups)

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care			
Comm Patients	139 (5.6)	63 (6.5)	92 (6.2)
Hygiene	228 (9.1)	188 (19.3)	437 (29.2)
Medication	268 (10.7)	6 (0.6)	7 (0.5)
Movement	56 (2.2)	53 (5.4)	91 (6.1)
Nursing proc	105 (4.2)	52 (5.3)	62 (4.2)
Indirect care			
Charting	176 (7.0)	47 (4.8)	30 (2.0)
Reporting	406 (16.2)	72 (7.4)	100 (6.7)
Associated			
Cleaning	84 (3.4)	57 (5.9)	61 (4.1)
Meals & drinks	23 (0.9)	33 (3.4)	77 (5.2)
Clerical	137 (5.5)	44 (4.5)	67 (4.5)
Admin comm	254 (10.1)	78 (8.0)	96 (6.4)
Non productive			
Breaks	45 (1.8)	47 (4.8)	76 (5.1)

Case site 2

In case site 2, all staff groups also spent the greatest proportion of their time on direct care activities; however, this was higher amongst the HCAs when compared to the RNs and APs. Across all of the activity groups, RNs and APs appeared to be spending similar proportions of their time on each. This was distinct from HCA who spent a smaller proportion of their time on indirect care, and a larger proportion of time on direct care and associated care (Table 16). A more detailed breakdown of the activities performed by each staff group in case site 2 is given in Table 17.

RNs spent the greatest proportion of their time on reporting activities (13.2%), followed by administration communication (11.6%) and medication (10.6%). Similarly, APs spent the largest proportion of time on reporting (14.4%), compared to HCAs who spent the greatest proportion of their productive time on hygiene activities (12.5%). For some activities all of the groups spent relatively similar proportions of their time performing (for example, nursing procedures and administration communication). However, APs were more similar to RNs for some activities – hygiene, charting and cleaning compared to HCAs and for some activities the proportion of time spent fell in between RNs and HCAs (medication and vital signs).

Table 16. Case site 2 - Activities divided into 4 categories performed across the three staff groups

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care	1512 (44.9)	349 (43.0)	416 (50.1)
Indirect care	774 (23.0)	198 (24.4)	63 (7.6)
Associated	686 (20.4)	164 (20.2)	231 (27.8)
Non-productive	396 (11.8)	100 (12.3)	120 (14.5)

Table 17. Case site 2 - Detailed breakdown of most common activities across the three staff groups (5% or more in any of the groups)

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care			
Comm Patients	146 (4.3)	54 (6.7)	31 (3.7)
Hygiene	209 (6.2)	58 (7.2)	104 (12.5)
Medication	356 (10.6)	25 (3.1)	5 (0.6)
Vital signs	127 (3.8)	42 (5.2)	88 (10.6)
Nursing proc	167 (5.0)	54 (6.7)	73 (8.8)
Indirect care			
Charting	196 (5.8)	61 (7.5)	19 (2.3)
Reporting	443 (13.2)	117 (14.4)	29 (3.5)
Associated			
Cleaning	78 (2.3)	27 (3.3)	71 (8.6)
Admin comm	390 (11.6)	70 (8.6)	79 (9.5)
Non productive			
Breaks	291 (8.6)	67 (8.3)	108 (13.0)

Case site 3

As in the other case sites, in case site 3, HCAs spent the greatest proportion of time on direct care activities, compared with RNs and APs and for whom in this case site the proportions were very similar. For indirect care, it was the RNs who spent the greatest proportion of time on these activities, with a similar pattern as observed in case site 1, with the APs falling between RNs and HCAs. APs were spending the greatest proportion of time across the three staff groups on associated activities and non-productive activities (Table 18). A more detailed breakdown of the activities performed by each staff group in case site 3 is given in Table 19.

In this case site, RNs spent the greatest proportion of their time on administrative communication (16.1%), followed by medication (14.3%) and reporting (14.1%). APs spent the largest proportion of time on administrative communication (15.8%) and hygiene (15.8%), and HCAs spent the greatest proportion of their productive time on hygiene activities (20.9%). In case site 3, the different staff groups spent differing proportions of time on all activities. However, APs were more similar to RNs for some activities – movement, nursing procedures, administrative communication, when compared to HCAs and for some activities the proportion of time spent fell in between RNs and HCAs (hygiene, vital signs, reporting, meals &

drinks, breaks). It was only medication activities for which APs had a similar profile to HCAs.

Table 18. Case site 3 - Activities divided into 4 categories performed across the three staff groups

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care	1438 (44.7)	321 (43.8)	752 (52.8)
Indirect care	703 (21.9)	76 (10.4)	108 (7.6)
Associated	828 (25.8)	235 (32.1)	397 (27.9)
Non-productive	247 (7.7)	101 (13.8)	166 (11.7)

Table 19. Case site 3 - Detailed breakdown of most common activities across the three staff groups (5% or more in any of the groups)

	RN - n (%)	AP - n (%)	HCA - n (%)
Direct care			
Hygiene	231 (7.2)	116 (15.8)	297 (20.9)
Medication	461 (14.3)	4 (0.6)	4 (0.3)
Movement	38 (1.2)	17 (2.3)	76 (5.3)
Vital signs	102 (3.2)	39 (5.3)	98 (6.9)
Nursing proc	189 (5.9)	45 (6.1)	59 (4.2)
Indirect care			
Reporting	452 (14.1)	57 (7.8)	88 (6.2)
Associated			
Meals & drinks	32 (1.0)	51 (7.0)	133 (9.4)
Admin comm	517 (16.1)	116 (15.8)	164 (11.5)
Non productive			
Breaks	180 (5.6)	62 (8.5)	129 (9.1)

As well as reported and observed work and activities, we gathered the perceptions of a variety of stakeholders across the organisations, using more qualitative techniques to gain further understanding of the work of APs. The following sections combine both qualitative and quantitative data to produce a 'rounded' picture of the AP role.

5.3 Complementing the work of RNs and providing relief

APs had an important role in complementing the work of RNs: that is performing activities alongside RNs to ensure care is delivered to patients. Importantly, there were discussions among case site participants (at organisational and ward levels), about the extent to which RNs were being taken away from the bedside to complete other patient care related activities, such as management and administration (Box 25). RNs described the flow of their work as being interrupted and felt they were being pulled in many directions rather than being able to focus on patient care at the bedside. This was perceived to have created a gap in bedside care by removing the RN. APs had been able to fill these gaps in care to support RNs and importantly the APs were perceived by a variety of stakeholders (both management and ward staff) to have had the necessary

training to undertake delegated patient care duties at the bedside to complement RNs' work. As such, the AP was viewed as being able to appropriately complement the work of RNs at the patients' bedside (Box 26). RNs reported that they had a level of confidence in APs and reported the positive contribution of the AP role to patient care. They reported that they did not have to continuously ask the APs to undertake activities (a feature of working with most HCAs was having to continuously instruct them about work to be done) and they had confidence that the APs would appropriately report patients' conditions to them (Box 27). APs involvement in other caring activities to complement the work of RNs, were often dependent on the needs of clinical areas and organisations. The AP role could extend to other indirect patient care related activities such as being involved in the multidisciplinary team (MDT) meetings and ward rounds and assisting with the coordination of patient care referrals to MDTs both within the hospital setting and community when preparing for discharge. In case site 2, for example, APs were complementing the work of specialist nurses by providing support to patients having complex surgery. This enabled the specialist to focus on more complex activities associated with this patient group.

Box 25: Changing roles of RNs

[Nurses] are too busy picking up the doctors, the junior doctors' role, okay… If you talk to the average nurse, they'll tell you that they're bogged down in documentation. (3: Organisational Manager: 49)

I think the staff nurse seems to be taking on more of a doctor's role. I don't know; everyone seems to be stepping up. You see I think the auxiliary was stepping up towards a staff nurse kind of role and that's why I think this [role] is good because that's helped bring in that stop gap there. (2: Surgical: AP178)

I mean the turnover [of patients] is phenomenal and, you know, in terms of documentation and paperwork that the registered nurses are expected to do, I think having an [AP] take responsibility for the health care assistant enables the registered nurse to maybe focus on some more of the maybe technical tasks that they have to do or maybe some of the documentation that is expected of them. (3: Organisational Manager: 53)

I do sometimes think that the staff nurse is being taken away a little bit from the bedside… You still don't want to lose that hands-on care because you're trained... But because of other circumstances, like I say, the amount of drugs that we have to give and different antibiotics and things, then that takes you slightly away from the basic hands-on fundamental care that needs to be given still. (2: Surgical: RN151)

Box 26: APs an appropriate complement to RNs at the bedside

Whereas sometimes the staff nurses who are on and might be managing the ward as well and from a patient point of view that's definitely an improvement because, you know, when [APs] are in [the bay] they're not necessarily pulled away to manage wards or to do ward rounds and that kind of thing. So they're very much more involved in everything that happens to that patient in their bay and they seem to manage caseloads very well that they've got. (2: Divisional Clinical: 7)

If [name AP] is ever concerned or worried about a patient she will always tell you straightaway… So it does make a difference because if we were ever short of staff, [name AP] is one of the best people to have on the ward. (1: Medicine: WM72A)

Box 27: RNs confidence in the AP role

I know the health carers are always about and they're fine but there is quite a bit of difference between health carers and staff nurses; we all do the same sort of role there is that. [But] obviously there is a gap there and I think [APs] fill that gap in. (2:Surgical: HCA213)

Potentially there is a lot more time for the patient and because [name AP] is still a HCA as well, if I don't have time to give a bed bath to a patient, I know that [name AP] will give that bed bath, but she'll be looking at pressure areas, she'll be talking to that patient, she'll be doing all, potentially what I wouldn't be able to do. Feed it back to me and then we'll kind of go through it that way. Whereas if I'd have asked another HCA to do a bed bath they might not necessarily even think about doing it unless I'd asked them and then even then they might not be sure what they're looking for. So, yeah, education and experience I guess. (3: Surgical: RN13)

The complementary nature of AP roles meant they were perceived as providing 'help' and 'relief' for RNs. APs described themselves as a 'backbone' and 'safe pair of hands' for RNs, enabling RNs to get on with other activities that may be more complex or require a RN to take the lead. To some extent, as we have seen, RNs tended to agree with them. The APs also felt that they promoted continuity of care to patients because there were less demands on the APs to complete duties away from the bedside. RNs view the AP role as being able to take on many duties that took 'pressure off' them and indicated a level of trust in APs to undertake the allocated duties (Box 28). In case site 1 particular examples were given of the AP role being extended with the specific purpose of providing relief for registered practitioners including escorting post-operative patients back from theatre to the ward (a role being considered in other case sites) and accompanying a therapist on a home visit to complete a patient's home assessment prior to discharge – this would usually require two registered practitioners and so was viewed as releasing time for patient treatments by one registered practitioner.

Box 28: APs providing help and relief for RNs

They're sort of much more at the coal face of things which I think is what they needed to get back to because they'd started moving people up and up and out of sort of working with the patient and I think they've realised that they had this gap in the middle where there wasn't anybody filling the role anymore and I think that was the important thing really to get people back working with the patients. (2:Divisional Clinical: 7)

Yesterday morning I had a perfect example. [Names AP] had to do the [medical] ward round because I was stuck doing IV antibiotics. I had several of them to do, and I just couldn't get [away]. So [names AP] took over and did the ward round. Otherwise you just, I just would not have been able to do that physically. (1: Medicine: RN25)

A16 But surely that's the essence isn't it, that we're there to alleviate and do as much as we can, so that trained nurse can get on with the things we can't do. So we can pick up all them little jobs and leave her to the really - that's how I see what the essence of the whole thing is and that's when I think the whole thing comes into play.

A61 Yeah it certainly does.

(1: AP focus group discussion)

So it's having somebody there who is back-up. It is a busy ward, as you can see whilst you've been on here, and it just takes a bit of the pressure off sometimes that, you know, you've got them there that are able to do tasks. (2: Medicine: RN324)

The fact that [the AP] actually takes [their] own patients and does all the documentation, makes a big difference to the ward because it means it frees somebody like me up or whoever is in charge to actually act as a coordinator for the ward rather than have direct responsibility for a group of given patients, which is obviously what I would normally have to do as well as coordinate the ward... Frees me up to coordinate the ward as a whole and maybe concentrate on the more complex patients and obviously supervise more junior nurses. (2: Surgical: WM191)

If there are any [patient] reporting issues and [APs are] dealing with those; escalating any concerns up to the qualified nurses or the ward manager and that's been great that they've taken on that role because that's really taken a lot of workload off the qualified nurses. (3: Surgical Divisional Manager: 18)

5.3.1 Everybody needs a leader: APs as role models for assistants and supporting others

APs were viewed (across case sites and by a range of participants) as potential role models and leaders of the assistant workforce within the organisations. This was potentially an important role for APs because there was recognition that HCAs did not always get (from RNs) the necessary support and supervision required for their role, particularly when new to the assistant role or undertaking their vocational qualification. APs, their senior nursing colleagues and senior managers noted that APs had responsibility for ensuring standards of care for patients and quality of care delivery by HCAs (Box 29). APs inducted new HCAs to fundamental patient care, the ward environment and the organisation. However, the level of formality, and recognition, of this activity by APs, varied considerably across the organisations. In case site 3, APs ensured all new HCAs were inducted to the organisation, and completed the induction competency pack. APs could provide ongoing support for HCAs when delivering patient care and could act as an intermediary between the assistant workforce and the ward managers. The majority of HCAs identified the APs as someone with extra knowledge and understanding that they could go to ask questions and seek advice: they reported that APs had more time to support them than RNs (Box 30). In addition, HCAs indicated they had a level of trust in APs because they had often worked together for many years as assistants, thus having established relationships, respect and ways of working together.

The APs also have a role in supporting HCAs undertaking NVQs. The formal responsibility for APs undertaking this role varied across wards within organisations and across organisations. However, future plans for APs to be NVQ assessors and also to undertake performance reviews, or appraisals, for HCAs were cited in all organisations. Amongst ward-level staff, APs were also recognised as an important source of support for student nurses and newly qualified RNs. The

APs were recognised as having extensive experience within the NHS and often within the same organisation (Box 31a). This could present a challenge for new RNs in the organisation; learning to work with an assistant who may have more knowledge of a speciality and years of experience was considered as potentially threatening to their authority.

Box 29: APs leading on quality of patient care

She's somebody that the health care assistants can come to for support and she's very good at giving them the support or pointing them in the direction that, you know, and encouraging the education, the NVQ training and stuff like that. (3: Medicine: RN10)

Yeah I always say [to HCAs], are you happy to do that? Do you know how to do it? Would you like me to show you how to do it? And, you know, I always ask that more now than I probably would have done. (3: Medicine: AP42)

So I think from a training point of view, I can see [APs] becoming more and more involved in that process because it used to be the staff nurses who ultimately would train [HCSWs] but I don't think it will, I think it will come back to [APs] to do really. (2: Divisional Clinical: 7)

And let's be honest, we must have made a massive impact... Not only have we, we know ourselves what we can and can't do anymore, we're actually telling other people [HCAs], you shouldn't really be doing that unless you've had the training, you know. So in effect with that little army [of APs] out there going round sort of, although we know what we're doing, we're actually also catching up with other people... So I mean that's a big achievement in itself. (1: Surgical: AP16)

Box 30: APs supporting HCAs

I would rather have one of them by my side than half a dozen nurses, I don't mean it badly… Maybe because I know them… As a [care] worker I have great trust in them because I know that I can rely on them and if I ask for something and they haven't got time to do it, they will try to do it that day but if they don't they'll come and apologise. (1: Medicine: HCA69)

If I'm not sure of anything, if there was an AP on I would probably ask the AP before I asked the staff nurse and then if the AP didn't know we'd ask the staff nurse. (Q: How come you would do that order?) Because the staff nurses are always really busy, you know, doing a drug or doing a ward round. (1: Medicine: HCA42)

Box 31a: APs supporting other members of the team

Say you've been qualified now for 18 months. I mean the, the [APs] on our ward, they've been working in the Health Service for 20 years and the wealth of experience that they got. (1: Surgical: RN2)

I mean they're very knowledgeable, they give a lot of support to the health carers and to the trained staff, you know. I would trust them with any type of patients. (2: Medicine: WM304)

That's something I didn't do as a health care [assistant] at all, work with the student [nurse]. You're put to work alongside them just because of the experience but actually working with them showing them what we're doing and explaining why we're doing it was something I never done as a health carer. (2: Surgical: AP208)

I mean some of these [APs] are supporting and, you know, giving advice to newly qualified nurses that, you know. They've got a lot of experience really now compared to a newly qualified nurse, you know, they've been on the floor, they know what it's about. (2: Medicine: WM304)

I often go to these people [AP] for things that I don't, I'm not sure about and I'll ask that. I'll ask her and she'll often come up with the answer and maybe not on some of the, the drug things, 'cause they wouldn't. But, you know, any, ask her anything about a dressing or anything about, you know, dietary requirements or anything, and she's on, she's on the ball totally. (1: Medicine: RN80)

5.4 Role 'fit': Determining the shape of the AP role

APs working in the observed wards reported job clarity and autonomy in their role (Appendix 11; Table 5); they knew their responsibilities (88%), felt consulted about changes that affect their work (88%), could decide how to go about their work (77%), reported receiving clear feedback about their work (59%) and were more likely than other members of the nursing team to feel they had time to carry out their work (29% APs report not having enough time compared with 65% of RNs and 53% of HCAs). The respondents to the national survey responded similarly to these questions (Chapter 6). However, RNs and HCAs were more likely to report knowing their responsibilities and this issue is picked up through the qualitative data. APs working in non-observed wards and other clinical areas reported having slightly lower levels of job clarity and autonomy.

The APs from observed wards felt positive about staff relationships and support in their role (Appendix 11; Table 5). They reported high levels of support from colleagues in relation to listening to them when they had a problem at work (94%), backing them up at work (82%), helping with a difficult task (88%) and helping in a crisis (88%). They also reported low levels of relationship strain at work (12%). Their ward nursing colleagues (RNs and HCAs) and APs from other non-observed wards and clinical areas, also reported feeling positive about relationships and support, but at lower levels than the observed APs.

Qualitative data provides further insights into the ways in which the roles of APs were shaped in practice.

5.4.1 Disputes about AP activities and areas of practice

Developing a new occupational position within an existing team, for any new role, requires a period of time to determine the occupational space of the role. Processes associated with defining this occupational space for the new worker can create challenges for the roles of existing staff: the 'new' role may start to overlap and be seen to encroach on existing roles and activities. Across all case sites, the AP role was largely recognised and established through negotiation and socialisation whilst in post and upon completion of training. In Chapter 4, we highlighted how the lack of communication regarding the organisational vision for the AP role led to development 'in practice'. There was widespread recognition in the case sites that the AP role had largely been developed in an *ad hoc* way, to support patient needs and the work to be completed within particular

specialities. Our analysis of job descriptions further supported this *ad hoc* approach. As such, it is unsurprising that there were variations in the roles of APs dependent on their specialities. However, this led to frustrations for APs both within and across case sites when they heard about the work of APs in other clinical areas in their own, or another, organisation.

Establishing an 'acceptable' role for the APs has created challenges to the boundaries of practice for existing staff (RNs in particular) and has led to discourse on what an AP can and can't do. There was also an indication that these roles would continue to be under review and evolve as the roles of professional staff continued to evolve and the APs developed their role competence. Across the organisations, the following activities and areas of practice were highlighted by senior managers and registered nursing staff across case sites as 'inappropriate' for APs to carry out: these were considered the RNs' domains of practice:

- Medicine administration
- Catheterisation
- Wound care and wound dressings
- Bed management
- Assessment of patients
- Planning of patient care
- Discharge of patients
- Care of acute highly dependent patients
- Nursing assessment and diagnosis
- Ultimate responsibility and accountability for patient care
- Communication of tests results to patients
- Communication of patient information at nursing shift handover
- Referral for medical attention
- Co-ordination of ward activity and care

However, variations existed across wards and organisations about the extent these defined activities and areas of practice were regarded as legitimate activities for APs. Even though these areas could be clearly defined as 'inappropriate' for APs, there was recognition that the situation was not so black and white: APs sometimes encroached on these disputed activities and areas and there were recognised benefits when they did (Box 31b). Context was important in understanding this and shades of grey occurred due to staffing situations; when there was limited RN availability on particular shifts or wards APs would be asked to perform an activity, but then told they were not able to perform the activity when more

RNs were available (Box 32). In addition, they could be asked to do more because of the relationships that existed between the APs and other staff members. The relationship and trust that existed between individual RNs and APs played a significant role in determining the AP role within clinical areas (this is addressed in a later section on supervision and accountability, p.111). These variations, and potential fluctuations in activities, may have contributed to APs expressing lower levels of job clarity than their RN and HCA colleagues (questionnaire responses discussed above, p.94). Interestingly, APs highlighted that relationships in the ward team were a key influence on the work of all assistant staff (including themselves and HCAs). They recognised that this might lead to the delegation of activities to HCAs that could potentially present a risk to patient safety: upon completion of training, APs recognised that they had often undertaken delegated duties as HCAs because they were trusted by RNs, when they had no understanding of the implications of their actions. AP training was perceived as developing AP confidence to know and accept the boundaries of their assistant practice (Box 33).

Box 31b: APs carrying out disputed activities and areas of practice

We have an on-going, I wouldn't say battle, awareness of assistant practitioners giving handovers which we're saying no to; it needs to be the registered nurse. But the registered nurses argue back the assistant practitioner is looking after the patients and therefore are the best person to give the handover report. That's a huge concern to me because what I'll say to the registered nurses, - well why do we need you? If you are saying that the assistant practitioner can completely manage total patient care, what is the role of the registered nurse? So I am very concerned when I hear that, very concerned. (1: Organisational Manager 8)

(Q: But if [AP] takes a bay [of patients], I presume [they're] not administering the drugs or is [AP]?) It depends who's on. (Q: So depending on how [RNs] view [AP] and [their]competence will detect whether certain things ….?) Yeah and that shouldn't be, should it really, you know. (3: Medicine: HCA6)

Some [APs] are doing simple dressings, some are. But again, there is part of me as a nurse that still has an issue with that. (3: Organisational Manager: 48)

We were asked to put down in writing what we would like them to do and one of the big issues that we've got here is most of our work is for qualified members of staff and obviously because of budget we try to get around that if the [AP] could even check, not give, but check a controlled drug, it would be of great benefit for all of us. (3: Surgical: SS22)

Box 32: Fluctuations in AP roles

It's one minute you do the job because you need to and the staff nurse will allow you and then the next minute, don't do that job, it's my job to do that sort of thing… it does depend on the staff nurses you're working with. (1: Medicine: AP61)

Today was fairly easy because we've got a lot of stable patients but previous week, [name] probably hasn't had any patients but [their] role then would revert back to being the senior health carer: where [name] is a runner and a support worker. And I don't know whether [name] would find that frustrating, but I would. If I didn't know each shift I came in whether I had a specific role to do, now that would frustrate me. (2: Medicine: WM234)

Well I think for the responsibilities that they take on, I don't think they, you know, one minute they can be working as an AP because it suits and the next

minute they can be on the off-duty down to work as a health carer because, you know, if there's a abundance of staff nurses and I think that's a bit wrong. As an AP they should be working as an AP, they've earned it, they've worked for it. (2: Medicine: HCSW331)

Box 33: Establishing the boundaries of AP practice

I have to say I'm completely horrified at maybe some of the things that we was being allowed to do [as HCAs] because we had no training or no real understanding of what we was actually doing and I find that quite frightening now because I've got so much more understanding of everything that I do do. And I don't do something just for the sake of doing it unless I have got an understanding now of what I'm doing. (1: Surgical: AP16)

But now they will come up and say, no sorry I'm not allowed to do that. (1: Surgical: WM1B)

At the end of the day the [APs] know that they are responsible to a registered nurse on the ward. They know their boundaries. (3: Organisational Manager: 52)

Development of the AP role was influenced, to a large extent, by RNs' willingness, or not, to delegate activities to APs. At more senior levels there was an indication that rather than owning tasks, RNs should be concerned with owning decision making for patient care. In addition, the AP role was largely dictated by the level of understanding that members of the ward team had about the role for APs within their clinical area. A lack of understanding of the AP role could potentially limit opportunities for fully utilising their skills. This was identified by APs and senior managers as a key area of development in nurse education and the preparation of future RNs to work and utilise the skills of their nursing teams. Allowing the development of APs roles raised some concerns about a two-tier nursing workforce being reintroduced: comparisons were made with the State Enrolled Nurse position that was gradually phased out during the 1990s. This was not always viewed favourably; RNs expressed that they felt they had little control or influence over the situation (Box 34). However, the idea that APs were replacing the old SEN grade was disputed because of differences in training and scope of practice for APs.

A highly contested area of practice was development of the AP role in medicine administration. APs expressed frustration that they could deliver the majority of patient care but then had to rely on RNs to administer medications to any patients they cared for. Some RNs described the extra burden that this created for them because they had to administer double amounts of medication to cover the APs work (Box 35). However, there were split opinions on whether APs should ever be able to administer medications. The majority of senior managers and RNs felt this was a step too far for the AP role and their level of practice and competence whilst a smaller number of senior staff conceded that a limited formulary of medicines for APs to administer was inevitable. Indeed, in one SHA, and potentially for one of the case sites, there were plans to train APs for administration of a limited formulary of medicines.

Box 34: Reintroduction of a two-tier nursing workforce

But it does tend to open up another dimension, a can of worms. Because then you get into the remit of going, are we creating a second level nurse? Are we going back to the old enrolled nurses that we got rid of with Project 2000? (3: Organisational Manager: 57)

I didn't really know what it was to be honest: what the roles were and how they were going to be evolved. And then the way it came across was that they were looking for a level of nurse that could act as a support to the trained nurses but they're not able to do everything that the trained nurse could. And I think initial thoughts were they were a little bit based on what used to be the enrolled nurse role. (1: Medicine: WM21)

They're like the old enrolled nurse really, you know, we had our registered nurses and our enrolled nurses years ago and I see them like the enrolled nurse who are a support to the qualified nurse. (2: Divisional Clinical: 5)

But it's how far do you train them and where do you stop. Do you get them, like you say, as a staff nurse and then you end up with a two tier nursing and then the danger is they'll say well, you can have less staff nurses and more assistant practitioners. I don't know, I don't know what the answer is. It's a situation we've been put into. (2: Medicine: WM234)

Box 35: APs not able to administer medication – the frustrations and wider impacts

If I have my own bay of patients, I feel like I give all the care, I follow the care plan, do all that and then [patients] say, can I have some painkillers? And I think, oh I have to go and get someone else to do that. (2: Surgical: AP178)

So it does sometimes puts pressure on the other staff nurses because they've got an extra set of medications to do to overlook that AP… Sometimes when they've replaced the staff nurse everybody is a little bit stretched. Even though they're doing a fantastic job, you know, the rest of the team are also stretched because they've then got to still do the staff nurse duties for another member of staff, if you like. (2: Surgical: RN151)

The expansion of APs' areas of practice was perceived as a potential threat by some RNs. There was a general indication that the AP role had developed to take on much of the work of RNs, apart from medicine administration and even that was beginning to be contested in the case sites. However, the AP role was perceived as more suited to looking after 'straightforward' or 'routine' patients. Senior RNs were more likely to draw out this distinction and emphasised the roles of RNs in managing the acutely ill, unstable and unpredictable patients. Some wards in case site 1 described reviewing their skill mix when a RN left the ward team and replacing the RN post with APs. However, this appeared to be the exception rather than the norm; APs replacing RNs was not widespread across wards or organisations. Indeed, it was expressed by APs and their colleagues that they could not 'replace' RNs because of limits to their practice. For many registered practitioners, the AP roles were perceived as a way of reducing staffing costs and providing 'cheap labour'.

5.4.2 A role in-between: not registered but more than an assistant

The AP role was described as being in a very difficult position: they have developed beyond the role of assistant, which creates organisational and ward level expectations, but yet are not registered, which can make it difficult for APs to make their change in status and activities visible. The role was viewed as being pulled in many directions: the role supports both RNs and HCAs. As a result, APs indicated they were not able to fulfil the potential of their role because of competing demands and often undertaking work they undertook as HCAs. This 'in-between' status decreased recognition of the potential contribution of APs to patient care and ward nursing teams amongst their colleagues (Box 36). Ward managers recognised difficulties for APs in being able to give up some of their HCA duties and the tension this created for their new role as an AP. This could be further exacerbated by lack of continuity in the AP role from day-to-day, whereby some days they assume the role of HCA and other days the role of AP. The work-based development of these assistants for their role as APs was viewed as creating difficulties for the APs. Staff reported difficulties in managing the change in role from HCA to AP and APs described difficulties establishing their changed positions (Box 37). It was suggested that the ability of APs to fulfil their potential was linked to whether members of the ward nursing team had developed confidence in the skills and abilities of the APs. Lack of support for the role by ward teams was viewed as limiting role potential and having a negative influence on the job satisfaction of APs. However, it was also recognised that within-ward promotion for any staff member poses particular challenges, but this was exemplified because the APs were assistants and had less power or influence within the ward team.

Box 36: The 'in-between' status of APs

I do think she does get dumped on sometimes. In fact I think sometimes, gosh she's in a difficult position because she's sort of piggy in the middle and, you know, some people sort of throw things in each direction at her. (3: Medicine: RN10)

I think the sad part is, I think they're between roles… I think what happens is they tend to be classed as an auxiliary, as well as a trained nurse and they end up doing two jobs. I think they're more abused in that role unfortunately. (1: Surgical: WM1B)

Well at first when [APs] were doing [the role], I felt like they were a bit like in the middle; nowhere land, that's what I thought. I thought it was a shame because they were doing all this, you know, doing all the work to get to this position and they were neither a health carer nor they weren't a staff nurse. (2: Surgical: HCA213)

You can be taken out [by RNs], but then you feel bad because you've left that [HCA] to do certain stuff on their own and you feel a bit torn sometimes because they [HCAs] still need the support as well. But you can get pulled away from doing nursing; like washing and dressing. (1: Medicine: AP38)

[Name AP] will try and do everything, which I don't blame her because like I say, she's trying to assume two roles… At the weekend you'd maybe think, maybe some of the basic care needs will be met by the health care support workers;

[name AP] will also try and do that as well because that's normally what is expected of them Monday to Friday. (1: Medicine: WM72A)

A key point of discussion was whether the APs were 'trained' or 'untrained' members of the nursing team. Perceptions about the level of training dictated whether AP were aligned with RNs or HCAs; in the main, these staff continued to be referred to as untrained and were part of the assistant establishment. Positioned between the roles of HCA and RN, the AP role was also perceived as sometimes being 'exploited'. Registered nursing staff were viewed as asking more and more of the APs even when this might go beyond the expected and even loosely defined boundaries of the role. RNs were described as controlling the APs by fluctuating their expectations of what APs should and should not do and suggesting to APs that they should agree to extra responsibilities because of their extra training (Box 38).

Box 37: Difficulties in transition from HCA to AP

I think if we could all have done the training and we could all have sort of been lifted and put somewhere else, where nobody would have known us, and it would have just been a complete new job, and nobody would have viewed us as an auxiliary, it would have been very different. But they just can't help seeing us as, well we're just auxiliaries that's extended our role a little bit. (1: Surgical: AP16)

I think traditionally because [name AP] has been a care support worker I think the nurses don't actually, a lot of them still see [them] as that. So they don't actually expect much of [name AP] at all. That's the other thing. (1: Medicine: WM72B)

But for me it was hard to get away from that auxiliary's role and it was hard for people that worked on the ward to think of me as an assistant practitioner because they still thought of me as an auxiliary. And sometimes, you know, sometimes I used to say to get on as an assistant practitioner I'd have to leave because I'd have to go somewhere they didn't know me as an auxiliary. (2: Surgical: AP177)

I did hear it said, am I health care [assistant] today or am I an assistant practitioner? Because they felt the role was very different and they were trying at first to break their necks and do everything, have their own bay of patients, have their own high care and work as a health care across the floor as well and they couldn't do it. (2: Surgical: WM149)

[HCAs] still see [APs] in the health carer role rather than as a practitioner role and I think they feel a bit frustrated. (2: Surgical: WM191)

The [APs] were pulled from side to side when they first qualified, you know, they were used as health carers and then sort of in their role as an AP. (2: Medicine: RN324)

Box 38: APs asked to take on more responsibilities

I think [name AP] feels that [they're] actually doing more than [they] should be doing. And I think [they] get frustrated with that as well. Because at the end of the day [name AP] doesn't get paid the same as I do and in that sense, I think we're always going to have a bit of a problem, people wanting them to do something and then [they] can't; well [name AP] is doing it and shouldn't be doing it. (3: Medicine: RN5)

I think some of them do more than what they should and personally I think that's wrong because they shouldn't be doing a lot of the stuff. But again it's the staff nurse saying, 'you can cope, you can do it, it doesn't matter'. That's not the point. (3: Medicine: HCA6)

There were only a few APs in the ward settings across case sites: there could be a sole AP for the entire ward but up to a maximum of 5 in another ward. Even in wards where they existed in larger numbers, the APs described feeling isolated because of the ways in which their work was organised: APs either worked on opposite shift patterns or were located in different areas of the ward even when on the same shift. This created feelings of isolation amongst the APs; as HCAs they were more likely to work alongside colleagues on the same grade because there were more HCAs employed in ward environments. Colleagues indicated that because the role existed in such small numbers the APs were limited in their ability to influence ward teams and to ensure maximum use of the role to impact on patient care (Box 39).

Box 39: Small numbers of APs have limited potential to impact on care and teams

I mean when you've maybe only got one AP on a ward I don't think that's really viable, you know, that poor AP is not going to make a great difference... I just think when there's 1 AP in an area, I just don' think, personally I don't think it particularly works. (1: Organisational Manager: 1)

If there was more than 1 of them on it, it would probably be more beneficial because they could expand their role more with they're being 2, you know. They could do more, like [name AP] could, I don't know, team up with the other practitioner and maybe do different aspects of the job. (1: Medicine: HCA96)

I think it does need pushing a bit more and getting a few more people into it because until there are a lot more of us, they won't be able to do a lot with us, will they. (2: Surgical: AP179)

For [name speciality], the number is probably too small to make that sort of assumption really [of an impact on the organisation]. But in day to day practice and the day to day activities I would say that they do make a difference. (2: Divisional Manager: 4)

Differences between Band 3 and Band 4 staff were raised as a concern and source of confusion. Whilst the roles may have appeared to be similar, differences were described. In case site 1, the AP role was about extended roles, such as podiatry or therapies. Across all case sites, it was also about level and type of knowledge gained during Band 4 training and using their initiative, stepping in to cover work of RN, taking responsibility for a patient caseload (apart from medications) and documenting care delivered, providing patient education and liaising with members of the MDT. However, it was suggested that the Band 4 position might have been an organisational strategy to formalise activities that assistant staff were doing anyway, so that the organisation was covered and staff appropriately rewarded.

5.5 A 'knowledgeable assistant' at the bedside: Potential impact of AP roles on patient care

The APs' role in delivering care at the patient's bedside is central for understanding the potential impact of such staff on patient care. The changing nature of RN work had meant their role had been taken

away from the bedside and so the APs were viewed by ward-based staff as having an important role at the bedside with patients because of their visibility (Box 40). The increased knowledge of APs after undertaking their training was recognised as having benefits for patient care (Box 41) because they were viewed by ward level nursing staff (including RNs and assistants) as able to:

- assess and recognise a deterioration in a patient's condition;
- provide advice to patients whilst undertaking caring duties and support relatives;
- understand the 'bigger' picture, for example the importance of nutrition for wound healing;
- provide continuity of care to patients; and
- release RN time to ensure their focus on acute patients.

However, the APs position at the bedside raised concerns for some senior managers regarding patient safety. Patient safety was viewed as having two key parts: a skilled and competent practitioner to deliver care and patient perceptions and experiences of what the AP can do. Whilst AP training was viewed as providing a more knowledgeable assistant, there were concerns that APs may not always introduce themselves appropriately to patients. Introducing a role brings with it expectations about competence by the patient and managers expressed concerns that patients may not be aware of the limitations of the AP role. APs did not share these concerns about their role and indicated that AP training had developed their understanding of their role as an assistant and what they should and should not be doing to ensure patient safety; a view reinforced by their ward managers (Box 42). However, given that the boundaries of the AP role were largely negotiated in practice, patient safety could potentially suffer where the AP and RN have confusion about who carries out the task.

Box 40: AP visibility at the bedside

[APs] are perhaps nearer to the patient than the trained nurses because the trained nurses are often doing other things. So… they're actually more patient based shall we say than some of the registered nurses are. (1: Medicine: WM47)

Yeah I think we do spend more time with the patients and give them more love, you know like the care because when I was a health carer, you like basically done the obs and you speak to them and chat to them and then you're off again aren't you because you've got that many jobs to do. Where if I've got my bay, I try and stay in my bay and the patients get to know you so they rely on you and they'll ask you things whereas before I used to be in and out. (2: Surgical: AP180)

[Patients say they] always feel very well cared for. The assistant practitioner isn't – if it works correctly and they look after their own small group of patients they spend all that time with those group of patients, so [patients] get a good quality standard of care because they're allowed to allocate that time. Sometimes staff nurses and, if there is only a health carer in there maybe or a health carer is shared between other teams, so they flit in and out. Whereas the assistant practitioner can focus all of her time on that group of patients. So certainly from feedback from patients it's been very positive. (2: Surgical: RN151)

Box 41: The 'knowledgeable' assistant

Now I know the reason behind a lot of things for nutritional value. It's like a normal nursing auxiliary would just think they're filling in a chart because they need to see what they're eating but they don't understand that nutrition plays a big part in the wound healing or just the general getting better of the patient. Whereas now I know that; I've got a bigger picture of things. (3: Surgical: AP3)

I've heard others on the ward, Band 2s, saying; oh don't they go on that patient. But why do their go on? And possibly if they would have had gone on the APs course, trainee assistant practitioners course, possibly it would have unleashed their mind a little more and thought, hold on a minute this is why they're like they are, I'd be like that if I'd COPD. Because it's not just the physical illness, your whole body, you know, mind, spirit and soul, it all works together so you've got your psychological side of this as well, your physical side and how they feel, morale, low esteem, all that has to be considered. So yeah I think you do see the bigger picture. (1: Medicine: AP62)

[Name AP] has just grown, and everything [name AP] does now, [name AP] thinks about why they're doing it, what [they] are doing and the staff have seen that and they don't question it anymore. (2: Medicine: WM234)

The [patient] has got somebody sensible looking after them that can deal with things and recognise things when they're not right and action it, you know. Rather than thinking, oh I've only left that Grade 2 health carer in there, you know, it's that kind of sense of knowing that the patients are safe and that [APs] can deal with what's going on. (2: Surgical: WM191)

Box 42: Managing patient expectations of the AP role

We have to be clear, we have to give the person, the assistant practitioner and the workforce, confidence to say who they are when they're introducing them to a patient and then we need to build up the confidence of patients that assistant practitioners aren't just substitute nurses or OTs or whatever and are actually competent to do that and I think there is a perception that they're not. I don't think individuals often do it themselves, they often can describe themselves as nurses. Well actually they're not nurses and the word nurse gives a perception to a patient. (1: Organisational Manager: 5)

I think that patients do see them as the nursing team but, and I don't know if it's that well explained to patients that there is a difference, you know - this person might be able to help you with some of your therapies as well, I'm not sure. (1: Divisional Manager 9)

I can remember as an auxiliary, you've looked at a staff nurse and you had to do what they said. Whereas with this [AP role], that's one thing the course has taught me, that you don't, if you're not happy to do something, you don't have to do it and if you've got a good enough reason not to have to do it. (1 Medicine: AP38)

So they would then look after that patient who's come back from theatre and put the oxygen on and stuff like that. Whereas now they won't do it; because it's not in their role. So we've now set boundaries, which is better because there were never any boundaries set before; it was always, well if you feel competent to do it and because they were competent we got them to do these things or they did them. But now they will come up and say, no sorry I'm not allowed to do that. (1: Surgical: WM1B)

At ward level, there was also recognition that HCAs who had developed as APs had changed in terms of how they perceived their levels of responsibility in relation to patient care and HCA support (Box 43). Not only were the APs delivering care to patients but they were also overseeing care delivery by HCAs and acting as a 'team

leader' for HCAs (discussed above). This leadership role was perceived as promoting patient confidence in care delivery by the assistants. However, patient characteristics were perceived as important for determining the suitability of the AP role within a speciality (also discussed above). These characteristics included: patient acuity, level of predictability in patient condition, pace of work (including patient turnover) and the different demands of patient during day and night shifts.

Examples of 'best practice' were provided. In case site 3, this focused on APs taking responsibility for developing an aspect of the Essence of Care (127), such as nutrition or incontinence management. In case site 2, APs were developing their expertise in wound care and management. In case site 1, APs were particularly noted for their contribution to patient care through use of their therapy skills. The AP roles were not used in this way in either of the other case sites. APs described incorporating therapies into their everyday nursing activities '*rather than just being one of the nurses*' (1 Medicine: AP63). This could be assisting a patient with exercises or walking, using techniques to promote self-care for patient or assessing a patient who requires crutches. Crossing these boundaries also provided some continuity of care for patients (particularly during the evening and at weekends). As such, the AP role was perceived as more suited to wards that could utilise these skills, such as rehabilitation. The therapy role was not welcomed by all senior nursing managers. Some expressed concern about supporting and funding the shortfall in therapy services through nursing APs. APs were part of the nursing establishment and as such, the ward budgets were considered to be supporting services beyond nursing. This could once more potentially limit the AP role to support patients with therapy; APs first had to prioritise their nursing work and this might not always have been in the best interests of patients.

Box 43: APs perceived levels of responsibility

Because [APs] have been trained more and they've had this 2 year training, I think they've got the passion behind nursing and what it's all about. It's just having the theory behind it, the knowledge. And because [HCAs] haven't got the passion, they don't seem to take that responsibility the same. Whereas [names APs] take it like a trained nurse takes more responsibility. They do take pride in their work but they do, do a lot more in general. If they admit a patient and as I say, if someone needs something doing they'll go off and do it. (1: Surgical: WM1B)

Well I try to finish off what I have to do but if I get home and I think, oh my god I forgot something - I'm ringing [the ward]. Whereas before it would have to be, oh I'll come in the morning and sort it out. But if it's something that needs doing or I forgot to pass a message on, which is not often, but if I do, I try to ring and let the staff know, you know, because I think – I have to stop and think and make sure everything is covered. (3: Medicine: AP12)

[Name AP] has always been the kind of person that takes pride in what she does anyway but I think it not only gives her a sense of extra pride, because she is wearing a different uniform, but I don't know – she's proud of what she's done and she takes some responsibility. (3: Surgical ward without AP: SS32)

AP39: I've got a bag full of NVQ stuff that I'm going to do tonight because I can't do it in work time. That will never be done in work time. It's never happened.
AP43: Well you just can't take the time off the ward, can you?
(3: AP focus group discussion 2: wards)

It was suggested that the potential of the AP role for contribution to patient care was not always maximised. Some additional areas of AP practice were identified, that could potentially improve patient care, if the APs were better utilised within the ward environment; examples included the restrictive nature of the team nursing philosophy that limited APs opportunities to take responsibility for a group of patients and tasks such as cannulation and catheterisation which RNs might defer to medical staff rather than using the APs' skills.

5.5.1 Observing the quality of interactions between APs and patients

To understand any potential differences in the quality and types of interactions between members of the nursing team (APs, RNs, HCAs) and patients, we observed and rated these interactions in 13 wards across three case sites using the Qualpac instrument (described in Chapter 3). Across all three case-sites, there were 361 Qualpac observation periods (each period x 2-hours) and a total of 17,543 interactions were observed between members of the nursing team and patients. These observations took place across 162 patients, with a range of 1-359 observations for each patient.

Quality of staff-patient interactions

Each observed interaction was given a quality score, which ranged between one and five. The findings relating to the quality scores are given in Table 20. The vast majority of interactions were rated as being of average quality. Only 3% of interactions were judged to be outside of the average category, with very few being rated at the extremes of this scale. Due to the lack of variation in the rated quality of interactions, it was not possible, or meaningful, to attempt to compare the quality of interactions across the categories of staff. This implies that regardless of the member of the nursing team observed to interact with patients, whether that was a RN, AP or HCA, the quality of interactions were similar.

Table 20. Overall range of Qualpac score for quality of interaction

	Poorest care	Poorer than average	Average care	Better than average	Best care
	1	2	3	4	5
N (%)	3 (0.0)	310 (1.8)	17003 (97.3)	153 (0.9)	5 (0.0)

Nature of interactions across staff groups

Each of the interactions observed were allocated to one of five categories according to the nature of the interaction. These categories included psychosocial, physical, general, communication or professional implications (detail of these categories was provided in Chapter 3). The results relating to the types of interactions observed, by staff group, are presented in Table 21. There appear to be differences across the staff groups in the nature of the interactions they were involved in undertaking. Across most of the Qualpac domains, the profile of AP interactions was more similar to RNs than those of HCAs. These data were also analysed by case site.

In case site 1, the nature of AP interactions was between the RN and HCA interactions (Table 22). In case site 2, interactions by all staff groups were similar (Table 23). In case site 3, the nature of AP interactions were more similar to those of RNs than HCAs (Table 24).

Table 21. Qualpac domain by staff group

	N observations	RN N (%)	AP N (%)	HCA N (%)
Psychosocial	8701	3772 (49.8)	3644 (50.7)	1285 (57.1)
Physical	2895	1339 (17.7)	1197 (16.7)	359 (16.0)
General	1762	784 (10.4)	781 (10.9)	197 (8.8)
Communication	201	110 (1.5)	80 (1.1)	11 (0.5)
Professional implications	3446	1567 (20.7)	1482 (20.6)	397 (17.7)

Table 22. Qualpac domain by staff group in case site 1

	N observations	Nurse N (%)	AP N (%)	HCSW N (%)
Psychosocial	3132	1327 (51.0)	1161 (55.4)	644 (62.6)
Physical	986	479 (18.4)	354 (16.9)	153 (14.9)
General	656	319 (12.3)	239 (11.4)	98 (9.5)
Communication	92	58 (2.2)	27 (1.3)	7 (0.7)
Professional implications	863	420 (16.1)	316 (15.1)	127 (12.3)

Table 23. Qualpac domain by staff group in case site 2

	N observations	Nurse (%)	AP (%)	HCSW (%)
Psychosocial	3077	1226 (49.7)	1612 (49.0)	239 (50.4)
Physical	1115	464 (18.8)	569 (17.3)	82 (17.3)
General	607	225 (9.1)	334 (10.2)	48 (10.1)
Communication	50	23 (0.9)	26 (0.8)	1 (0.2)
Professional implications	1379	529 (21.4)	746 (22.7)	104 (21.9)

Table 24. Qualpac domain by staff group in case site 3

	N observations	Nurse N (%)	AP N (%)	HCSW N (%)
Psychosocial	2490	1217 (48.7)	871 (48.4)	402 (53.9)
Physical	794	396 (15.8)	274 (15.2)	124 (16.6)
General	499	240 (9.6)	208 (11.6)	51 (6.8)
Communication	59	29 (1.2)	27 (1.5)	3 (0.4)
Professional implications	1204	618 (24.7)	420 (23.3)	166 (22.3)

Patient dependency across staff groups

The dependency of each of the 162 patients involved in the observations was rated between 1 (least dependent) and 4 (most dependent). We have compared the proportions of interactions observed for each of the three staff groups by the dependency of the patient (Table 25). There was evidence of a relationship between the proportion of interactions performed by the staff groups and patient dependency scores. RNs had a greater proportion of interactions with both the most and the least dependent patients when compared with other staff groups and spent the majority of their time interacting with least dependent patients. APs had the greatest proportion of interactions with patients of lower dependency (level 2) and HCAs with level 3 dependency patients. Proportions of interactions observed for each staff group by dependency of patient for each of the case sites are also presented (Tables 26, 27 and 28).

Table 25. Patient dependency by staff group

	N observations	RN N (%)	AP N (%)	HCA N (%)
1	5357	2885 (38.3)	1868 (26.1)	604 (26.9)
2	5341	2097 (27.9)	2500 (34.9)	744 (33.1)
3	4670	1731 (23.0)	2103 (29.3)	836 (37.2)
4	1577	815 (10.8)	697 (9.7)	65 (2.9)

Table 26. Patient dependency by staff group in case site 1

	N observations	RN N (%)	AP N (%)	HCA N (%)
1	2536	1736 (66.7)	616 (29.4)	184 (17.9)
2	1322	436 (16.8)	612 (29.2)	274 (26.6)
3	1414	389 (14.9)	519 (24.8)	506 (49.2)
4	457	42 (1.6)	350 (16.7)	65 (6.3)

Table 27. Patient dependency by staff group in case site 2

	N observations	RN N (%)	AP N (%)	HCA N (%)
1	1872	676 (27.04)	1036 (31.5)	160 (33.8)
2	2594	1004 (40.7)	1370 (41.7)	220 (46.4)
3	979	279 (11.3)	606 (18.4)	94 (19.8)
4	783	508 (20.6)	275 (8.4)	0

Table 28. Patient dependency by staff group in case site 3

	N observations	RN N (%)	AP N (%)	HCA N (%)
1	949	473 (19.3)	216 (12.1)	260 (34.9)
2	1423	655 (26.7)	518 (29.0)	250 (33.5)
3	2277	1063 (43.3)	978 (54.8)	236 (31.6)
4	337	265 (10.8)	72 (4.0)	0

5.6 AP satisfaction but concerns about their levels of accountability and lack of registration

APs in the observed wards reported high levels of satisfaction with their roles and work (Appendix 11; Table 6). There were, however, indications in the interview data that APs did not feel that their role and skills were always fully utilised. They reported in questionnaires that they were satisfied with the recognition they get for their work (71%), the support they get from their manager (82%), freedom they have to get on with their work (71%), support from colleagues (82%), their amount of responsibility (88%) and opportunities they have to use their abilities (88%). In general, APs working in other clinical areas reported lower job satisfaction. Only between a quarter and a third of the RN and AP groups were satisfied with the extent to which the Trust valued their work, although around half of the HCAs were satisfied with this (Appendix 11; Table 6). RNs reported higher levels of considering leaving their Trust (24%) than their AP (12%) and HCA (12%) colleagues. However, a third of APs working in non-observed wards (33%) and other clinical areas (30%) had considered leaving the Trust. The most frequently given reasons for considering leaving were career development (n=40), 'unhappy with current job' (n=29), 'more pay' (n=21), 'change of career' (n=18), 'family or personal reasons' (n=13), and 'other' reasons (n=19). Perceptions of support from a line manager were highest among the observed APs and lowest among those APs working in unobserved other clinical areas (Appendix 11; Table 7).

This chapter has already considered the work and activities of APs alongside the ways in which these were negotiated in practice. In addition, we have examined their potential impacts on patient care. In this section, we will consider in particular the potential areas of overlap for the AP role with that of RNs and issues of accountability and registration. A major point of discussion for the AP role related to the level of accountability assumed by these workers in the delivery of patient care. There were concerns at senior management level that RNs had to retain accountability for the actions of APs because APs were not registered and yet were performing some 'advanced' technical activities (such as catheterisations). At divisional management level and amongst ward based RNs, concerns were expressed about the work of the APs and accountability issues (Box 44). APs viewed RNs as being ultimately responsible and in charge of patient care and that certain aspects of their role should be more closely supervised by RNs, for example admission assessments and care planning.

The level to which concerns were expressed about accountability for APs' work was closely linked to relationships that existed between ward staff and the level of trust that existed between RNs and APs (p.96). Where APs had been employed for a long time within a unit (as HCAs and then APs) and the RNs knew them, then this created

less concern about checking the work of APs and accountability issues (Box 45). Indeed in case site 1 (where the role was most established), RNs had stopped countersigning the APs' documentation in the majority of observed wards but in case site 2 and 3 (where the roles were more recently introduced) there were ongoing debates regarding countersigning of documentation and the reluctance of RNs to do this. Ward managers discussed the need for APs to have their care documentation counter-signed by a RN. However, RNs and APs suggested this did not make sense and defeated the purpose of having the APs undertake the role if there had to be close monitoring of the AP work and countersigning of documentation. There was a feeling that the APs had been assessed as competent to a certain level and therefore did not require close supervision.

Box 44: Accountability and the roles of APs

They're at the band 4 but they're still not a registered nurse, so even though they're going to be putting catheters in, [RNs are] still retaining a certain accountability for what they're doing because you're directing them irrespective of the fact that they've gone through competencies and they've been signed off as competent, you know, there's still accountability and I don't think that's been fully resolved. (3: Organisational Manager: 57)

[There has been] concern coming from qualified nurses about accountability because obviously qualified nurses are very much aware of their own accountability, so it was really a question that was coming from them, not from the [APs]. (3: Surgical Divisional Manager: 18)

[RNs] certainly felt vulnerable in supporting [the AP] with patients. And in the beginning [RNs] were signing off things for [AP] and they felt vulnerable. They wanted to know that [the AP] could do that job really. (2: Medicine: WM233)

I mean we all know that even when we admit patients, it's actually [registered] nurses that should write the care plans. But we still admit them and put the care plans in and then I ask nurses to approve my work to see if they're happy. And once I've admitted, it's up to them. I'll sign that I've done it, but it's up to them to second sign and to say that they agree. Because at the end of the day, as I say, the nurses are the ones who provide the care, as such. (1: Medicine: AP90)

Maybe a lot of it is around risk. You start going to a busy medical ward and you add an assistant practitioner responsible for a group of 8 patients and then you think, ah I'm not quite sure whether I like that because you're not a nurse, you haven't got all that skill and knowledge. And we don't necessarily need all your therapy stuff here; what we need is nursing skills, assessment skills. And that's not what the [AP] role was designed to do - assessing. It was about delivering, assessed and planned care as far as I was aware. And that made me feel quite comfortable. (1: Divisional Manager: 2)

Box 45: Trust relationships between RNs and APs and accountability

I think I know that we're still accountable for whatever the [AP] is doing but however, I certainly trust the two people that are here more than I would do anybody else on what they're supposed to be doing because they're very intensive people… I know them and I trust them quite well and they're not stupid people…So in that sense I think it would depend on who the [APs] were. (3: Medicine: RN5)

I think I do a better job than some of the trained nurses and I find that most trained nurses would ask me to do certain things which because they know if they ask me it will be done to the standard where they wouldn't have to come and check. (3: Medicine: AP12)

I think it works well that we relieve the staff nurses and I think it works well in the fact that the staff on here know [name AP] and I, they know how we work, they know we're responsible nurses if you like. (2: Medicine: AP306)
We know who's looking after [the patients] and they're very good, you know, if they're stuck with anything they come to us, you know. (2: Medicine: RN324)

Registration was discussed in all case sites but fewer concerns were expressed in case site 3 as compared with the other organisations (case site 1 and 2). This may be because the APs were more firmly located within the 'assistant' workforce in this organisation. However, without registration, there were perceptions that the AP role had developed as far as it could. Registration of the APs was suggested by a variety of stakeholders at ward and management levels as offering a way of (Box 46):

- protecting the APs as they practice;
- promoting clarity of the role;
- increasing recognition of the role by other staff;
- clarifying lines of accountability;
- protecting patients;
- promoting responsibility amongst APs

However, not all staff (again represented by both ward and management staff) felt the AP role should be registered and the means by which registration and regulation would be achieved were not at all clear. In case site 1, this was further complicated by the APs working across professional boundaries.

Box 46: Registration for APs
Maybe for her own safety then maybe [registration] probably wouldn't be a bad idea or like, give [the AP] something to be proud of because we're all proud of the fact that we're on a register and, you know, that we're actually recognised and, you know, accountable for things. (3: Medicine: RN10)
I think God who is accountable? Am I fully accountable for everything because we've got no registry body have we really at the moment, so that's a bit of a worry for me. (1: Medicine: AP38)
If we had been registered at the beginning, once we'd qualified, I believe we would have been recognised a little more. I really do. Because one auxiliary said to me, all that you are is a glorified auxiliary and so are the rest of you. (1: Medicine: AP62)
I wish [registration] was in place for when we qualified. I think it would have made things a lot easier for a lot of members of staff, and myself, knowing where we were with everything. And I still don't know what's happening with the registration. (2: Surgical: AP226)
I think one of the things that with any of, both the assistant practitioner and health care assistants, what concerns me a little bit is that they're not registered with the Nursing and Midwifery Council and if you looked at what the professional body is all about, it's the protection of the public and so therefore we're saying that now a large number of practitioners can do quite sophisticated tasks with patients and they are not registered. (2: Organisational Manager: 2)

5.7 The 'ceiling effect': Shaping the future direction of the AP role

Around three quarters of the questionnaire respondents had had an appraisal or development review in the last 12 months (Appendix 11; Table 8); APs working in the non-observed wards were least likely to have had a review (66% reported having a review). Of those who had a review, many reported that it was useful in helping them improve how they do their job; non-observed APs working in other clinical areas were least likely to agree with this statement (63%). Of those who had a review, around 90% agreed clear objectives and a personal development plan, but only around half felt their work was valued by the Trust after the review: this varied from one third for APs working in other clinical areas (33%), half for the RNs (49%) and around two thirds of the HCAs (68%) and ward-based APs from observed (64%) and non-observed wards (68%). HCAs were least likely to report receiving the training identified in their personal development plans (38%) and APs working in other clinical areas felt least supported by their manager to access training identified in their plan (38%).

There were few apparent differences between staff groups in training, learning and development received (Appendix 11; Table 9). Training received by more than half of the staff included infection control (94%), health and safety (83%), handling confidential information about patients/clients (70%) and computer skills (54%). Attitudes towards training, learning and development also did not vary greatly between staff groups. However, RNs were more likely to report that skills development occurs in their own time (46%) and that the Trust provides minimal training for the job (50%) (Appendix 11; Table 10). Two-thirds of staff (67%) agreed with the statement that their Trust believes in the importance of training and 58% believed that the Trust encourages staff to develop their skills. Three quarters agreed that training has helped to stay up to date with the job (76%) and with professional requirements (74%), but only around a fifth agreed with statements about training actually improving their skills (19%) and job performance (20%). APs were more likely to consider that training improved their chances of promotion.

The AP role was described by assistant staff as a role that assistants can aspire to. However, it was often presented in the organisations as a route for assistants who did not want to undertake registered nurse training; assistants undertaking AP training were discouraged from pursuing their nurse training and where the assistant wanted to move on this was perceived as a 'failure'. This was because the organisation had invested money in retaining an assistant and if they moved on to registered training they lost their resource and had also funded the person through an expensive training route. In case site 2, staff expressed more appreciation of the AP training as a route to registered training (Box 47). However, upon completion of training

for a Band 4 position, concern was expressed about the lack of opportunities for subsequent development of this group of staff and issues of equity compared with other staff groups (Box 48). There were suggestions that a scheme for rotation of APs across the organisations would enable those APs who wanted to develop skills to have the opportunities to do so. There was recognition that not all AP were receiving opportunities for an appraisal of their work. In addition, APs reported lack of mentorship upon qualification as an AP and a lack of guidance about future opportunities for their roles. This, despite the fact that APs were taking on appraisal of their assistant colleagues and being increasingly expected to provide support, training and mentorship to more junior assistants: roles for which they had received minimal preparation and that were not welcomed by all APs. In case site 3, the Trust supported the development of a forum for APs to hear from this developing group of staff and for the APs to offer each other support, given that the majority were isolated within clinical units. This was viewed as a positive development by senior managers but it was reported by APs that they were experiencing difficulties in negotiating time to attend the forum.

Box 47: AP training as a route to registered training

I'm not sure, when I think about it really carefully, if there is a certain frustration with that role in themselves that I've done all this but there's still something better, or how they perceive it if I become a registered nurse. And so there is a danger of leakage out of that role really I think and I don't know how that happens in other Trusts but I can totally understand why somebody, you know, especially if they get an appetite for studying and knowledge and development, absolutely and I don't ever want them to be limited and say, no you can't go off and be a registered nurse, you know. (2: Organisational Manager: 1)

I think certainly in terms of some of the assistant practitioners that we have in surgery at the moment, now that they've bit the bullet and got some further development and involved in stuff that they've never been involved in before, they've got a real urge to continue their development and, you know, maybe go on to become trained nurses. (2: Organisational Manager: 3)

Senior managers raised concerns about their lack of ability to succession plan for AP positions because of (i) the financial implications of the posts, (ii) the pool of available HCAs able to take on the role and (iii) the transferability of AP skills across the organisation and to other NHS organisations. Currently, it is identified that the lack of a national model for this level of worker is hampering development and preventing opportunities for these staff to transfer skills and develop (Box 49).

Box 48: Limited ongoing opportunities for APs

I just feel, right there's your certificate, you're an assistant practitioner. Good luck, maybe we'll see each other in another 2 years. (1: Medicine: AP61)

I'm actually working on a career pathway for the band 4 [APs]. It's been something that's been noticeably lacking in this Trust for them because what I've noticed since I've taken on the role is it's a wonderful, fantastic, great qualification but then what? What happens to them? What are their prospects after that? Where do they actually go after that? (3: Organisational Manager: 48)

The band 4s, because they are home-grown, if they want to move somewhere else, there's nowhere for them to go. They have to lose their grade and that to me is a real big disadvantage for the person who is the band 4. Especially if

they're relatively young and definitely do not wish to go on to become a qualified nurse because they're then stuck. (3: Medical Divisional Manager: 19)
I was aware that they had these 2 years and it was really intense and everybody was looking at them and reports were being filled in and then they finished and that was it… They felt like it'd just died a bit of death at the end of it. There wasn't anything. What next? (1: Divisional Manager: 2)
The training, it's either for staff nurses or auxiliaries and we go on the auxiliary things and we think this really isn't for us but the staff nurse stuff can be a bit - 'phew'. And we want something to work for us so that we can develop and go on and there really isn't, they've not really planned that in our training. (1: Surgical: AP16)

Box 49: Succession planning for AP roles
I think if nationally, if everybody had the same sort of model it would be easy because they would be able to move… I think it's difficult for them to move across organisation to organisation. So I think for us it will be home-grown for a little while until there's a whole, you know. (3: Organisational Manager: 51)
There's been no clear direction, so to be honest it was like pulling teeth the last 2 years... People were coming to me, the health care assistants were coming to me, and the managers were saying, 'no we're not funding you'. Because the big consideration is, they have to pay them that 4 and a half grand difference from a band 2 to a band 4... It's all very well education saying, we can give you the money for the back-fill and we'll pay for the course, but they're on their own afterwards, so it's down to the divisions and the ward managers and we were meeting a lot of resistance from that. (3: Organisational Manager: 48)
The assumptions are made that [the role] is going to continue… But my personal feeling is a. the reservoir of people who are able to do it will have dried up because what you're looking for is experienced HCAs, motivated to take on that challenge and b. also I think money is going to get quite tight and it might be seen actually, are we getting the additional value for money from it. (3: Medical Divisional Manager: 19)
I don't understand it being recognised really outside [names SHA]. I know there are roles that are called assistant practitioners, but if they've got the same sort of credence that they have in [name area]. (1: Organisational Manager: 1)

5.8 Summary

This chapter reports on the personal characteristics of APs working in ward-based nursing teams in acute care, perceptions of the AP role on ways in which the role contributes to patient care and nursing teamwork from a variety of key stakeholders (including the APs themselves), as well as observations of their activities and interactions with patients in everyday practice. The accounts of various stakeholders highlighted disputes surrounding the boundaries of the AP role and that the role was largely negotiated in practice; this led to opportunistic development of the AP role by various stakeholders, including the APs. We have highlighted ways in which the AP role complemented the work of RNs and provided 'relief', as well as their contribution to the support of other assistant staff, newly qualified RNs and student nurses. The APs were perceived to make a valuable contribution to care delivery processes, being visible and knowledgeable at the patients' bedsides. However, future developments for the role largely depend on resolution of a number

of issues, in both local and national policy arenas. These include registration and regulation of the AP role and opportunities for career development and progression through the standardisation of educational preparation, mentorship and CPD.

6 Findings: The national picture

6.1 Introduction

To date, the AP workforce has been poorly defined in terms of who they are, what they do, how they have been prepared for their role and their experiences of developing within a relatively new role in Acute NHS Trusts. This chapter moves findings beyond the case study work and reports on findings of a national survey of workers in these positions and settings (up to January 2010). The aim is to offer a broader context to the findings of the three fieldwork sites, described in the previous chapters (4 and 5). To this extent, this chapter contributes to the four aims of the study (outlined in chapter one). The questionnaire was administered November 2009 to January 2010 and represents the only national survey of APs across all ten Strategic Health Authorities (SHAs) in England. Findings reported include AP responses to closed structured questions and the open text comments made by the APs about their role. Almost half of the respondents (48.6%; n=161) provided additional comments. The findings will describe:

- type of worker behind the title of AP;
- work, role and activities of APs;
- job clarity and autonomy, staff relationships and support and job satisfaction of APs; and
- attitudes towards training, learning and development.

6.2 What's in a title?

There were 381 questionnaire respondents (35%) in total; 1090 questionnaires were distributed (see Chapter 3). Of these, almost three-quarters (71.1%; n=271) reported that their current job title was Assistant Practitioner. However, 109 (28.6%) respondents indicated having another job title (Table 29). Over half of those reporting another title were called trainee Assistant or Associate Practitioners (57.8%; n=63).

The majority of respondents (69%; n=263) were employed at Band 4 (Agenda for Change Framework), with 21.3% (n=81) employed at Band 3 and 8.7% (n=33) at Band 2 (4 respondents did not provide their pay band). Many of the respondents (76%) who indicated being paid at Band 3 and 2 were trainees. However, open comments revealed that after completion of training some APs were not offered a Band 4 position but maintained on their original banding (Box 50).

Table 29. Current job titles for those not called Assistant Practitioners

Current job title	Number (%)
Trainee Assistant/Associate Practitioners	63 (57.8%)
Associate Practitioner	10 (9.2%)
Healthcare Assistant/Support Worker	7 (6.4%)
Senior Healthcare Assistant/Support Worker	5 (4.6%)
Infection Control Assistant	4 (3.7%)
Environment Infection Control Assistant	3 (2.8%)
Clinic Administrator	1 (0.9%)
Clinical Training AP	1 (0.9%)
Nursing Auxiliary	1 (0.9%)
Occupational Therapy Assistant	1 (0.9%)
Orthotics Manager	1 (0.9%)
Physiotherapy AP	1 (0.9%)
Senior Auxiliary	1 (0.9%)
Ward Assistant	1 (0.9%)
Workplace Learning Facilitator	1 (0.9%)
No titled provided	8 (7.3%)
Total	109 (100%)

Box 50: Band 4 position upon completion of training not guaranteed
When I first qualified as an Assistant Practitioner… I was not offered a Band 4 role. I was offered my previous role as an HCA Band 3; with the reason the ward did not have enough funding. After lots of communication with the SHA, I was offered the role in January 2007. (AP 206)

Most of the respondents (88.5%; n=337) indicated that they had experience of working in health care positions prior to being employed in their current role; this was mainly as a health care assistant or support worker in a hospital setting (69.1%; n=233) (Table 30).

Table 30. Health care positions prior to current role

Previous health care job title	Number (%)
HCA/Support Worker (hospital setting)	233 (69.1%)
Auxiliary Nurse Titles	36 (10.7%)
HCA/Support Worker (NOT hospital setting)	8 (2.4%)
Therapy assistant role	7 (2.1%)
Technician role	6 (1.8%)
Assistant/ Associate Practitioner	2 (0.6%)
Bank HCA role	5 (1.5%)
Nurse training	3 (0.9%)
Other title*	9 (2.7%)
No response	28 (8.3%)
Total	337 (100%)

**Included job titles such as: Housekeeper; Senior Housekeeper Mental Health; Donor Carer; Ward Clerical Assistant; Project Worker; Clinical Training Assistant; Junior Doctor Assistant; Medical Lab Assistant*

Almost half (49.1%; n= 187) the respondents indicated that they were currently employed in a medical or surgical ward (Table 31). 'Other' was a category used by APs who were not employed in one of the predefined clinical wards or areas listed in Table 31. Examples in

this category included radiology, radiotherapy, community nursing teams, occupational therapy, blood transfusion services, and microbiology laboratory. Subsequently, these respondents (n=50) were excluded from any further analyses because they were not located in a clinical ward or area where they worked to support the work of RNs. Further analyses therefore include 331 respondents, 76.1% (n=252) of whom indicated that they solely supported the work of RNs and 22.1% (n=73) supported the work of RNs and another discipline (such as a therapist or dietician); there were 6 non-respondents to this question.

Table 31. Type of wards respondents are employed in as APs

Type of ward	Number (%)
Surgical	94 (24.7%)
Medical	93 (24.4%)
Out Patient Departments	28 (7.3%)
A&E	27 (7.1%)
Intensive Care	26 (6.8%)
Rehabilitation	17 (4.5%)
Elderly Medicine	16 (4.2%)
Theatres	19 (5.0%)
Maternity	10 (2.6%)
Other	50 (13.1%)
No response	1 (0.3%)
Total	381 (100%)

Most of the respondents were female (88.8%; n=294) and the average (mean) age of the respondents was 44 years (95% confidence interval 43-45 years). In terms of an ethnic breakdown, the majority of the respondents (96.1%; n=318%) identified themselves as British white. On average, the respondents had worked for 12.1 years in the NHS, with a range from 2 months to 34.5 years. Over three-quarters of respondents (78.5%; n=260) have been employed in the NHS over 5 years, and over half of these (n=150) over 10 years. Therefore, these staff demonstrated considerable length of service in the NHS, and clinical experience, prior to taking up their current positions as APs (Table 32).

Table 32. Length of time in total as employee in NHS

Total time employed in NHS	Number (%)
≤ 1 year	3 (0.9%)
> 1 year but ≤2 years	1 (0.3%)
> 2 years but ≤5 years	28 (8.5%)
> 5 years but ≤10 years	110 (33.2%)
> 10 years but ≤15 years	66 (19.9%)
> 15 years but ≤20 years	38 (11.5%)
> 20 years but ≤25 years	26 (7.9%)
> 25 years but ≤30 years	15 (4.5%)
>30 years	5 (1.5%)
No response	39 (11.8%)
Total	331 (100%)

Respondents demonstrate variations in the amount of time they have been employed in post with over a quarter reporting to have been employed less than 1 year (30.5%; n=101) and another quarter

between 2 and 5 years (27.8%; n=92). A very small number (0.9%; n=3) report being post over 10 years (Table 33). For APs that had served 2 years or more in their current post , there was little difference in their distribution between the specialties. The majority of APs work full-time (74%; n=245).

Table 33.Length of time in current post as an AP

Time in current post	Number (%)
≤ 1 year	101 (30.5%)
> 1 year but ≤2 years	43 (13.0%)
> 2 years but ≤5 years	92 (27.8%)
> 5 years but ≤10 years	29 (8.8%)
> 10 years but ≤15 years	3 (0.9%)
> 15 years	0 (0%)
No response	63 (19.0%)
Total	331 (100%)

Almost all respondents (91.5%; n=303) reported undertaking a qualification for their current position as an AP. Of these, 39.0% (n=129) reported completing a foundation degree and 43.2% (n=143) a National Vocational Qualification at level 3 (32.9%; n=109) or level 2 (10.3%; n=34). A range of other qualifications were cited in small numbers.[6] Upon qualification, we were interested in establishing whether they were guaranteed a position as an AP or not. Over half (55.0%; n=182) reported that they were guaranteed a position, whilst 31.1% (n=103) applied for a position upon completion of their training; 12.7% (n=42) were still in training and so this was question was not applicable, and there was a small number of non-respondents (1.2%; n=4). Open comments further substantiate these data (Box 51).

Box 51: Availability of Band 4 positions upon completion of AP training

I was chosen for the AP course by my manager in 2006 with the guarantee of a job at the end of the course. I finished the K100 in 2007 whilst on maternity leave. On returning to work, early 2008, I was left to find out there was no AP position for me as promised. I was advised not to complete competencies as these would become out of date before I got an AP position. June 2009, I applied for an AP position in a different area which I got on Band 4 as long as I completed competencies within a 6 month period. (AP 28)

I am currently studying for my foundation degree and am not employed as an AP yet but am worried that there is not a job for me at the end of my training. (AP 48)

6.3 Work, role and activities

Almost three-quarters of these APs (74%) were contracted to work full-time (37.5 hours per week). Shift patterns for these staff were in the main internal rotation on day and night shift (44.7%) or

[6] Qualifications cited in small numbers included: FdSc Healthcare Practice, Higher Professional Diploma (Health & Wellbeing), OU K100 Level 4, OU K114 Level 4, OU Certificate Level 4, Level 4 High Diploma in Health & Wellbeing, Access to Nursing, BTEC Award/Certificate/Diploma, AVCE in Health & Social Care, Certificate in Health & Social Care, Diploma in Health Care & Social Well Being and 'other' indicated but not named.

permanent day duty working both early and late shift patterns (32.6%). Small numbers worked permanent night duty (3.3%) or had regular day shift hours (19.3%).

Table 34 and 35 reports the respondents' views of their work role and activities. The majority of respondents view their role as providing care (97%) and treatment (70%) to patients, with a role in assessing and planning this care (65%). Over half of APs indicated that they had a role in reporting on patient care, both in written care plan documentation (61%) and verbally at nursing shift handover (57%). However, less were involved in communications with the wider multi-disciplinary team, such as medical ward rounds and with allied health care professionals (30%). Many were also engaged in administrative duties (64%). The APs indicated they had a role in providing continuity of care to patients (72%) and over half reported discussing concerns about care with patients (59%) and relatives (51%). Thirty-nine per cent of respondents indicated that they would be given responsibility to look after a group or team of patients on a shift. Only very small numbers (6%) reported being involved in administration of medications. In the open comments, APs reported providing total care for patients, apart from medicine administration. This was perceived to create extra pressures for the RNs (Box 52). In some cases, APs reported that they had undertaken some training with regard to medicine administration but were then informed that they could not administer any medications whilst the role was not registered.

With regard to their supervisory roles, APs were most likely to indicate that they had a role supervising and supporting other assistant staff delivering care to patients (64%); with smaller numbers indicating they supervised junior RNs (38%) and student nurses (42%). Examples of the support provided by APs to other staff were provided (Box 53).

Table 34. AP activities

Each week my role involves:		Number (%)
Number (%) reporting 'quite a lot' or 'a great deal'	delivery of care to patients	320 (97%)
	delivery of treatment to patients	233 (70%)
	carrying out examinations of patients	132 (40%)
	assessing and planning the delivery of care to patients	215 (65%)
	assessing and planning the delivery of treatments to patients	148 (45%)
	assessing and planning for carrying out examinations of patients	107 (32%)
	planning for the discharge of patients from hospital	128 (39%)
	supervising and supporting other assistants delivering care to patients	213 (64%)
	supervising and supporting newly-appointed or junior RNs delivering care to	127 (38%)

	patients	
	supervising and supporting student nurses delivering care to patients	140 (42%)
	supervising others delivering treatments to patients	106 (32%)
	supervising others carrying out examinations of patients	74 (22%)
	discussions with patients about their concerns about treatment or condition	196 (59%)
	discussions with relatives	169 (51%)
	providing continuity of care to patients	237 (72%)
	administrative duties / data entry	212 (64%)
	attending meetings	97 (29%)
	report writing	203 (61%)
	delivering a verbal handover of patient care to nursing staff on the subsequent shift	188 (57%)
	participating in a medical ward round to communicate patient conditions with medical staff and allied health care professionals	98 (30%)
	taking a caseload/team/bay of patients	130 (39%)
	administering medications	21 (6%)

Table 35. The AP role

The AP role....		Number (%)
Number (%) 'agreeing' or 'strongly agreeing' with these statements	was developed in my organisation to fill a skills gap in the nursing team (between RNs & HCAs)	226 (80%)
	was developed in my organisation to reward long-serving assistant staff	24 (7%)
	is all about meeting patient need	262 (79%)
	provides an opportunity for career progression for assistant staff	284 (86%)
	provides an opportunity for staff that are not able to undertake RN training	228 (69%)
	is successful when the AP has worked in the organisation for many years and is an 'insider' (rather than from outside)	111 (34%)
	provides an opportunity for staff that do not want to undertake RN training	277 (84%)
	is suitable for all clinical specialities	213 (64%)
	is better suited to some specialities	129 (39%)
	provides support and relief for RNs	281 (85%)
	frees up time for RNs to focus on more	272 (82%)

	complex patients	
	can replace/substitute for a RN during a shift	146 (44%)
	has knowledge and skills that can be easily transferred and used across a variety of settings	274 (83%)
	has knowledge and skills that are particular to a clinical setting and not easily transferable	97 (29%)

Box 52: APs unable to administer medications and impact on RNs

I work on [Medical Admissions Unit] and work in different areas of the ward. We have an area called short stay and I found it hard to look after the patients because I am unable to do the drugs and I feel I am putting pressure on the RN as we are all working in a very stressful job at present, with sickness and staff leaving. (AP 17)

I feel that in not being able to administer drugs/medications it can sometimes feel, depending on who one is working with, like one is a burden to the shift, and getting someone to give out my patients' medications is hit and miss, I do ensure my patients do get these meds but some RNs are more willing than others to do so. (AP 338)

Box 53: APs supervisory and support role

On my present ward I feel valued for my role and am often approached by senior staff asking for advice, or for help, with tasks they are unsure of. We have a large number of recently qualified staff on the ward and they appreciate any help I can give them, [example] patient care, which paperwork to use and how to complete it, doing ECGs, cannulation, catheterisation, venepuncture etcetera. (AP 26)

I feel [the AP role] will become an increasingly important role over the next 5-10 years. Not only as a support role but as a role model to set practice standards that can be followed by other support nurses. (AP 132)

I have also taken on teaching, in-house, skills I have learnt and impart this knowledge to both trained and untrained, as necessary… I am also a NVQ assessor for other departments as well as my own and do some practical teaching in the local university for student nurses. (AP 197)

I work well with members of the multi-disciplinary team, such as physio, OT and [speech and language therapists]. I also have a lot of involvement with Social Workers who will ask me for my input on patients. (AP 26)

Whilst APs reported that they carried out a great deal of delivery of care to patients, quite a lot of delivering treatment to patients, a moderate amount of examinations of patients, quite a lot of assessing and planning the delivery of care and so on, there were differences noted between these activities and type of ward and time in post (Table 36). APs in surgical wards were more likely to be involved in planning the discharge of patients, supervising and supporting student nurses but least likely to be involved in discussions with relatives. APs in specialist units were more likely to be involved in carrying out examinations of patients and providing continuity of care but less likely to be involved in supervising and supporting other assistants or newly appointed RNs, or in supervising others in the delivery of treatments. Those in 'other' clinical areas were more likely to report that they were delivering treatment to

patient, involved in supervising the delivery of treatments to patients and attending meetings, but less likely to be involved in assessing and planning the delivery of care and planning for discharge of patients.

There was not much difference by type of ward in the extent to which APs agreed with various statements about the rationale for the AP role (Table 37). However, APs in:

- medical wards were more likely to agree that the role was better suited to some specialties (than others), and less likely to agree that the AP role was more successful after several years;
- surgical wards or theatres tended to be more disparaging with, for example, 1 in 8 thinking that their role had been developed as a reward for long term staff and more likely to be able to substitute for an RN during a shift;
- specialist clinics were more likely to agree that the AP role was better suited to some specialties; and
- other areas were more likely to agree that the role was more successful when the AP had worked for many years and suitable for all clinical specialties, but were be less in agreement for example that their role had been developed as an opportunity for those not able to do RN training and that the role was better suited to some specialties.

There was also not much difference by time in current post in the extent to which APs agreed with statements about rationale for introduction of the role. However, APs who had served less than one year were least likely to agree that the AP role was more successful when the AP had worked for many years, was better suited to some specialties and could substitute for RN during a shift. APs who had served for 5 + years were more likely to say that the AP role was suitable for all clinical specialties but also more suited to some specialties, that they can replace the RN during a shift and has transferrable knowledge.

Those who had been there less than one year were unsurprisingly least likely to agree that they were involved in supervising others. Those who had been there 5 or more years were more likely to agree that they were involved in examination of patients or assessing and planning those examinations and in administrative duties/ data entry (Table 36).

A large number of the AP respondents perceived their role to have been introduced to fill a skills gap between the role of the RN and that of the HCA (80%) and to better meet patient needs (79%) (Table 35) (Box 54). The AP was viewed as providing support and relief for RNs (85%), freeing up the time of RNs to focus on more complex patient care (82%). Less than half of APs (44%) indicated

that the role could substitute for a RN during a shift, indicating subtle differences in the roles of these staff (Box 55).

Table 36. Activities typically carried out by type of ward and by time in current post (%)

Type of ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	93	113	69	57	332	78	71	112	39	300	
delivery of care	92	98	100	95	96.4	95	97	96	95	96	19.6
delivery of treatment	66	71	68	81	70.6	58	73	79	79	72	45.1
carrying out examinations	39	36	49	41	40.5	36	40	41	55	41	49.3
assessing and planning delivery of care	62	72	68	54	65.3	53	69	71	76	67	47.2
assessing and planning the delivery of treatment	41	49	43	47	45	38	52	44	53	46	49.9
assessing and planning for carrying out examinations	29	33	38	32	32.5	23	37	32	47	33	47.1
planning for the discharge	39	50	36	20	38.7	18	44	50	56	41	49.2
supervising and supporting other assistants	66	70	51	68	64.5	62	55	68	71	63	48.2
Supervising/ supporting newly appointed RNs	38	44	26	45	38.6	29	34	48	53	40	49.2
supervising / supporting student nurses	35	51	35	46	42.4	33	38	51	55	44	49.7
supervising others delivering treatments	31	36	19	43	32.2	24	23	41	45	33	47
supervising others carrying out examinations	23	25	17	23	22.5	18	18	25	37	23	42.1
discussions with patients	53	63	57	66	59.2	50	59	62	67	59	49.3
discussions with relatives	52	43	58	56	50.9	36	55	60	62	53	50
providing continuity of care	67	73	84	63	71.8	63	71	74	79	71	45.4
administrative duties/ data entry	58	70	62	65	64	49	54	72	87	64	48.1
attending meetings	25	26	29	44	29.3	18	23	37	42	29	45.5

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

Table 37. Agree or strongly agree with statements about rationale for AP role (%)

Type of Ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	92	113	69	57	331	78	71	111	39	299	
The AP role should be registered and regulated	88	87	81	95	87	85	89	89	85	87	33.4
Registration would enable APs to expand their practice	91	89	80	93	89	88	89	87	90	88	32.2
Registration would increase AP responsibility for their own actions	91	89	88	89	90	92	90	88	87	90	30.6
Registration would protect patients	90	76	77	88	82	86	82	80	77	82	38.9
Registration would protect APs	89	86	83	89	87	90	85	87	82	87	34.1
Registration would increase RN confidence in the AP role	87	89	84	89	88	87	92	88	79	88	33.1
Registration would increase other health care professionals confidence in the AP role	88	89	84	91	88	86	94	87	85	88	32.3
All assistant staff should be registered and regulated	63	63	55	51	60	55	63	60	54	59	49.3

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

Box 54: APs filling a skills gap

I feel that the [AP] position is long overdue. Since the enrolled nurse position was discontinued there has been a gap in carers who want to focus on patient care and not on moving up the ladder into more senior roles. The AP role has filled that gap. (AP 181)

The Assistant Practitioner role is one that I believe is very valuable to all Trusts across the country. As registered nurses are taking on more and more roles and responsibilities that have traditionally been seen as junior doctors' jobs, the gap between HCAs and RNs is growing wider. APs have the potential (with the correct training) to relieve some pressure from the whole team and fill the growing gap. (AP 263)

Box 55: AP as substitute for RN

I can replace, or substitute, an RN for nursing care of an ITU patient provided another RN is available to administer drugs. Also the patient has to be in a stable condition and off the ventilator. (AP 258)

APs indicated (in their open comments) that in some cases they were doing a lot of the same work as RNs but being paid less: creating feelings of inequity. However, other open comments by APs indicated that some APs did not feel that their role was fully utilised and that they had not progressed much beyond their role as a HCA. It was suggested that RNs were cautious with the tasks and activities that they passed on to APs because the RNs perceive potential risk to their own registration. Preventing APs from undertaking activities that they have been trained to do, and may have completed in other clinical areas, creates frustration and disappointment with the role (Box 56).

Box 56: Under utilisation of AP role

I feel strongly that all APs are not used correctly in their jobs that they have been trained for. They are only doing their existing role as a healthcare assistant, and not that of an AP… If managers do not want APs then they should not put them forward. All the training they have done, skills and knowledge they have gained are falling on deaf ears. (AP 66)

There is also a lot of difficulty surrounding accountability in this role. RNs are sometimes afraid to delegate, despite the training we have undertaken, as they don't understand the role. (AP 160)

I consider that as trainees or APs, we should not be undertaking the nursing assistant's role. I am undertaking the AP training to move upwards and move away from the nursing assistant role; that is why I did this training. It is no point being an AP if this is not the case. All the training is practical and theory is a waste of time and energy because you do not require the amount of in-depth knowledge and training to be a nursing assistant. At present it appears the case, as with other APs or TAPs, that we are glorified nursing assistant, which I am very cross and angry about. If I had known this I would have not bothered undertaking 2-year training, which has been a lot of intense pressure and a lot of hard work day and night. (AP 155)

A third of respondents felt the AP role was better suited to assistants from inside the organisation (34%); however, a third neither agreed nor disagreed with this statement (35%). The role was, in the main, perceived to be suitable for all clinical specialities (64%) and that APs have knowledge and skills that can be used across a variety of settings and that are easily transferable (83%). Smaller numbers felt the role better suited to certain specialities (39%) and had knowledge and skills peculiar to one setting that was not easily transferable (29%). Many of the respondents felt that the AP role offered a progression route for

assistant staff (86%); a career pathway for assistants who did not want (84%), or were not able (69%), to undertake professional training (Box 57).

Box 57: Career progression for assistant staff

I have worked as an auxiliary nurse, health care assistant, for all of my adult life. From time to time I considered doing my training, but never felt sure it was what I wanted. When the new 'band 4' training was offered I felt excited and positive that the role would be useful. I believe it was a replacement for the old style enrolled nurse, although very few people would admit to that! (AP 163)

Respondents were clear that they perceived some form of registration and regulation as important for the AP role (87%) (Table 38). Two-thirds of respondents (60%) felt that all assistant roles (regardless of banding) should be registered and regulated. Registration was viewed as:

- providing protection for patients (82%) and APs themselves (87%);
- increasing APs sense of responsibility for their own actions (89%);
- increasing RN confidence(87%), and other health care professionals' confidence (88%), in the AP role;
- enabling APs to expand their practice (89%).

There was no significant difference between types of ward in the extent to which APs agree or strongly agree with a series of statements about registration and regulation, although those in other clinical areas were more likely to agree that all assistants should be registered (Table 39). In general, the longer APs have been in post the more sceptical they appear to become about the impact of registration on their own working conditions or patients welfare (Table 39).

Open comments from APs further substantiated the perceived need for registration (Box 58). APs who expressed that registration was not required for APs were less likely to provide additional comments. However, a reason presented for not being registered was to ensure continued recruitment to the AP role (Box 59).

Table 38. Perceptions about registration of APs

		Number (%)
Number (%) agreeing or strongly agreeing with these statements	the AP role should be registered and regulated	289 (87%)
	registration would enable APs to expand their practice	293 (89%)
	registration would increase AP responsibility for their own actions	295 (89%)
	registration would protect patients	271 (82%)
	registration would protect APs	287 (87%)
	registration would increase RN confidence in the AP role	288 (87%)
	registration would increase other health care professionals' confidence in the AP role	291 (88%)
	all assistant staff (regardless of agenda for change banding) should be registered and regulated	197 (60%)

Table 39. Agree or Strongly agree that Assistant Practitioners should be regulated and registered by type of ward and time in current post

Type of Ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	92	113	69	57	331	78	71	111	39	299	
The AP role should be registered and regulated	88	87	81	95	87	85	89	89	85	87	33.4
Registration = APs to expand their practice	91	89	80	93	89	88	89	87	90	88	32.2
Registration =increased AP responsibility	91	89	88	89	90	92	90	88	87	90	30.6
Registration = protect patients	90	76	77	88	82	86	82	80	77	82	38.9
Registration = protect APs	89	86	83	89	87	90	85	87	82	87	34.1
Registration = increase RN confidence	87	89	84	89	88	87	92	88	79	88	33.1
Registration = increase other HCP confidence	88	89	84	91	88	86	94	87	85	88	32.3
All assistant staff should be registered and regulated	63	63	55	51	60	55	63	60	54	59	49.3

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

Box 58: Perceived need for AP registration

I feel very strongly that assistant practitioners should be registered as this would enable the role of an assistant practitioner to be clearly defined and protect myself, colleagues and patients. [Lack of registration] has produced barriers to be able to fulfill my role as an assistant practitioner. (AP 3)
Registration will greatly improve status and recognition. It will also protect both patient and practitioner (and trust). But it is important to note that the training does teach you when not to practice and why restrictions are vital. That awareness is there with or without registration. The training makes you aware of how responsible you are for your own actions. (AP 62)
The role has developed to a point where it is agreed I work beyond my grade. However, I cannot progress as I am not a registered practitioner. This is an issue which I have very strong feelings. During my training in 2004 it was promised we would be registered and still no progress five years later. (AP 137)
The most important thing to stress on this form is that registration is vital. We need to be made accountable, and therefore need to be registered. I am so frustrated, having completed and achieved a commendation in my Foundation Degree, that I am still unable to use my skills. I have suggested that competencies could be used as a way to develop in my area, but this has been rejected, due to being 'unregistered'. Everyone seems afraid to take this role anywhere, and the future for APs in this trust looks bleak… The only way forward is registration. (AP 163)

Box 59: Reasons for not being registered

I'm not sure about APs being registered; we are all responsible for our actions, whether a HCA or AP. I think it could put off future APs as they may as well do their full training as a RN… I hope you don't register us just yet as I think it will put a lot of people off becoming successful APs. (AP 127)

6.4 Job clarity and autonomy, staff relationships and support, and job satisfaction

The majority of APs (84%) reported being clear about the responsibilities associated with their role (Table 40). However, only 54% of APs indicated that they have a clear job description. This clarity may be promoted through receiving feedback about how well they are doing in their work (57%) and being consulted about changes that will affect their work (65%). Most APs feel supported in carrying out their work. They can count on colleagues to: listen to their problems at work (62%); back them up (60%); help with a difficult task (74%); and help them in a crisis (66%). In addition these respondents reported feeling supported by their line managers (Table 41). Three-quarters reported that their line manager encouraged team work (75%), could be counted on to help with a difficult task (72%) and was supportive in a personal crisis (76%). Over half reported that they received clear feedback from their manager (57%) and that their managers consulted them about changes that would affect their work (51%). Open comments provide further evidence f the importance of support from ward managers for the AP role (Box 60).

There was little difference by type of ward in the extent to which APs agreed with various statements about counting on colleagues, although once again those in surgical wards or theatres and in other clinical areas tended to be less in agreement, and those in other

clinical areas were less likely to agree that they could count on colleagues to back them up at work. There was not much difference by time in current post, although those having served for 5 + years were more likely to say that they can count on colleagues to listen to their problems but less likely to say that they could count on colleagues to back me up (Table 42).

APs were asked about support they get from management and other colleagues (Table 43). Those working in medical specialties were more likely to agree that they got support from their immediate manager, that s/he can be counted to help with a difficult task, that s/he gives clear feedback and asks for opinion before making decisions that affect APs work and is supporting in a medical crisis. Those working in surgical/ theatres were less likely to agree that they got support from their immediate manager, that team working was encouraged, that manager could be counted to help with a difficult task or is supportive in a personal crisis. Those working in specialist units were more likely to agree that the manager would support team working, and those working in other clinical areas were least likely to agree that they got recognition for good work, that they got support from their immediate manager, had freedom to choose own method of working, give clear feedback about their work and be asked for their opinion before making decisions that affected their work.

Those working 5 or more years were more likely to agree that they got recognition for good work, had freedom to choose their own method of working, they got support from their work colleagues, had more APs working in their department, and had opportunities to use their abilities.

A large number (78%) of respondents indicated fluctuations in their work responsibilities dependent on numbers of other available nursing staff and over half (56%) indicate that their work is dependent on which members of the registered nursing team they work with on a particular shift (Box 61). However, 68% indicate having autonomy when planning how they go about their work. A third of APs reported feeling time pressured in their work (33%), and a large number report feeling pulled in many directions by their workload demands (65%) (Box 62).

Those in medical wards were more likely to agree that they did not have time to carry out all their work, and least likely to agree that they had a clear job description for their role as an AP. APs in specialist wards were more likely to agree that what they did depended too much on what other nurses said they could do, but less likely to agree that staff they worked with understood their role as an AP. Those in other clinical areas were least likely to agree that they were consulted about changes that affected their work, that they got clear feedback about how well they were doing their job and could decide on their own how to go about doing their work (Table 42).

The APs perceived that their role was not well understood. They reported that under half of the nursing staff they work with had an understanding of the role (47%), and only small numbers of APs reported that staff in their organisation (21%), patients (23%) and their relatives or visitors (16%) understood the role. Open comments by APs further substantiate their concerns of a lack of understanding about their role (Box 62). The issue of uniforms was brought up on a number of occasions: APs wanted different uniforms so that their role could be recognised and distinguished from other assistant staff (Box 63). Whilst there was an appreciation that a lack of understanding of the role migh be related to the 'newness' of it, some APs felt this might also be related to resistance by staff groups who felt threatened by the AP role (Box 64).

Table 40. Job clarity and autonomy, and staff relationships and support

		Number (%)
Number (%) 'agreeing' or 'strongly agreeing' with these statements	I always know what my responsibilities are	279 (84%)
	I am consulted about changes that affect my work	215 (65%)
	I do not have time to carry out all my work	108 (33%)
	I get clear feedback about how well I am doing my job	188 (57%)
	I can decide on my own how to go about doing my work	225 (68%)
	I often feel pulled in many directions because of my workload demands	215 (65%)
	I have fluctuating responsibilities depending on the shift I am working and numbers of other nursing staff on duty	259 (78%)
	What I do depends on which RN I am working with	187 (56%)
	What I do depends too much on what other nurses say I can do	101 (31%)
	I have a clear job description for my role as an AP	179 (54%)
	Staff that I work with in my ward understand my role as an AP	156 (47%)
	Staff in the wider organisation understand my role as an AP	70 (21%)
	Patients understand my role as an AP	76 (23%)
	Relatives and visitors to the ward understand my role as an AP	54 (16%)
Number (%) answering 'quite a lot' or 'a great deal' to the question 'to what extent can you…'	Count on your colleagues to listen to you when you need to talk about problems at work?	206 (62%)
	Count on your colleagues to back you up at work?	199 (60%)
	Count on your colleagues to help you with a difficult task at work?	246 (74%)
	Really count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?	218 (66%)

Table 41. Perceptions of support from line manager

'My immediate line manager …		Number (%)
Number (%) agreeing or strongly agreeing with these statements	…encourages those who work for her/him to work as a team'	247 (75%)
	…can be counted on to help me with a difficult task at work'	239 (72%)
	…gives me clear feedback on my work'	189 (57%)
	…asks for my opinion before making decisions that affect my work'	170 (51%)
	…is supportive in a personal crisis'	252 (76%)

Table 42. Agree or strongly agree with statements about responsibilities of AP and their relative autonomy (%)

Type of ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	93	113	69	57	332	78	71	112	39	300	
I always know my responsibilities	86	85	84	79	84	73	87	85	95	84	37
I am consulted about changes affecting me	63	69	67	56	65	63	70	62	67	65	47.9
I do not have time to carry out all my work	40	32	29	28	33	26	36	30	54	33	47.2
I get clear feedback about my job	65	59	54	45	57	61	61	49	64	57	49.6
I can decide on my own how to do my work	71	71	70	58	68	71	66	65	82	69	46.4
I often feel pulled in many directions	67	65	62	65	65	55	69	67	74	65	47.7
I have fluctuating responsibilities	82	78	78	75	79	76	79	80	72	78	41.8
What I do, depends on which RN I am working with	57	61	57	52	57	56	57	62	37	56	49.7
What I do, depends too much on what other nurses say I can do	31	43	49	42	41	47	37	41	23	40	49
I have a clear job description for my role	59	59	52	42	55	40	51	59	74	54	49.9
Staff that I work with in my ward understand my role	56	52	36	39	48	31	49	55	67	49	50.1
Staff in the wider organisation understand my role	28	23	10	21	21	19	21	19	31	21	40.8
Patients understand my role	29	21	28	14	23	19	27	26	29	25	43.3
Relatives and visitors understand my role	24	13	22	5	17	14	21	17	21	18	38.4

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

Table 43. Agree or strongly agree with various statements about support they get from management and other colleagues (%)

Type of ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	93	112	69	57	331	78	71	112	39	300	
Recognition I get for good work	63	66	71	51	64	63	66	60	74	64	48.1
Support I get from my immediate manager	84	62	75	61	71	71	72	70	69	70	45.8
Freedom to choose own method of working	62	63	67	54	62	60	59	60	82	63	48.5
Support I get from work colleagues	79	81	86	83	81	83	75	82	90	82	38.8
Amount of responsibility I am given	68	69	72	75	70	63	75	72	82	72	45.2
Number of APs working in my ward/ department	46	49	42	40	45	36	47	48	61	46	50
Opportunities i have to use my abilities	76	67	67	77	71	63	75	75	80	72	44.8
Extent to which Trust values my work	38	34	29	35	34	31	44	27	45	34	47.5
Encourage team working	79	66	85	72	75	77	70	74	79	75	43.6
Can be counted on to help with a difficult task at work	81	63	78	70	72	69	75	72	68	72	45.2
Given clear feedback about my work	67	54	54	51	57	63	52	50	63	56	49.8
Asks for my opinion before making decisions that affect my work	63	47	49	44	51	54	48	50	50	51	50.1
Is supportive in a personal crisis	89	65	81	72	76	80	78	72	74	76	43

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

Box 60: Ward manager support

We have a fantastic ward manager who has supported our role and encouraged us when other staff were fast to pull us down. (AP 30)

When I qualified as a AP I was lucky I had great support from the staff and my manager. My manager has pushed me and encouraged me to develop my role. (AP 272)

Box 61: Fluctuations in AP work

Since qualifying as an Assistant Practitioner I can't say that my role has changed that much, in fact it is quite difficult to say where I actually do fit into the ward team; this depends mainly on who else makes up the team on a day-to-day basis. I have been allocated jobs, roles, to perform only to be told I cannot carry them out, which is very frustrating. (AP 195)

My role is very much 'controlled' by the Matron of the clinic. One day it is acceptable to do a job, then the next day it is not, depending on her mood. [I] always struggle to know what I am to do on a daily basis. I find this very demoralising. Also it is very difficult for the rest of the team to understand

exactly what it is I am 'allowed' to do. This is not a good position to be in, for any of us. At least when I was an HCA people knew my role, and the limitations of it. I feel the role is dependent on the people who are in charge of a given area. (AP 275)
I hate tick questionnaires for they don't give a complete overview of situations. For example, my Ward Manager uses APs as 'glorified' HCAs for most of the time, using our AP skills when it suits, i.e. at times of RN staff shortage. (AP 288)

Box 62: Lack of understanding of AP role
I find myself often having to explain to junior doctors, patients, patients' relatives, what our roles entail. Most consultants know what we do, as they take particular interest when we do ward rounds with them. (AP 127)
The role of Assistant Practitioner is not well known in this area, which makes it difficult for me. I feel people do not take me seriously is when I am handing patients over to another ward they might say, 'when is the staff nurse going to come and hand over?' (AP 161)
I have worked hard to promote my role on my ward, and am always being asked by new patients and their families what my role is due to my 'jazzy epaulettes'. As I am the only AP on the ward, they make me stand out, and I feel this is good, as it makes people ask questions about the AP role. (AP 26)

Box 63: The importance of uniforms
I would just like to take this opportunity to voice my feeling on uniform for Assistant Practitioners. Our uniform is the exact same as a nursing auxiliary who has worked within the trust for one day. Until a new colour uniform is provided the role of AP will always be under-valued; which is very sad. (AP 122)
The trust I work for have been very pro-active in their training of APs and I have been well supported in my role but they refuse to recognise us as APs by not giving us our own uniforms. We work in HCA uniforms and are instantly only recognised as HCAs by all NHS employees except our own Ward Colleagues and also by the patients and patient's relatives. I have been questioned on several occasions as to my professional ability to perform enhanced practice treatments by patients as my uniform denotes HCA status. Despite bringing this topic up at quarterly meetings (which are attended by top management), the trust does not agree that we should be in our own uniforms. Our direct line managers are supportive of us in this quest. The Board Executives fail to give a reasonable and acceptable reason as to why they fail to support us. (AP 160)

Box 64: Resistance to the AP role
Since qualifying as an AP some staff have been supportive but others, I feel, are threatened by my role. I am seen as 'half a nurse'. 'Glorified rubbing rag' has been said! I try to explain my role as fully as I can, but have given up trying now. I work a lot with 'old school' nurses who are against my progression. (AP 23)
My day-to-day working life is spent listening to trained staff explaining how they are the trained members of staff. If that is the case, then why did APs spend 2 years working hard and getting training that is not even recognised? I agree that my training wasn't three years long, but it was a two year course. What a waste of time, money, having skills to be treated like a healthcare assistant. It's a joke!! (AP 300)

The majority of APs reported high levels of satisfaction with (Table 44):

- recognition for their work (64%);

- levels of responsibility (70%) and opportunities for using their abilities (72%);
- freedom for choosing how they work (62%); and
- support they received from their line manager (71%) and work colleagues (82%).

Some of the open comments provide APs' insights into the satisfaction they experience in their role (Box 65). A particular area of frustration for APs in their role related to the lack of consistency and standardisation of AP roles across different areas, both within and across specialities in a Trust and across different Trusts (Box 66).

Table 44.Job satisfaction

		Number (%)
Number (%) moderately or very satisfied with these areas of their job	The recognition I get for good work	211 (64%)
	The support I get from my immediate manager	235 (71%)
	The freedom I have to choose my own method of working	205 (62%)
	The support I get from my work colleagues	270 (82%)
	The amount of responsibility I am given	232 (70%)
	The number of APs working in my clinical ward/department	143 (43%)
	The opportunities I have to use my abilities	237 (72%)
	The extent to which my Trust values my work	113 (34%)
Number (%) that agree or strongly agree with these statements	I often think about leaving this Trust	75 (23%)
	I will probably look for a new job in the next 12 months	69 (21%)
	As soon as I can find another job, I will leave this Trust	33 (10%)
	If I leave my current job, I would want to stay in the NHS	231 (70%)

Box 65: AP role satisfaction

The role of the Assistant Practitioner is exciting and rewarding. The training was hard, but if you put the work in, you get so much back; recognition, more responsibility, and the ability to give total patient care. I'm glad I didn't miss the opportunity to be one of the first APs in the hospital where I work, and would encourage anyone interested in the role to undertake the training. (AP 45)

I am very pleased with my role on the day surgery that I work on now… I am following my role and have job satisfaction. I enjoy coming to work and knowing I go home at night that I have cared for my patient and given the best care to all my patients. (AP 53)

During my 2 years training as an Assistant Practitioner, I encountered much resentment and hostility from many RNs who saw the Assistant Practitioner role as a threat to their position. Nevertheless, after completion of the course I have

adopted a more confident, mature and responsible outlook which gives me endless job satisfaction. My new position has enabled me to take the lead role in many clinical areas. I believe with the future training of mature, confident HCAs, the NHS would benefit greatly in the delivery of a much needed, high quality role, the Assistant Practitioner. (AP 84)

Box 66: Frustrations with lack of role standardisation
The clinical area I work for have a set of surgical procedures that I can scrub for. I have further found out that other areas and Trusts are allowing their APs to scrub for more complex cases. I do find this very frustrating, as I am competent to expand my role. (AP 13)
I feel the role of AP in my Trust is very inconsistent across departments. What APs are allowed to do appears to be down to the ward or department, manager as opposed to clear job description boundaries for the role. (AP 34)
There are grey areas, we are not permitted to administer medication, however O2 therapy, nebulisers and food supplements are prescribed and we can administer those. APs in some areas are allowed to train for cannulation but others aren't in the same hospital. (AP 131)

The APs were less likely to be satisfied with the recognition and value associated with their work by the Trust (Table 43), that is outside their immediate working environment and beyond their line manager and colleagues (34%). Under half (43%) reported being satisfied with the numbers of APs employed in their clinical areas. Open comments suggest that this can create isolation for the APs (Box 67).

Small numbers of APs reported considering leaving their job (21%) or their employing Trust (23%) (Table 44). The main reason provided by those considering leaving their roles was career progression. This is further supported by AP open comments (Box 68). Other reasons (in descending order) included: more pay, feeling unhappy in current position, family or personal reasons, a change of career, entering full-time education, retirement or not wanting to working in the NHS any longer.

APs in specialist units were least likely to show dissatisfaction with their role (as indicated by the proportions thinking of leaving) and those in surgical wards or theatre and 'other' most likely to be dissatisfied (Table 45). The proportions looking for another job increased steadily the longer the APs had been in the post, with about twice as many of those who had been 5 years or more showing disillusionment, and more likely to report wanting to leave the Trust or look for another job, than those who had been in post for less than one year.

Box 67: Role isolation
I am the only AP on the department so I have nobody to discuss and work alongside. (AP 197)
There are too few AP in the Trust for us to make a difference. (AP 39)

Box 68: Lack of career development
The trust I work for will let you do the AP course but there is then no career development. I will have to leave my full time band 4 job. (AP 17)

Table 45. Agree or Strongly agree with various statements about staying or leaving by type of ward and time in current post (percentage)

Type of ward	M	ST	Sp	Ot	All	< 1	1<2	2<5	5+	All	s.d.
N	93	112	69	57	331						
I often think about leaving this Trust	22	28	12	28	23	17	20	26	32	23	42.0
I will probably look for a new job in the next 12 months	18	28	15	19	21	14	18	26	26	21	40.8
As soon as I can find another job, I will leave this Trust	4	14	6	16	10	5	11	13	18	11	31.4
If I leave my current job, I would want to stay in the NHS	66	72	82	62	71	67	82	67	66	70	45.7

Key: M=Medical; ST=Surgical/Theatre; Sp=Specialist; Ot=Other; <1 year; 1<2 years; 2<5 years; 5+years

6.5 Attitudes towards training, learning and development

The majority of APs have had a performance development review or appraisal (70.1%) and reported that it was useful in helping them improve how they do their job (73.7%) and provided a sense of the Trust valuing their contribution (64.7%). However, this still means that over a quarter did not have a review (30.2%) and of those that did a quarter felt it did not influence their job (26.3%) and did not increase their sense of the Trust valuing their contribution (26.3%). A large number of APs have personal development plans (85.8%) and of these over half (52.6%) reported that they had received the training, learning and development that was identified in their plan; 47.4% had not. Under half of APs reported having a mentor (45%). Mentors were predominantly RNs (73.8%). However, problems in negotiating time with a mentor were highlighted (Box 69).

Box 69: Mentorship

I am worried that I have only been in my new role for just over 1 year and am already losing some of these skills. I have had to change mentors 3 times as the previous ones have left. Time with my mentor is very limited on the ward, as the workload and pressures of a busy acute ward has made this difficult to arrange meetings. (AP 249)

Table 46 demonstrates that most respondents were positive about the training, learning and development that they had undertaken and that their organisation valued and supported their development. However, only half (50%) reported on continuing development opportunities being available for them, others expressed concerns about the lack of CPD for APs (Box 70). Open comments revealed that some APs were not supported to continue their development due to financial constraints in their organisations (Box 71). Training was perceived to help them to do their job better (79%), and to stay up-to-date for their job (80%) and professional requirements (77%).

However, under a third (30%) felt the training would improve their chances of promotion. Some of the respondents indicated that they had reached a 'ceiling' and that extra training would not provide any personal financial gains for them (Box 72).

APs completing the foundation degree reported in their open comments that they found it difficult to manage their work-life balance, to ensure they received an appropriate level of mentorship and reported difficulties with establishing their position in the ward team; trainee APs are often still employed as HCAs (Box 73).

Table 46. Attitudes towards training, learning and development

		Number (%)
Number (%) that agree or strongly agree with these statements	The training I received fully prepared me for my role as an AP	216 (65%)
	The skills of staff are developed so that they can improve their job performance	276 (83%)
	The Trust strongly believes in the importance of training	277 (84%)
	People are not properly trained in the Trust when new procedures are introduced	88 (27%)
	Staff are strongly encouraged to develop their skills in the Trust	232 (70%)
	Staff can only develop skills if they are prepared to do it in their own time	87 (26%)
	The Trust only gives people the minimum amount of training they need to do their jobs	85 (26%)
	There are plenty of opportunities for my continuing development	167 (50%)
Number (%) that agree or strongly agree with these statements with regard to training in the past 12 months	Your training, learning and development has helped you to do your job better	261 (79%)
	It has improved your chances of promotion	99 (30%)
	It has helped you to stay up-to-date with the job	266 (80%)
	It has helped you to stay up-to-date with professional requirements	256 (77%)

Box 70: Lack of CPD for APs

I thoroughly enjoy my role as an AP, however, I sometimes find there is a lack of study days aimed towards people doing this role. Most study days are for RNs and Support Workers there is no middle ground for APs. I have not attended an AP study day since I completed the training for my role. (AP 110)

I find APs don't get put on as much training as staff nurses and feel this is unfair as I constantly get people saying 'you are just as valued as a RN', but then don't get given the same opportunities. (AP 194)

After finishing the [foundation degree] training, I have not received any ongoing training. RNs are offered ongoing training and courses to expand and enhance their knowledge and qualifications. The Trust paid for my A1 NVQ assessor award, only because it is part of our job description and a cheap alternative to outside assessors. My job has not developed or expanded in the 5 years I have been a qualified AP. This is very frustrating. (AP 220)

Box 71: Limited ongoing organisational support
I enjoy my role, but due to family circumstances, I cannot afford to fund further training myself, and was disappointed when, on completion of my foundation degree, I was offered the chance to do a further 18 months to obtain a BSc Honours Degree in Rehab studies. But the Trust would not fund this. I was told that I had had my funding and it was someone else's turn now… I do feel that there should be more opportunities to progress further, but at the present time, that does not appear to be the case. (AP 26)
I have also found that continuing my professional development has become difficult, I would like to be seconded by the trust to complete my registered nurse training but have found that they do not want this, as I am cheaper for them to remain as I am, also I have been told that due to financial difficulties in the NHS there is no money to second me. (AP 112)

Box 72: 'Ceiling' effect
I cannot go any further now in my AP role, I have hit the ceiling so to speak! I can do further study days to get more skills, but it doesn't give me any more money. (AP 127)
Although I found the Diploma beneficial to my role as an Assistant Practitioner, a year down the line barriers have arisen in certain areas of my role, which has been increasingly frustrating!! Since my appraisal at the end of last year I have decided to put in to do my nursing training, as there is no further career developments available in the present post. (AP 355)

Box 73: The challenges of making the transition from HCA to AP
The problem I have found is work-study-home life balance. I work full time: 37.5 hours and 1 day a week at university for this role. Days off I have to use for study and coursework. We have no supernumerary status on the ward, so I am counted in the staff template as an 'HCA'. When on shift I have two roles to play: one as an HCA and one as trainee associate practitioner. I feel I have to split myself in two. If I work with my mentor the HCAs are waiting for me to help them and vice versa. (AP 57)
A student nurse will be taken under the wing of a mentor, a RN, and shown the procedures as they will need them 'when they gain their registration' and the trainee AP is relegated to making beds etcetera, as they are the only HCA on shift. If a RN does show or explain a procedure then generally the full explanation is not completed as another nurse will ask you, as the HCA, to carry out normal HCA tasks. (AP 58)
Since embarking on the Foundation Degree at university, 2 days out of my working week, no problems arose having the study days allocated to me. I feel the problems arose on the days I was on duty. I had ongoing competencies to acquire throughout the 2-year course. However, when on duty I was treated as if I was in a HCA role and given little opportunity to work with my mentor. . (AP 186)
My main concern as a trainee AP is when on the ward you are not seen as a student and are not taken out of the numbers. You have to do your usual duties alongside putting in extra learning to enhance your role and knowledge. Student nurses are not in the numbers on shift and everybody recognises that they are 'students' and clearly get more provision for training and development. (AP 258)

6.6 Summary

This chapter has described, for the first time, the national AP workforce in Acute NHS (Hospital) Trusts in England. In particular,

who they are, what they do, how they are prepared for their role and their experiences of developing within a relatively new role. In doing so, these findings further substantiate and develop findings from the case study fieldwork. Personal characteristics of the national survey respondents were very similar to the APs in the case study sites. APs were (in the main) aged over 40 years, female and identified themselves as British white. They also demonstrated considerable length of service with the NHS prior to their appointments as an AP, the majority having worked over 10 years

There is some fluidity of job titles and preparation for the role. Not all assistants working at this level have the same title: over a quarter reported having some other title. Most APs reported completing a National Vocational Qualification (NVQ) or a Foundation Degree (FD), however other qualifications for the role were cited. Importantly, the respondents indicated lack of standardisation of pay bands across Acute Trusts: APs were not always banded at the same level on the Agenda for Change framework. These issues might contribute to the confusion that was perceived to accompany the introduction and development of the AP role.

The APs reported their contribution to care delivery and the processes associated with this, such as assessment and planning, written and verbal communication. They also indicated their contribution to continuity of patient care. Medicine administration was not a feature of AP work: this is covered in the case study findings and identified as a key area of practice differentiation between RNs and APs (Chapter 5). Type of clinical area and length of time in post influenced the types of activities reported by APs: APs in post over 5 years were more likely to report their involvement in examinations of patients and in administrative duties whilst those in post less than 1 year were, perhaps unsurprisingly, less likely to report their involvement in supervising others. Variations in activities and development of these over time relates to the negotiations that were identified in the case study fieldwork. In addition, APs identified fluctuations in their activities and work responsibilities dependent on numbers of available RNs and which members of staff they worked with on a particular shift. This was a feature of the APs' work in the case studies (Chapter 5). APs were likely to agree that they understood their responsibilities but many (almost half) reported that they did not have a job description. Most APs felt supported in their roles by their colleagues and their immediate line manager. However, there were variations across the specialities, with APs in medical wards expressing most satisfaction with the support they received. Whilst APs felt supported at ward-level, the majority considered the role was not recognised or valued in their organisations.

The role was viewed by most APs as filling a skills gap in ward-based nursing care and supporting RNs to focus their skills on more complex patient care. APs were less likely to agree that they could substitute for RNs, indicating differences in the perceived roles of

these staff. However, concerns were expressed about the ongoing lack of understanding of the AP role and APs reported that their skills were not fully utilised. This was attributed to the failure of work colleagues to recognise their changed status from HCA to AP in the same clinical environment, reluctance of RNs to delegate tasks because of concerns about accountability and concerns about the AP being an unregulated and non-registered role. AP respondents were clear that some form of registration and regulation was important for the future development and integration of role.

Undoubtedly, the AP role was recognised as offering a career progression route for assistant staff. However, concerns were expressed about the opportunities for continued development and progression for these staff. There was a perception that APs reached a 'ceiling' that limited their opportunities to progress unless they undertook a registered practitioner course. This was also expressed in the case study findings.

7 Main headlines and conclusions

7.1 Introduction

This study was concerned with understanding the introduction and development of a relatively new type of assistant worker: the assistant practitioner. Whilst assistant practitioner roles are being introduced and developed across a variety of health and social care settings, we were particularly concerned with understanding AP roles being developed to support the delivery of patient care by ward-based nursing teams in acute hospitals. We used a case study approach (three NHS Trusts provided the context for fieldwork) and mixed quantitative and qualitative methods to gain in-depth understanding of:

- key drivers informing changes in the nursing workforce and development of the AP role to support RNs in acute hospital wards (national and local policies, organisational documents, research evidence, interviews and focus groups);
- tasks and activities that APs are undertaking in the ward setting (questionnaires, observations and interviews);
- organisation, management and supervision of AP roles in wards (interviews, focus groups and questionnaires);
- influence of introduction of AP roles on the practice, activities and workload of RNs, existing nurse support workers (e.g. HCAs) and roles in the wider clinical setting (e.g. therapists, managers) (interviews, focus groups, observations and questionnaires);
- relationships between formal policy (national and local) expectations of AP roles and local practice in a hospital and ward;
- factors that facilitate or act as barriers for development of the AP role;
- potential impacts of the introduction of APs on quality of patient care, staff recruitment and retention, career development for support staff and staff well-being (non-participant observations of activities of the nursing team and their interactions with patients, questionnaires, interviews and focus groups).

As explained earlier (Methods, p.46), we were not able to address staffing costs within this study of the AP role due to a lack of organisational data specific to this category of staff.

In addition, we used these case study findings to develop a questionnaire, administered nationally to ward-based APs working in

acute hospitals in England, to explore wider introduction and development of AP roles and, in particular, to gain understanding of:

- personal characteristics of APs;
- their actual roles and responsibilities in practice;
- factors that helped or hindered their integration into existing ward-based nursing teams;
- supervision of the role and lines of responsibility; and
- career opportunities and organisational support for the role.

Importantly, our approach enabled us to gather the views of various key stakeholders (including RNs, HCAs, ward and senior managers, other roles in the wider clinical team and APs themselves) and to explore potential tensions between policy expectations, what people say APs do and what they are observed to do in practice.

The review of existing literature and policy highlighted that, to date, there is very limited evidence about the potential contribution and impact of AP roles in ward-based nursing teams. The study of these AP roles is therefore important and timely. We outline here our reflection on our approach and methods and then the main headlines from our research, discussing the potential contribution of these findings to the future introduction and development of AP roles in these settings.

7.2 Reflections on research approach and methods

A multiple case study design was selected as being the most appropriate because we were able to study the introduction and development of AP roles in depth and in context, using a range of methods and incorporating varied stakeholders. Representativeness of the findings may be questioned. However, the organisations were purposively sampled based on a range of characteristics, such as length of time APs had been employed, variability of clinical areas utilising the AP role, differences in numbers of APs employed and different geographical characteristics. Importantly, these organisations were also willing to co-operate and internal key stakeholders offered their support for the research to be carried out. Interestingly, and contrary to our original expectations, it was the various stakeholders sampled from within the organisations that demonstrated variation in their perspectives of the AP role (for example senior managers compared to ward managers) rather than findings being context specific, despite variations in introduction of the role in each case site. In the second stage of the study, we moved beyond in-depth scrutiny and described the national perspective of ward-based APs working in acute care. These findings further substantiate case study findings. Finally, considering these findings within the context of the literature and policy documentation

provided wider contextualization of the findings and the ability to draw out main lessons from the study findings.

Our research followed the original brief and answered most of our original aims and objectives. Our findings are limited in that we were not able to provide evidence of the impact of AP roles on patient care outcomes or staffing costs in these contexts. Limited numbers of APs in these organisations and limited opportunities to work collaboratively with Human Resource departments, prevented the use of some of our originally proposed methods to address these concerns. As the AP role develops and becomes more established it will be possible to investigate these important issues and to study cost effectiveness of these roles in future studies. However, we have been able to describe for the first time the possible ways that APs impact on the processes of patient care, service delivery and nursing teamwork and have the potential to influence, and benefit, the quality of care experienced by patients. We did not specifically gather the views of patients for this study. Instead we used a structured observation instrument (Qualpac) to understand interactions between patients and different members of the nursing team. Given APs represent a new role development, our concern was with organisational context and how this mediated the role of the AP rather than how patients viewed their interactions with APs. Such a focus was felt to give more substance to understanding what an AP does and the various negotiations involved in mediating this. Future studies, however, could usefully look at the patient and carer experience of care delivery by different members of the nursing team. We recognise some potential limitations in use of the Qualpac instrument for the study including: judging what should be considered an interaction between a patient and the member of staff (some interactions were very brief); using the same researcher to gather observation data because we were unable to recruit RNs from the organisations; use of the 'average' category for the majority of observations (a limitation highlighted in other studies using this instrument); and having to gain written consent from all patients when observing their interactions with staff so that staff and patients were then aware that they were being observed and there were challenges in gaining written consent from patients in certain clinical units (for example acute stroke units).

We also recognise that contemporary development of AP roles is not restricted to acute hospital wards and the support of registered nurses. AP roles are developing across a range of health and social care settings, supporting the work of a range of registered practitioners. However, we believe that the rich description and transparency of our research will enable readers to judge the transferability of these findings to their own practice settings and organisations and that some of these findings will be relevant to other contexts.

7.3 Main headlines and conclusions

We had the privilege to study the AP role in its early stages of development. In essence, we have conducted a study of the realities (both the challenges and opportunities) of introducing the ward-based AP roles in acute hospitals as they occurred in practice and have been able to capture the ways in which organisations dealt with managing the introduction of this new initiative. In addition, our approach has enabled us to feedback interim findings to organisations about the potential impact of the role within their organisations. This contribution to organisations was valued by participants, particularly since organisations were grappling with the introduction and development of the role. In conducting the research and feeding back we acknowledge that we may have influenced some of these organisational developments and stimulated discussions about the role within these organisations.

Our findings will make an important contribution to future directions for the AP role and its subsequent development; we would argue that it is important for policy makers, managers and practitioners to learn from these experiences to plan for any future introduction and development of the role.

7.3.1 National and local policies for AP roles need to be developed to promote direction for role development whilst maintaining flexibility and scope for local discretion

Key findings

- Organisations were developing AP roles with little national policy guidance;
- AP role introduction was mainly driven by external pressures from Strategic Health Authorities rather than perceived organisational need;
- Analysis of job descriptions suggested confused organisational interpretations of the AP role and in particular the extent to which the role was envisaged as an 'assistant' or 'substitute';
- Various job titles and forms of training have contributed to ongoing confusion about the role;
- Pay bands were not standardised for APs;
- APs were clear that some form of registration and regulation was important for the future development and integration of the role

There was sparse national policy guidance on the AP role, either from the Government or professional bodies, for the organisations that took part in the study when planning the introduction of the role.

Therefore, the 'shape' of AP roles has been locally determined; we have presented the AP role as it was being developed in three very different ways in three organisations. Whilst these organisations appreciated the opportunity to exercise some discretion over the ways in which the AP role developed within their organisations they indicated that they would have welcomed clearer guidance on certain aspects of the role. In particular, organisations felt they required guidance because they were trying to implement a workforce policy initiative that was perceived to be largely driven by external pressures from Strategic Health Authorities rather than organisational need.

Recent policies have emphasised the importance of ensuring optimal numbers and mix of staff for ensuring productivity, efficiency and quality in the health service. However, there is little guidance specific to the role of APs in this agenda, such as proposed numbers (especially minimum numbers) or whether there is a role for a Band 4 worker in all clinical wards and level of training or educational preparation for the role. The extent to which the national vision for the role is one of 'assistance' to, or 'substitution' for, registered professionals is also unclear. This confusion translated into organisational job descriptions and was also apparent through use of varied job titles and forms of training, as well as the lack of standardisation of pay bands.

Further, and importantly, despite many years discussion, there are no recommendations about whether assistant staff working at the level of Band 4 (APs) should be registered or regulated. APs themselves have stated that they would like to be regulated to provide protection for patients, protection for themselves and increase their sense of responsibility, increase RN and other health care professionals' confidence in the role and enable APs to expand their practice. Currently, APs feel vulnerable carrying out their work without any regulatory framework. The lack of decision on regulation had led to the development of some scepticism amongst APs who have been in the role for several years. Our findings suggest that accountability and management of the AP role are key concerns for the future development of these roles and guidance on these issues is required by managers in organisations who are introducing and developing these roles. Perceived benefits for registering APs were recognised however, there were also concerns relating to whether registration would reduce flexibility of the role, an attribute which makes it attractive to many organisations. The means by which registration would be achieved were not clear and further complicated when APs worked across professional boundaries.

7.3.2 The AP role is determined by 'negotiated compromise' among key stakeholders in practice

Key findings

- Organisational visions for the AP role were poorly communicated to staff in practice;
- The 'shape' of the AP role was negotiated in practice by key stakeholders and was influenced by the relationships that existed between RNs and individual APs;
- Filling a skills gap, APs were described as 'in-between' the role of RN and HCA

The lack of clear job descriptions within organisations, alongside poor communication of the organisational vision for the AP role, has led to it being determined through 'negotiated compromise' by various stakeholders, including APs themselves. The AP role has largely been recognised and established through negotiation in the ward environment and socialisation whilst in post upon completion of their training. The *ad hoc* development of the role means that these roles can support patient needs within particular specialities but this has also led to wide variations in the remit of these roles both within and across organisations. Without clear guidance from senior managers, ward staff reached their own decisions about the 'acceptable' role for an AP within a speciality. The AP role in ward-based nursing teams had developed into a role 'in-between' that of RN and HCA; introduction of the role was not generally viewed as an opportunity to develop something new to support the delivery of patient care. Even within the one organisation that had used the role to support the patient journey (case site 1) there was a general sense that the post-holders had to first complete nursing duties before undertaking any therapy duties. This in-between status constituted a compromise that decreased recognition of the ways in which the role might contribute to patient care and support ward nursing colleagues.

7.3.3 Lack of AP role clarity leads to opportunistic role development at ward level

Key findings

- Fluctuations in APs work responsibilities and activities was dependent on the numbers of available RNs and individual relationships between APs and staff
- APs complemented RN work and, in some circumstances, they substituted for RNs and other registered practitioners
- RNs demonstrated reluctance to delegate tasks because of concerns about accountability and APs being unregulated and non-registered

Lack of standardisation of the AP role and lack of organisational clarity meant that the APs role had potential opportunities to continue to develop in practice. Lack of clarity meant that at certain times APs could be asked to take on additional duties that may not have been considered within the original remit of the role by the organisation. APs could be described as a 'flexible pair of hands' who could respond to requests to take on additional duties. The opportunistic development of AP roles occurred at times of staffing shortages – this could be for a particular shift or reflect variations in staffing during the week and weekend or day and night shift – and was also dependent on the relationships that existed between the APs and other members of the nursing team. APs were often promoted within the same ward that they had worked as HCAs. They had established trusting relationships with RNs and this played a significant part in determining what APs could and could not do. The willingness of RNs to delegate work to APs was a major determinant of the ways in which the roles developed and as such influenced the wide variations in roles for these staff within and across organisations. The only areas of patient care identified in the study that remained the RNs sole domain were medicine administration, bed management, nursing assessment and diagnosis, and ultimate responsibility and accountability for patient care. Most other areas of nursing work had been transferred or migrated to the AP role, albeit to varying degrees within and across wards and organisations. We would argue that it is this ultimate responsibility and accountability for patient care, and the decisions that RNs make associated with that care, that are the key differentiating factors between the roles of RNs and APs.

7.3.4 Realisation of the AP role is largely determined by stakeholders

Key findings

- The focus of organisational support for AP role development was largely focused on individual APs rather than supporting staff to integrate the new role
- The success of the AP role was largely dependent on the 'vision' of nursing teams about the potential contribution of APs
- Outside of the APs' immediate teams, there was ongoing confusion about the role in the wider organisations

We have highlighted that the AP roles have been developed in three very different ways across the three organisations. However, we were struck at how many similarities there were in terms of the opportunities and challenges faced by all the organisations when introducing and developing the AP role. We therefore propose that the AP role is largely determined by the various key stakeholders rather than context. In all case sites there were splits between the

senior management (organisational) vision for the AP role and then how the role was recognised at ward level by ward managers and members of the nursing team (including APs themselves). Different stakeholders have different priorities and it is the priorities of the ward based staff that have largely shaped the AP role in practice. Importantly, there were suggestions from participants working at all levels that the role of APs was not well understood within and across organisations. Any lack of understanding of the AP role could have been clarified through careful planning and management. It is not entirely clear from our study whether or how senior managers tackled misconceptions and resistance to the AP roles or whether the various stakeholders had vested interests in maintaining a lack of understanding of the role, for example to protect areas of RNs' work or maintain the status quo rather than engaging in skill mix discussions. Of particular interest is what leaders and champions for the AP role chose to lead on: the focus was usually on supporting individual APs through their training rather than supporting the organisations in managing the introduction of this new role. Many of the APs developed within the same clinical environment said that they had worked as HCAs prior to taking on their AP role. Managing the transition of this worker is therefore dependent largely on what the ward's nursing team thinks of the AP role, as compared to the HCA role, and their vision of the potential contribution the role could make within the ward team. Targeting ward staff and supporting and managing these transitions seem an obvious area for future successful development of these roles. Future developments of the AP role should target these various stakeholders to support implementation and those organisations planning to introduce the role should consider how to support the whole organisation rather than just individuals.

7.3.5 The potential contribution of APs to patient care is not always realised or maximised

Key findings

- APs were generally perceived to make a valuable contribution to care delivery processes, being 'visible' and 'knowledgeable' at the patients' bedside
- APs provided leadership for the assistant workforce and also supported newly registered nurses and student nurses
- APs tended to be white British females in their mid-forties, with considerable experience of the NHS as healthcare assistants
- APs were mainly 'home-grown' and the role was used as an opportunity to reward 'stars' of the assistant workforce
- APs were not always fully utilised to contribute to patient care

Our activity analysis and non-participant observation revealed that APs provided substantial proportions of fundamental care to patients at the bedside. They were 'visible' to patients, using their knowledge and initiative to complement the work of RNs in patient care delivery: assessing and recognising patient deterioration, providing advice to patients and supporting relatives, understanding the holistic nature of patient care, providing continuity of care to patients and releasing RN time to ensure they could focus on more acutely ill patients. The APs role in providing leadership for HCAs was viewed as promoting standards and quality of care delivered to patients by all assistant staff. In some situations, they provided timely interventions for patients (for example carrying out a procedure for a patient rather than the patient having to wait for a RN or doctor) and could promote flexibility and choice for patients, although this was context specific (for example in case site 1 the APs could use therapy skills to promote timely discharge for patients post surgery). APs tended to be 'home-grown' and 'stars' of the assistant workforce, recognised for the extended periods of service and experience within the NHS (and often the same organisation) and for their interest in patient care. However, it was expressed by various stakeholders that the potential contribution of APs to patient care was not always realised or maximised.

APs existed in small numbers in all of the clinical areas studied and for this reason, their potential contributions to overall patient care were limited. In addition, there were suggestions from a range of stakeholders, including RNs, that the AP role and their skills were not fully utilised by RNs within the ward environments to maximise their potential contribution. The ways in which nursing work was structured (such as team nursing) or tasks that were considered the domain of another professional group (such as cannulation or catheterisation) restricted the potential contribution of APs to patient care in some ward environments.

Whilst the AP role could generally be perceived as a beneficial initiative - the study highlights APs' potential contribution to the process of care delivery - we are limited in what we can conclude about their impact on outcomes for patients due to the small numbers working on individual wards.

7.3.6 There is a danger that APs will reach a 'ceiling' in their role, with limited opportunities for development and promotion

Key findings

- Assistants training as APs were not expected, nor were they encouraged, to go on to registered nurse training

- The AP role has offered career progression for some assistants, but concerns were expressed about ongoing opportunities for their development and progression for these workers
- APs may be limited in their opportunities for career progression

The AP role provided a career progression route for assistant staff but was generally presented as a route for those unable or unwilling to commit to registered practitioner training, rather than as a stepping stone to professional training. APs might potentially be disadvantaged in their career progression if organisations limit opportunities for their continuing development beyond this role. Upon completion of AP training there is a lack of specific continuing professional development (CPD) opportunities for APs: courses for RNs being too advanced but assistant training too basic. APs also reported lack of mentorship and guidance for planning their continuing development. This raises issues of equity for continued development of this group of assistant workers when compared with other staff groups (RNs and HCAs).

The work-based preparation of APs and lack of standardisation of educational preparation also raises issues about the ease of transferability of the AP role both within and across organisations and specialities. APs may potentially be limited in their opportunities to apply for another AP role in another ward or organisation. The lack of a national model for this level of worker may hamper their development and prevent opportunities for these staff to transfer their skills and develop. As such, this valuable resource may not be fully utilised and developed to support patient care and service delivery among ward-based nursing teams.

7.4 Conclusions

Any new role takes some time to establish itself and all three fieldwork sites, in their different ways, were struggling to establish the role of APs. Our national survey of APs also highlights the opportunities and challenges that APs themselves are experiencing when trying to establish their positions within ward-based nursing teams. Learning from these struggles is likely to be valuable for other Trusts, who might be contemplating or in the early stages of introducing this relatively new role. Our conclusions also highlight a range of organisational and individual tensions raised by the introduction of the AP role. How these are resolved, whether through implementation of formal policy initiatives from the central government or through more local policy initiatives that are sensitive to specific contexts, will mediate the development and definition of the AP role. Much of this has yet to be worked through and to this extent our evaluation is concerned with 'work in progress', while debates about the AP are still ongoing.

7.5 Policy and practice implications

- National clarification of the broad aims of the AP role to reduce confusion and highlight potential areas of benefit to organisations and to patient care, while allowing flexibility for local role development;
- Within organisations, when APs are considered and introduced, local leaders should ensure clarity of roles and good communication across the organisation so that APs are integrated within a nursing team;
- Local and national standardisation of the training and educational preparation of APs to support the development of practice-focused APs with skills and competencies that are transferable within and across contexts;
- Local consideration of policies and processes for AP recruitment to ensure fairness and equity;
- In practice, APs should be supported by registered nurses and other colleagues to work at their level on the career framework and to their level of skill and competence;
- Local and national consideration of continuing development opportunities for APs to support their career progression and aspirations;
- National policy guidance on regulation and registration of APs.

7.6 Future areas for research

- Evaluation of the AP role in other contexts such as other clinical areas in acute care, primary and community care and mental health;
- Studies of the impact of APs on patient outcomes;
- Studies of the cost effectiveness of the AP role across a variety of service contexts;
- Development of sensitive measure of nursing care quality for contemporary nursing practice.

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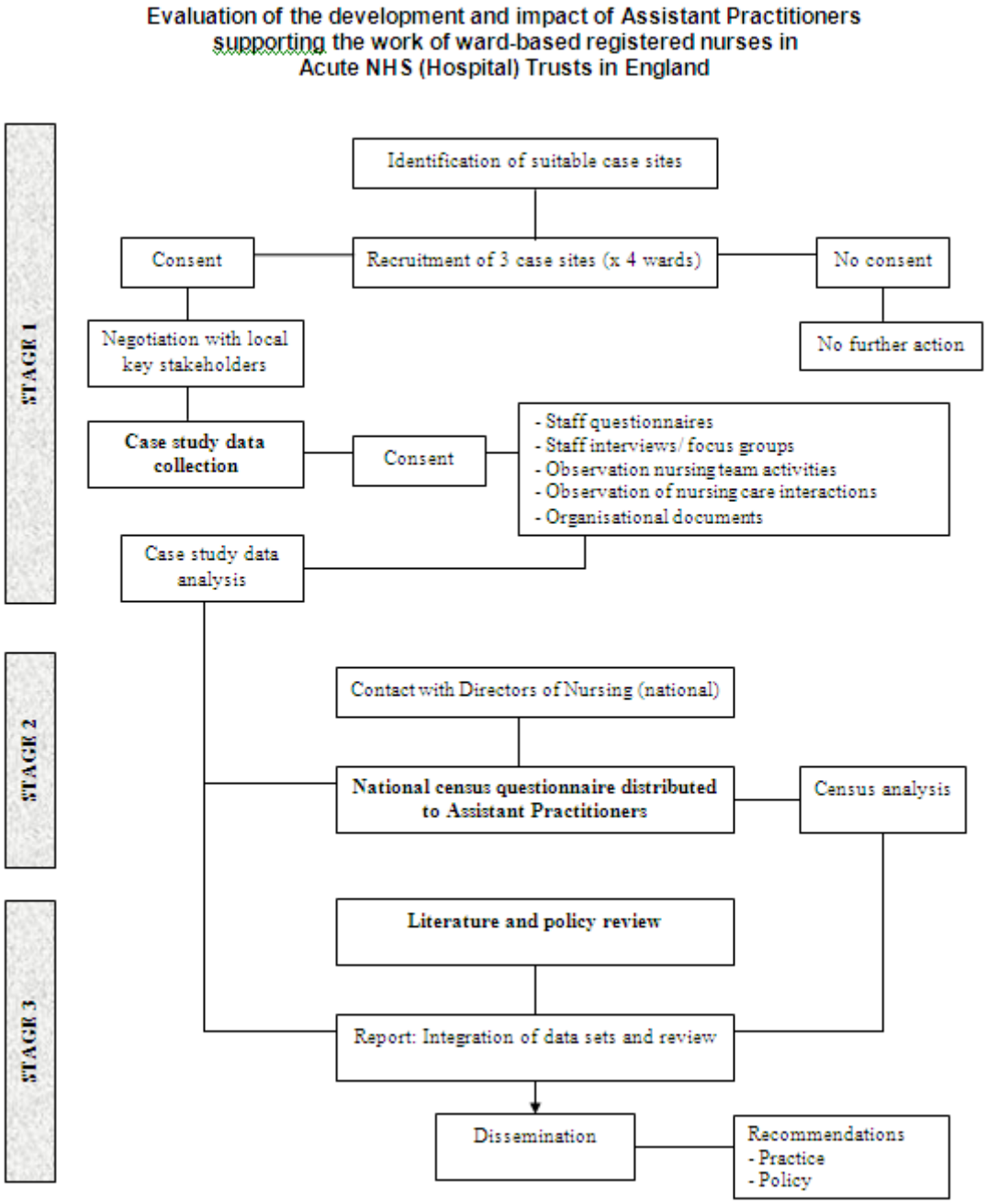
Appendix 1 Overview of the study



Appendix 2 Detail of clinical divisions in each case site

Case site 1

1) Surgery

a) Specialist

- **Burns & Plastics**
- **Breast Surgery**
- **ENT**
- **Maxillofacial Surgery**
- **Orthopaedics**

b) General

- **General Surgery**
- **Urology**
- **GI Services**
- **Paediatrics**
- **Obstetrics**
- **Gynaecology**
- **Lithotriptor Unit**

2) Medicine

- **Adult Medicine**
- **Emergency Services Disablement Services**
- **Rehabilitation**

3) Heart and Lung

- **Cardiology**
- **Respiratory Medicine**
- **Vascular Surgery**
- **Transplant**
- **Cardiothoracic Surgery**
- **Thoracic Medicine**

4) Clinical support

- **Sterile Services**
- **Pathology**
- **Radiology**
- **ICU**
- **Outpatients**
- **Anaesthetics**
- **(Cardiothoracic/ General)**

Case site 2

1) Surgical

- General Surgery
- Urology
- ENT
- Ophthalmology

2) Medicine

a) Acute

- Accident & Emergency
- Acute Medicine
- Care of the Elderly
- Medicine
- Clinical Infection Department
- Critical Care Services
- Diabetes/Endocrinology
- Gastroenterology

b) Speciality

- Dermatology
- Haematology
- Radiotherapy/Oncology
- Nephrology
- Rheumatology

3) Neurosciences

- Neuro-radiology
- Neurology
- Rehabilitation Unit
- Neurophysiology
- Neurosurgery
- Disablement Services Centre

4) Cardiothoracic Services

- Cardiology
- Cardiothoracic Surgery
- Cardiac Anaesthesia/Intensive Care

5) Women and Children

- Gynaecology
- Obstetrics & Neonates
- Paediatrics & Community Child Health
- Gynaecology Services
- Maternity Services
- Children's Services
- Neonatal Services
- Obstetrics & Gynaecology
- Paediatrics & Neonate

6) Trauma

- Orthopaedic - Elective
- Orthopaedic - Trauma
- Oral Surgery & Orthodontics
- Plastic & Reconstruction

7) Anaesthesia and Theatres

- Anaesthesia
- ICU
- CICU
- Pain Management
- Sleep Service

Case site 3

1) Surgical
- Theatre & Day Surgery
- Anaesthetics
- Chronic & Acute Pain Service
- Critical Care
- Trauma & Orthopaedic
- Physiotherapy Service
- Vascular
- Colorectal
- Upper GI
- Breast
- Urology
- Ophthalmology
- ENT
- Oral & Maxillio Facial

2) Medical
- Gastroenterology
- Emergency Department
- Renal Service
- Dermatology
- Cardiology
- Respiratory
- Rehabilitation
- Diabetes
- Neurology
- Rheumatology
- Acute Medicine

3) Women and Children
- Obstetrics
- Midwifery
- Gynaecology
- Acute Paediatrics Community Paediatrics
- SCBU/NICU
- Clinical Genetics

4) Diagnostic and Specialist
- Oncology
- Psychology
- Dietetics
- Radiology
- Pathology
- Pharmacy
- Palliative Care
- Clinical Haematology
- Medical Physics
- Medical Photography
- Private Patients

Appendix 3 Researcher descriptions of the AP roles by sampled ward in each case site

Case site 1: Description of AP roles within 4 sampled wards (December 2007 to March 2008)

Ward 1 APs undertake a wide variety of nursing care activities in this ward, including standardised assessments and protocol-based clinical care (the Trust uses 'Pathways of Care'), including admission and discharge of patients. The patient care requirements of this ward include observation and delivery of fundamental care post surgery. APs report on patient care and transfer patient information via nursing handover and care documentation. All patient care documentation completed by an AP is countersigned by a RN. APs are involved in discussions of patient care with relatives and other health care professionals. The ward does not have 'formal' medical ward rounds and so there is no opportunity for APs to contribute to these. APs escort patients between the ward and theatres (pre and post surgery). APs do not administer medications. If physiotherapists were not available (such as outside 9am to 5pm working hours), then APs could carry out assessment of patients prior to discharge (for example a patient's ability to mobilise up and down stairs, or fitting crutches for a patient). If these activities were not performed by an AP then the patient would require an overnight stay to be assessed by a physiotherapists the following morning prior to discharge.

Ward 2 Nursing APs on this particular ward have been trained to deliver both nursing and therapies to patients requiring rehabilitative care. The role was realised in practice: APs were observed to deliver therapy to patients whilst providing everyday fundamental nursing care. It had originally been envisaged that this type of role would be particularly useful at the weekend when therapy teams were not at work. However, the opportunities for the role to work in this way were hampered by some operational and organisational issues (these are discussed in the findings section). APs do not administer medications. However, APs were able to carry out some activities that some RNs on this particular ward did not undertake, such as cannulation, phlebotomy, carrying out ECG tracings and catheterisation. APs were also sometimes called to other wards to assist with these tasks when these wards had no registered staff on duty who were competent to perform these activities. APs were observed to initiate patient care plans with the approval of RNs. One AP also had responsibility for assisting with assessment of the suitability of patients referred for rehabilitation from A&E and other wards. All APs were involved in documentation of patient care (counter-signed by a RN), the transfer of patient information at nursing shift handover, and discussions with relatives and other health care professionals, as well as admission/discharge and referrals. APs rarely participated in medical ward rounds but had a representative present at the weekly multidisciplinary meetings.

Ward 3 There was one AP on this ward. The AP was involved in all aspects of fundamental patient care. APs do not administer medication. It was generally expressed (by ward staff) that the AP role was not being utilised to its full potential. The AP generally worked with a RN delivering care to a group of patients. However, at weekends (particularly Sundays) this changes with the AP being allocated their own group of patients to care for. The AP on this ward has competencies in wound care and nutrition and was undertaking a cannulation competency during the period of data collection. RNs and HCAs were observed consulting the AP on both nutritional issues and on wound care. The AP was sometimes requested to complete activities on other wards (such as catherisation). The AP was involved in documentation of patient care, the transfer of patient information at nursing shift handover, and discussions with relatives and other health care professionals as well as admission/discharge and referrals. All care documentation was countersigned by a RN. The AP did not participate in medical ward rounds.

Ward 4 Nursing APs on this particular ward have been trained to deliver both nursing and therapies to patients requiring rehabilitative care. However, during the observation period it did not appear obvious how the APs were able to use their therapy skills with patients: they appeared to be under utilised. APs were mainly responsible for fundamental patient care. They were also observed carrying out tasks that some RNs did not have competencies in, such as cannulation, phlebotomy, carrying out ECG tracings and catheterisation. On occasions, APs from this ward were sent to assist with these tasks on other wards. The APs did not administer medications. All APs were involved in documentation of patient care (counter-signed by a RN) and discussions with relatives and other health care professionals, as well as admission/discharge and referrals. APs rarely participated in the transfer of information at nursing handover, did not participate in medical ward rounds but had a representative present at the weekly multidisciplinary meetings. This ward was the only ward observed (and more widely that researchers were aware of) that requested an AP to cover a bank shift: all other wards requested RNs or HCAs.

Case site 2: Description of AP roles within 5 sampled wards (April to July 2008)

Ward 5 The AP role had been developed to undertake a variety of nursing activities. The AP took their own patients under the supervision of the co-ordinator (a RN), typically those who were of lower dependency (category A), although they were occasionally seen caring for more dependent patients (category B and C). The AP provides comprehensive care for the patient, and although unable to administer medications alone, was observed dealing with, and dispensing, medications alongside the co-ordinator. However, this AP retained some aspects of their HCA role: being responsible for the stock and ordering on the ward, and also working with patients

in the Exercise Testing Room with the Coronary Nurse Specialist. The AP was involved in documentation of patient care and transfer of patient information via handover and care documents. This was counter-signed by the RN co-ordinator. The AP was also responsible for interpreting ECGs and lab results for their patients and informed Consultants and/or Co-ordinators of any anomalies. The AP was involved in discussions of patient care with consultants, other health care professionals and relatives as well as taking handovers from A & E and from helicopter and/or ambulance crews. During the observation (and by conversations with staff) it became clear that the extended catchment area had led to an increased number of highly dependent patients resulting in limited possibilities for the AP to be allocated patients.

Ward 6 APs on this ward were responsible for the fundamental care of the patients in any of the low dependency bays. They were also responsible for tasks such as simple dressings or, but did not administer medications. One of the registered staff administered medication on the requests of the APs. During our observations the APs were seen to prepare IV fluids but not connect these to a patient, and disconnect IV fluids but not flush cannulae. The AP documented patient care, made referrals and carried out assessments and discharges for patients. All documentation was counter-signed by registered nursing staff. The APs did not have the competencies to escort patients to, or back from, theatres. They did not attend the medical ward round but were seen to discuss patients with relatives and other health care professionals. Some of the APs had developed specialist knowledge in some areas - for example wound and stoma care. All the APs planned to spend 4 weeks with the stoma care specialist in the clinic to develop these skills further.

Ward 7 One AP worked on this ward. Typically the AP would take one bay of patients and be supervised by the co-ordinator (a RN) who would administer medications to patients being cared for by the AP. The AP would be responsible for the fundamental care of the patients in the allocated bay as well as for checking surgical drains and simple dressings, including packing of wound sites and stoma care. The AP performed tasks such as cannulation (including flushing of these), phlebotomy, bladder scans, and catheterisation. During our observations the APs were seen to prepare IV fluids but not connect these to a patient, hang drips (not connecting), disconnect IV fluids, change the drip speed of these fluids and remove cannulae. The AP documented patient care, made referrals and carried out assessments and discharges for patients. All documentation was counter-signed by registered nursing staff. The AP attended the medical ward round and was seen to discuss patients with relatives and other health care professionals both face to face and on the phone. The AP also handed over information about patients and their care to subsequent shifts of nursing staff. During the team's observation sessions this AP was sometimes allocated to supervise and mentor first year Student Nurses.

Ward 8 One AP worked on this ward. Typically the AP would care for 2-6 patients (usually in the same bay) whilst one of the two registered nurses would administer the medication. The AP was responsible for the fundamental care of the allocated patients as well as for

checking surgical drains and simple dressings, including packing and/or stopping of nose bleeds. The AP also performed tasks such as cannulation (including flushing of these), phlebotomy, bladder scans, and catheterisation. During our observations the APs was seen to prepare IV fluids but not connect these to a patient, disconnect IV fluids, change the drip speed of these fluids and remove cannulae. The AP documented patient care, made referrals and carried out assessments and discharges for patients. All documentation was counter-signed by registered nursing staff. The AP attended the medical ward round and was seen to discuss patients with relatives and other health care professionals both face to face and on the phone. They were not permitted to transfer patients from, or to, theatre. The AP also handed over information about patients and their care to subsequent shifts of nursing staff. During the team's observation sessions this AP was sometimes allocated to supervise and mentor first year Student Nurses.

Ward 9 Two APs worked on this ward. Typically the AP would provide total care for 2-6 patients (usually in the same bay) whilst the co-ordinator (a RN) would administer medications for patient being cared for by the AP. The AP was responsible for the fundamental care needs of the allocated patients, as well as other care such as checking any wound/ surgical drains, or simple dressings. The APs performed tasks such as cannulation, phlebotomy, bladder scans, carrying out ECG tracings and catheterisation. During our observations the APs were seen to prepare fluids for infusion but did not connect these to the patients. They did disconnect IV fluids and remove cannulae, but never flushed these. The APs documented patient care, carrying out referrals and assessments, and admitted and discharged patients. All documentation was counter-signed by the RN co-ordinator. The AP communicated information about the patient and their care at nursing handover and attended the medical ward rounds. They discussed patient care with relatives and other health care professionals both face to face and on the phone. Durin the team's observation sessions these APs was sometimes allocated to supervise and mentor first year Student Nurses.

Case site 3: Description of AP roles within 4 sampled wards (September 2008 to January 2009)

Ward 10 The AP was usually allocated three to four of the least dependent patients, and predominantly worked in the male bay. The AP was then responsible for their basic care, observations, simple wound dressings, as well as for the documentation and assessments (i.e. standardised measures in the Trust care documentation) of their allocated patients. On occasions, the AP was responsible for referrals, admissions and discharges and assisted the registered nursing staff with more complex wound dressings. APs did not administer medications, transport to or from theatre or participate in the medical ward round. The AP was observed to discuss patients with relatives and other health care professionals both face to face and on the phone as well as to handover their allocated patients to

nurses on the subsequent shift. Other common responsibilities of the AP were to supervise, assess, train and educate the other HCAs. It was indicated by senior nurses that the AP was expected to be a role model for Essence of Care but this was not so obvious to the researchers during their period of observation work on this ward. It was noted that at time of data collection this ward had significant staffing problems and the SS described *'serious staff morale problems'* in the ward. This was observed as creating sickness amongst ward staff and many days where the ward was not staffed to required nurse staffing levels. The AP was often one of the most experienced staff on duty and so called upon to take charge of a bay and to supervise new RNs. The patient workload was heavy with rapid activities to care for dependent and acutely sick patients.

Ward 11 APs were mainly allocated to one of the bays to work with a RN but were expected to cover all areas of the ward if required by RNs. During the period of observation, APs were occasionally allocated a bay to manage without a RN. The AP was responsible for fundamental care, transporting patients to other areas, observations, simple dressings, documentation and assessments (i.e. standardised measures in the Trust care documentation), referrals, admissions and discharges. AP did not administer medications. One AP was observed flushing cannula with saline and to connect and disconnect intravenous fluids, to cannulate, carry out venepuncture, catheterise and do ECGs. This was attributed to a previous position held by the individual. Other common responsibilities for APs were to assess, supervise and train other HCAs. They were expected to be a role model for Essence of Care but staff suggested this was not a major part of the role. APs were observed to participate in medical ward rounds, discuss patients with relatives and other health care professionals, face to face and on the phone, as well as to handover their patients to nursing staff on the subsequent shift.

Ward 12 The AP was routinely allocated to one bay area but during the observation period they were often called upon to work across all bay areas, supporting HCAs and RNs in the delivery of bedside care in addition to caring for their own allocated patients. The AP was responsible for the patient's fundamental care, observations, bladder scans, ECG, simple dressings, as well as for the documentation (i.e. standardised measures in the Trust care documentation), referrals and assessments of these patients. On occasions, the AP was also responsible for admissions and discharges and assisted the RNs with more complex nursing tasks, such as wound dressings or catheterisation. The AP did not administer medications or participate in medical ward rounds. The AP was observed to discuss patients with relatives and other health care professionals, face to face and on the phone, as well as to handover their patients to nurses on the subsequent shift. Other common responsibilities of the AP were to asses, supervise and train the other HCAs in the 11 Essence of Care benchmarks through the competency pack, as well as being the role model for Essence of Care. Their remit in relation to Essence of Care was obvious on this particular ward with the AP continuously updating information boards for each benchmark etc. The AP was also heavily engaged in the Trust teaching sessions for newly appointed HCAs and in teaching sessions on the ward for all staff (registered and non-

registered).

Ward 13 The AP was mainly allocated to one bay area (most commonly the High Dependency Bay) to work alongside the RNs. The AP was responsible for delivering fundamental care to patients, observations, bladder scans, ECGs, simple dressings, simple stoma care and DVT prophylaxis (appropriate use of anti-thrombolytic stockings). On occasions the AP assisted the registered staff in more complex nursing tasks, such as wound dressings, stoma care and catheterisation. The AP did not administer medications, document care, or assess patients. They were also never asked to transport patient between the ward and theatre. The AP was observed discussing patients with relatives and other health care professionals, face to face and on the phone, but did not participate in nurse handover or medical ward rounds. Other common responsibilities of the AP were to asses, supervise, train and teach the other HCAs and to ensure they completed their Trust competency packs. The AP role as lead in Essence of Care was not apparent on the ward during the period of observation and the AP was not yet engaged in the Trust-wide clinical skills training sessions.

Appendix 4 Stage 1 questionnaire with ward-based nursing teams

THE UNIVERSITY of York

ID NUMBER_____

A survey about your work

What is this survey?
This is a survey about your job as a registered nurse, assistant practitioner or health care assistant. It concerns your opinions of the job that you do. We want to know your personal views on the issues raised in the questionnaire.

This is not a test. There are no right or wrong answers.

Who will see my answers?
The information you give is totally confidential. Survey findings will be made available to all who participate. We will be writing a report from the findings but this will be written in such a way that it is not possible for individuals, or their place of work, to be identified. These questionnaires will be handled by researchers from the University of York. The Trust where you work will at no time have access to any of the questionnaires completed by individuals.

How long will it take?
The questionnaire will take 30-40 minutes to complete.

How do I fill in this survey?
Please complete the questionnaire for your current job (the job you do most of the time).

What is covered in this survey?
The questionnaire is divided into 2 sections.

Section A: The first section asks for background details about you and the work you do. This information is important so that we can distinguish between different members of the nursing team (or assistant practitioners working in different clinical areas) when we analyse the questionnaire.

Section B: This section is concerned with your views about your job and opportunities for development in your role.

How should I respond?
Please read each question carefully. For some questions you are required to write your answer in the space provided. For other questions there are statements and you are asked to tick one response which best fits your views. There are instructions for each question. Please answer all questions as openly and honestly as possible. Respond according to your first reaction. Do not spend too long on one question.

For example, the question below asks about the extent of your involvement in the delivery of care to patients/ clients. If you consider that you are involved in the delivery of care quite a lot, you would answer like this:

Each week my role involves:	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
(a) Delivery of care to patients/ clients	☐1	☐2	☐3	☑4	☐5

Now that you have read the instructions, please begin the survey. Please read every question carefully before responding and answer every question. Thank you.

SECTION A. BACKGROUND DETAILS

It is important that we know some of your background details. This will enable us to compare the views of different groups of staff.

About your job

Please insert details of your:

1. a. Current job title_____

   b. Year appointed to current job_____

   c. Agenda for Change Pay Band_____

   d. Previous health care job titles. Please insert whether you have worked in other health care positions (for example you may be a registered nurse who has worked as a health care assistant) or insert not applicable (N/A) if you have not held any previous positions

   _____

   _____

2. Current speciality/ type of ward_____

3. Name of department/ ward/ clinic_____

4. How long have you worked **in total** as an employee in the NHS?	5. How long have you worked in your current post?
Please insert number of years and/or months:	Please insert number of years and/ or months:
_____years_____months	_____years_____months

6. Listed below are health care qualifications that you may have undertaken to prepare you for your clinical role. Please indicate the highest level qualification that you have completed by **ticking one box only** and insert the year you obtained the qualification in the spaces provided:

☐1 RN degree……_____ (year)	☐2 RN diploma……_____(year)
☐3 RN pre-diploma (formerly SRN)…… ……_____ (year)	☐4 EN……_____(year)
☐5 Foundation degree…….. _____ (year)	☐6 S/NVQ….Level ___(insert)…….. _____(year)
☐7 GNVQ…… _____ (year)	☐8 BTEC/FE……. _____(year)
☐9 City & Guilds…… _____ (year)	☐10 Access course (H&SC/Nursing) _____ (year)
☐11 In-house training……_____(year)	☐12 Other, please state _____(year)

The following questions require you to think about your last full working week. (Exclude a week in which you took holiday or any other absences from work). Include your on-call hours.

7. In your last **full working week**, how many hours were you contracted to work?
(These hours are stated in your employment contract)

Please insert number of hours: _____hours

8. In your last **full working week**, did you work any hours that were in addition to your contracted hours, i.e. overtime hours? Please tick:

Yes ☐1 → Please answer Q9a to 9f

No ☐2 → Please go to Q10

9.a. What was the total number of **additional hours** you worked in your last full working week?

Please insert number of hours: _____hours

b. How many of these additional hours were paid?	c. How many of these additional hours were unpaid?	d. How many of these additional hours will you take as time in lieu?
_____hours	_____hours	_____hours

e. In your last working week, how much notice did you get before working the extra hours? Please tick:		f. Were you able to choose whether or not you worked those extra hours?	
Less than 24 hours	☐1	Yes	☐1
Between 24 hours and 1 week	☐2	No	☐2
More than 1 week	☐3		

10. Please circle your shift/ rota systems/ normal working hours:

☐1 Permanent day duty which includes early and late shifts

☐2 Permanent night duty

☐3 Internal rotation (mix of day and night shifts)

☐4 Permanent day duty with regular hours (e.g. 8am to 4pm or 9am to 5pm)

11. Are you on a fixed-term contract? That is, does your contract state a start and end date for your employment in the Trust?

No ☐2 → Please go to Q13

Yes ☐1 → Please answer Q12a to 12c

12.a. How long do you have left on this contract? Please tick:		b. Is this contract likely to be renewed by the Trust?		c. Do you have another job to go to?	
Less than 3 months	☐1	Yes	☐1	Yes	☐1
3 months to 6 months	☐2	No	☐2	No	☐2
More than 6 months	☐3			N/A (if answer yes to 12b)	☐3

About you

13. What was your age on your last birthday?

Please insert age in years: _____(years)

14. Are you:		15. Are you:	
Male	☐1	Single	☐1
Female	☐2	Living with partner/ married	☐2
		Separated/divorced/widowed	☐3

16. How would you describe your ethnic origin? Please tick one box:

White:

☐1 British ☐2 Irish ☐3 Other

Mixed:

☐4 White and Black Caribbean ☐5 White and Black African ☐6 White and Black Asian ☐7 Other

Asian or Asian British:

☐8 Indian ☐9 Pakistani ☐10 Bangladeshi ☐11 Other

Black or Black British:

☐12 Caribbean ☐13 African ☐14 Other

Other ethnic group: Please write here:

SECTION B. YOUR JOB

The following questions ask you to describe your job. Please answer all the questions, ticking ☒ the answer which best describes the job you do *most of the time*.

17. Listed below are activities which your job might involve. Please estimate how much your present work role involves these activities each week.

Each week my role involves:	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
a. Delivery of care to patients/ clients	☐1	☐2	☐3	☐4	☐5
b. Delivery of treatments to patients/ clients	☐1	☐2	☐3	☐4	☐5
c. Carrying out examinations of patients/ clients	☐1	☐2	☐3	☐4	☐5
d. Planning the delivery of care to patients/ clients	☐1	☐2	☐3	☐4	☐5
e. Planning the delivery of treatments to patients/ clients	☐1	☐2	☐3	☐4	☐5
f. Planning for carrying out examinations of patients/ clients	☐1	☐2	☐3	☐4	☐5
g. Supervising others delivering care to patients/ clients	☐1	☐2	☐3	☐4	☐5
h. Supervising others delivering treatments to patients/ clients	☐1	☐2	☐3	☐4	☐5
i. Supervising others carrying out examinations of patients/ clients	☐1	☐2	☐3	☐4	☐5
j. Discussions with patients/clients about any concerns they have relating to their treatment or condition	☐1	☐2	☐3	☐4	☐5
k. Discussions with relatives	☐1	☐2	☐3	☐4	☐5
l. Administrative duties/ data entry	☐1	☐2	☐3	☐4	☐5
m. Attending meetings	☐1	☐2	☐3	☐4	☐5
n. Report writing	☐1	☐2	☐3	☐4	☐5

18. To what extent do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a. I always know what my responsibilities are	☐1	☐2	☐3	☐4	☐5
b. I am consulted about changes that affect my work	☐1	☐2	☐3	☐4	☐5
c. I do not have time to carry out all my work	☐1	☐2	☐3	☐4	☐5
d. I get clear feedback about how well I am doing my job	☐1	☐2	☐3	☐4	☐5
e. Relationships at work are strained	☐1	☐2	☐3	☐4	☐5
f. I can decide on my own how to go about doing my work	☐1	☐2	☐3	☐4	☐5

19. The following questions ask about the extent to which other people provide you with help or support.

To what extent can you:	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
a. Count on your colleagues to listen to you when you need to talk about problems at work?	☐1	☐2	☐3	☐4	☐5
b. Count on your colleagues to back you up at work?	☐1	☐2	☐3	☐4	☐5
c. Count on your colleagues to help you with a difficult task at work?	☐1	☐2	☐3	☐4	☐5
d. Really count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?	☐1	☐2	☐3	☐4	☐5

20. How satisfied are you with each of the following areas of your job?

	Very dissatisfied	Moderately dissatisfied	Not sure	Moderately satisfied	Very satisfied
a. The recognition I get for good work	☐1	☐2	☐3	☐4	☐5
b. The support I get from my immediate manager	☐1	☐2	☐3	☐4	☐5
c. The freedom I have to choose my own method of working	☐1	☐2	☐3	☐4	☐5
d. The support I get from my work colleagues	☐1	☐2	☐3	☐4	☐5
e. The amount of responsibility I am given	☐1	☐2	☐3	☐4	☐5
f. The opportunities I have to use my abilities	☐1	☐2	☐3	☐4	☐5
g. The extent to which my Trust values my work	☐1	☐2	☐3	☐4	☐5

21. To what extent do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a. I often think about leaving this Trust	☐1	☐2	☐3	☐4	☐5
b. I will probably look for a new job in the next 12 months	☐1	☐2	☐3	☐4	☐5
c. As soon as I can find another job, I will leave this Trust	☐1	☐2	☐3	☐4	☐5
d. If I leave my current job, I would want to stay in the NHS	☐1	☐2	☐3	☐4	☐5

22. If you answered 'agree' or 'strongly agree' to Q21a, b or c, then please indicate why you are considering leaving. Please tick all boxes that apply:

Career development	☐1	Unhappy with current job	☐2	Don't want to work in NHS	☐3
Change of career	☐4	Family or personal reasons	☐5	Retirement	☐6
Would like more pay	☐7	Entering full time education	☐8	Other reason	☐9
				Not considering leaving	☐10

23. To what extent do you agree with the following statements about your immediate (ward-based/ department-based) manager?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
My immediate manager...					
a... encourages those who work for her/ him to work as a team	☐1	☐2	☐3	☐4	☐5
b... can be counted on to help me with a difficult task at work	☐1	☐2	☐3	☐4	☐5
c... gives me clear feedback on my work	☐1	☐2	☐3	☐4	☐5
d... asks for my opinion before making decisions that affect my work	☐1	☐2	☐3	☐4	☐5
e... is supportive in a personal crisis	☐1	☐2	☐3	☐4	☐5

The following questions ask you about performance reviews and training. Please answer all the questions, ticking ☑ the answer to indicate your response.

24. Have you had an appraisal or development review in the last 12 months?

Yes ☐1 → Please answer Q25 (a-c) and Q26
No ☐2 → Please go to Q28

25. Appraisal or development review	Yes	No
a. Was your appraisal or performance development review useful in helping to improve how you do your job?	☐1	☐2
b. Did you agree clear objectives for your work during the appraisal/ review?	☐1	☐2
c. Did the appraisal or performance development review leave you feeling your work is valued by your Trust?	☐1	☐2

26. In the past 12 months, as part of your appraisal or performance development review, did you agree a Personal Development Plan?

Yes ☐1 → Please answer Q27 (a-b)
No ☐2 → Please go to Q28

27. Personal development plans	Yes	No	Too early to say
a. Have you received the training, learning and development that was identified in the plan?	☐1	☐2	☐3
b. Has your immediate manager supported you in accessing this training, learning and development?	☐1	☐2	☐3

28. Have you received any training, learning or development (paid for or provided by your Trust) in any of the following areas?

	Yes, in the last 12 months	Yes, more than 12 months ago	No
a. Equal opportunities	☐1	☐2	☐3
b. Race awareness	☐1	☐2	☐3
c. Gender awareness	☐1	☐2	☐3
d. Disability awareness	☐1	☐2	☐3
e. Harassment and bullying awareness	☐1	☐2	☐3
f. Religious and faith awareness	☐1	☐2	☐3
g. Cultural competence	☐1	☐2	☐3
h. Age awareness	☐1	☐2	☐3
i. Other (please state) _____	☐1	☐2	
j. Other (please state) _____	☐1	☐2	
k. Other (please state) _____	☐1	☐2	
l. Other (please state) _____	☐1	☐2	

29. Have you had any training, learning or development (paid for or provided by your Trust), in the following areas?

	Yes, in the last 12 months	Yes, more than 12 months ago	No	Not applicable to me
a. Health and safety (e.g. manual handling)	☐1	☐2	☐3	☐4
b. Handling a major incident or emergency	☐1	☐2	☐3	☐4
c. Preventing/ handling violence and aggression	☐1	☐2	☐3	☐4
d. Infection control (e.g. hand washing)	☐1	☐2	☐3	☐4
e. Computer skills	☐1	☐2	☐3	☐4
f. Handling confidential information about patients/clients	☐1	☐2	☐3	☐4
g. Asking patients/clients about their use of alcohol or drugs (including illegal drugs)	☐1	☐2	☐3	☐4
h. Handling patients/clients who are drunk or under the influence of drugs (including illegal drugs)	☐1	☐2	☐3	☐4
i. Providing information to patients/clients on diagnosis, medication, side effects etc.	☐1	☐2	☐3	☐4

30. Thinking about training, learning or development provided by the Trust, please indicate how much you agree with the following statements:

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
(a) The skills of staff are developed so that they can improve their job performance	☐1	☐2	☐3	☐4	☐5
(b) The Trust strongly believes in the importance of training	☐1	☐2	☐3	☐4	☐5
(c) People are not properly trained in the Trust when new procedures are introduced	☐1	☐2	☐3	☐4	☐5
(d) Staff are strongly encouraged to develop their skills in the Trust	☐1	☐2	☐3	☐4	☐5
(e) Staff can only develop skills if they are prepared to do it in their own time	☐1	☐2	☐3	☐4	☐5
(f) The Trust only gives people the minimum amount of training they need to do their jobs	☐1	☐2	☐3	☐4	☐5

31. Thinking of any training, learning or development that you have done in the past 12 months (paid for or provided by your Trust), please indicate how much you agree with the following statements:

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
a. Your training, learning and development has helped you to do your job better	☐1	☐2	☐3	☐4	☐5
b. It has improved your chances of promotion	☐1	☐2	☐3	☐4	☐5
c. It has helped you stay up-to-date with the job	☐1	☐2	☐3	☐4	☐5
d. It has helped you stay up-to-date with professional requirements	☐1	☐2	☐3	☐4	☐5

32. Would you like to receive a copy of the report detailing the findings of the questionnaire?

Yes ☐1

No ☐2

If you have any further comments to make about your work or role, please feel free to write them in the space below. Please continue on the back page if you need extra space.

Thank you for completing this questionnaire. It will be a valuable contribution to our study. Please place the questionnaire in the addressed envelope provided, seal it, and put it in your internal mail.

If you have any questions or concerns about the questionnaire, please contact:

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Thank you again for your co-operation.

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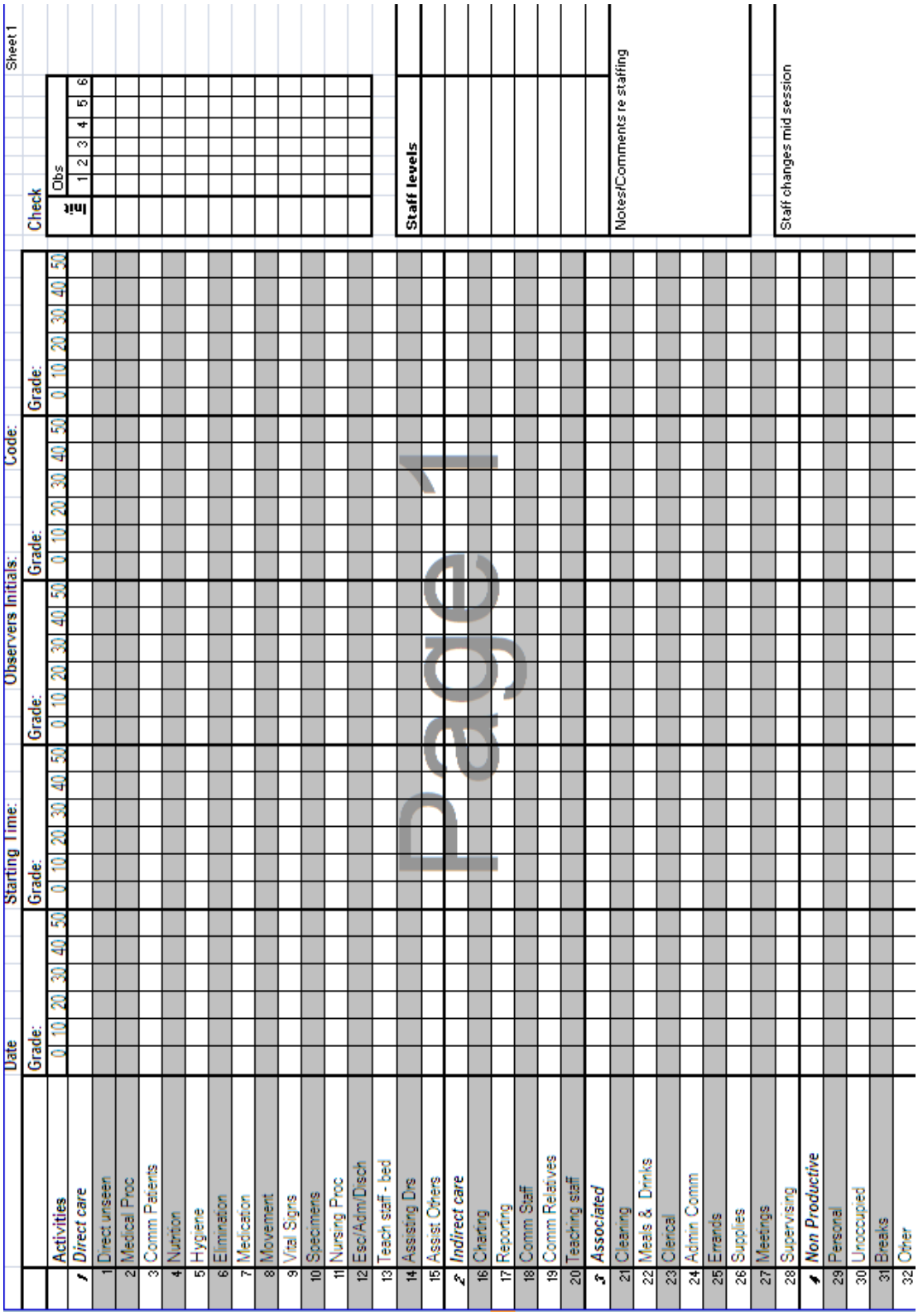
Appendix 5 Stage 1 structured observation instrument for recording activities of ward nursing teams (Hurst, 2005)



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Appendix 6 Activity Analysis observation instrument: description of items

DIRECT CARE

1. Direct care unseen

This cue is to be used if the activity is taking place behind a closed door/ curtain and it is impossible/ inappropriate to ascertain the specific nature of that activity. It may be checked, and then later if an opportunity arises to be updated, if it is possible to speak to the nurses involved.

2. Medical Procedures

Undertaking an extended-role procedure, including:

Inserting venous cannula	Defibrillation[7]	Genital wart treatment
Venous blood	Intubation[8]	Vaginal packing
Intra Venous drugs	Theatre first assistant	PCWP pressures
Intra Venous Morphine	Suturing	Prostaglandin pessaries
Intra Muscular Methotrexate[9]	Epidural anaesthesia	Endocervical swab
Arterial line sampling	Local anaesthetic	Cervical smear
Immunising	PCAS[10]	Post-coital test
Bladder cytotoxic therapy	PeG tube	Curretage
	Punch and shave biopsy	

3. Communication - Patients

a. giving support and reassurance
b. teaching
c. explaining procedures and treatments
d. demonstrating, for example, how to use a wheelchair
e. showing a patient around a ward
f. assessing physical and mental state
g. preparing a nursing care plan for or with a patient
h. observing
i. preparing a patient for theatre

4. Nutrition

a. cutting food for patient
b. feeding a helpless patient
c. encouraging a patient to eat and drink
d. feeding via a Naso Gastric tube
e. preparing diets for patients with special needs (e.g. nutritional drinks)

5. Hygiene

a. helping a patient to wash, bathe, or shower
b. bathing or washing a (bedfast) patient

[7] Might see if there is a cardiac arrest
[8] Might see if there is a cardiac/ respiratory arrest
[9] This is a form of chemotherapy so unlikely to observe
[10] Might see this. It stands for patient controlled analgesia. Usually an anaesthetist sets it up but might see a nurse

c. caring for a patient's pressure areas[11]
d. supervising a patient in the bathroom
e. shaving a patient
f. cleaning an incontinent patient
g. cleaning a patient's hair, nails, mouth, teeth or dentures
h. stripping and making an occupied bed
i. making a patient comfortable in bed[12]
j. tidying an occupied bed

6. Elimination

a. recording bowel function including urine output
b. giving or removing bedpans/ commodes
c. recording drainage from a wound
d. giving and removing vomit bowls
e. assessing elimination

7. Medication

a. administering medication by mouth or by parenteral injection
b. administering intravenous therapy
c. checking drugs
d. monitoring patient's self medication regimen
e. preparing to administer drugs

8. Movement

a. turning and repositioning a patient[13]
b. placing a patient on an orthopaedic frame or bed
c. helping porters to lift a patient onto a trolley
d. helping a patient to exercise
e. assisting a patient with active or carrying out passive movements
f. assisting a patient to walk
g. helping the patient to sit on the edge of the bed
h. adjusting traction or other bed equipment
i. moving a patient from the bed to a chair
j. assisting a patient with breathing exercises
k. assisting a patient to the toilet/ bathroom

9. Vital Signs

a. weighing a patient
b. measuring and recording a patient's blood pressure
c. measuring and recording a patient's temperature, pulse and respiration
d. measuring and recording neurological signs
e. measuring and recording central venous pressure
f. cardiac monitoring
g. interpreting vital signs
h. measuring oxygen saturation (sats)

10. Specimens

a. gathering and labelling specimens for the laboratory
b. gathering specimens for testing in the ward
c. testing specimens in the ward

11. Nursing Procedures

a. catheterising a patient
b. starting, maintaining or discontinuing oxygen
c. starting, maintaining or discontinuing suction
d. assembling or dismantling traction

---

[11] Any activity related to pressure areas which **does not** involve a dressing (preventative rather than treating).
[12] Could be making sure the sheets are on straight, changing and fluffing a pillow, moving pillows for a patient etc. Whereas 8a involves moving the person.
[13] Repositioning could also be getting someone in and out of bed.

e. applying or modifying plaster casts
f. treating pressure sores
g. giving an evacuant enema
h. irrigating the bladder, ostomies or douching
i. redressing a wound
j. inserting or removing a Naso Gastric tube
k. sterilising equipment
l. preparing trolleys for nursing/medical procedures
m. applying or removing anti-embolism stockings
n. cooling or warming a patient
o. caring for a patient who has died
p. procedures that require 'scrubbing up'
q. removing an intravenous cannula
r. hand washing before or after a procedure
s. putting on or removing gloves/apron before or after a procedure
t. monitoring blood glucose

12. Escorting

a. supervising a patient moving from the ward to another department
b. transferring a patient to another hospital
c. escorting a patient to and from theatre
d. escorting a patient to another area in the ward
e. admitting a patient to the ward
f. discharging a patient from the ward

13. Teaching

a. instructing staff (such as student nurses) at the bedside

14. Assisting Doctors

a. assisting doctors on a ward round
b. assisting doctors with technical procedures

15. Assisting Others

a. assisting other staff, e.g. radiographer, physiotherapist with technical procedures

INDIRECT CARE

16. Charting

a. starting a kardex or other nursing record
b. maintaining a kardex or other nursing record

17. Reporting

a. recording/retrieving patient information on/from the computer patient administration system
b. contributing to team conferences about a patient
c. giving or receiving information about a patient (inc telephone calls[14])
d. handing over to nurses on the next shift
e. updating the patient board

18. Communicating with Staff

a. arranging specific investigations, for example, x-rays
b. liaising with other health/social care professionals

19. Communicating with Relatives

a. asking/answering questions of/from relatives

20. Teaching

a. instructing staff[15]

[14] determine/ or ask if the call was about patient care or admin/ clerical which will distinguish it from 24a

[15] Looking at the larger categories (i.e. direct, indirect etc) might help here. Read **20a as instructing staff about patient care** (even though it is not at the bedside – covered by 13a) and that **28a falls under associated work** – so this refers more to more general

ASSOCIATED WORK

21. Cleaning

a. stripping, cleaning and making an empty bed
b. cleaning equipment not in use
c. cleaning and tidying store cupboards
d. light cleaning and dusting
e. tidying the ward
f. changing curtains
g. washing crockery and tidying the kitchen
h. cleaning the bathroom or sluice
i. disinfecting crockery
j. washing soiled clothing etc:
k. laundering items such as sheepskins
l. disposing of soiled linen
m. emptying bins and disposing of rubbish
n. moving beds, lockers and chairs
o. flower care
p. hand washing un-associated with any procedure

22. Meals and Drinks

a. setting for meals
b. distributing food and drinks (inc water jugs)
c. collecting and clearing meals (inc water jugs)
d. asking patients for menu selections

23. Clerical

a. completing (not choosing food) menu lists
b. completing daily bed returns
c. delivering mail and flowers
d. making out patient's identification bracelets and assembling notes
e. dealing with deceased patient's belongings
f. general clerical duties
g. recording/retrieving information on/from the computer nursing information that is not related to a specific patient
h. management system
i. dealing with information on the ward computer system
j. assessing and recording patient's dependency
k. referring to /using own notes (e.g. handover sheet)
l. authorising a sick note

24. Communication

a. dealing with administrative telephone calls
b. making out duty rotas
c. informing staff of break times

25. Errands

a. delivering or collecting patient's notes/reports from off the ward
b. collecting drugs from the pharmacy
c. collecting blood from the blood bank
d. looking for staff or patients off the ward

26. Supplies

a. borrowing or lending equipment or stores
b. safety checks on fire equipment, televisions etc:
c. checking, reordering, and issuing routine ward supplies
d. restocking emergency trolleys or trays

---

activities associated with supervision, for example discussing a medical condition to determine what a student understands, perhaps completing their learning portfolios etc.

27. Meetings

a. attending management and administrative meetings/ training sessions

28. Supervising

a. teaching or assessing learners
b. supervising/assessing the work of nursing assistants
c. completing learners' reports
d. showing new members of staff around the ward
e. giving general in-service education
f. staff appraisals

NON-PRODUCTIVE ACTIVITIES

29. Personal
30. Unoccupied
31. Breaks
32. Other

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Appendix 7 Calculation of number of observation sessions (Qualpac and activity) for each ward based on numbers of APs

The number of sessions (patient observations) were calculated as follows:

- The square route of the number of AP staff employed on each ward was added together.
- The number of sessions at the site was then divided by this total and each wards sessions (n) was then multiplied by the square route of the number of APs.

TOTAL SESSIONS FOR CASE SITE (120)
SUM: SqR n=APs Ward1, SqR n=APs Ward2, SqR n=APs Ward3, SqR n=APs Ward4
= X
Number of Sessions on a ward =
X * n=APs Wd y

Example for case site 1:
Ward 1 APs n=2. Sq route 2 =1.41
Ward 2 APs n=3. Sq route 3 = 1.73
Ward 3 APs n=1. Sq route 1= 1
Ward 4 APs n=3. Sq route 3 = 1.73
Total = 5.87
(number of sessions required = 120)/5.87 = 20.44
Therefore:
Ward 1 = 20.44*1.41 = 29 Qualpac sessions (rounded up to 30 Qualpac sessions) (approx 15 activity sessions)
Ward 2 = 20.44*1.73 = 35 Qualpac sessions (approx 17 activity sessions)
Ward 3 = 20.44*1 = 20 Qualpac sessions (approx 10 activity sessions)
Ward 4 = 20.44*1.73 = 35 Qualpac sessions (approx 17 activity sessions)

Appendix 8 Stage 1 structured observation instrument for recording quality of interactions between nursing team and patients (Carr-Hill et al., 1992)

QUALITY PATIENT CARE SCALE (QP)

Patient Code:

.....

Bed number:

.....

GENERAL FIELD NOTES

General Observational Notes for data collection session
Objective descriptions of mood of ward, events & conversations. Information such as time, place, activity & dialogue are recorded as objectively as possible.

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INTERACTION SPECIFIC FIELD NOTES

Inter Action Notes for interaction specific observations
Detailed descriptions of each interaction taking place such as specific activities (in relation to each grade), contextual details occuring during the observation session. Please make sure to start notes by writing down grade/s of those participating in the interaction. Interaction 1: Time: ..... Grade(s): .... Interaction 2: Time: ..... Grade(s): .... Interaction 3: Time: ..... Grade(s): .... Interaction 4: Time: ..... Grade(s): .... Interaction 5: Time: ..... Grade(s): ....

INTERACTION SPECIFIC FIELD NOTES

Inter Action Notes for interaction specific observations
Detailed descriptions of Assistant Practitioner specific activities, contextual details occuring during the observation session Interaction 6: Time: ..... Grade(s): .... Interaction 7: Time: ..... Grade(s): .... Interaction 8: Time: ..... Grade(s): .... Interaction 9: Time: ..... Grade(s): .... Interaction 10: Time: ..... Grade(s): ....

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Psychosocial Care: Individual Actions directed towards meeting psychosocial needs of individual patients [15 items]

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
1. #D Patient receives nurse's full attention.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
2. #D Patient is given opportunity to explain his/her thoughts & feelings.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
3. #D Patient is approached in a kind, gentle, and friendly manner.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
4. #D Patient's inappropriate behaviour is responded to in a therapeutic manner.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Psychosocial Care: Individual Actions directed towards meeting psychosocial needs of individual patients:

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
5.#D Appropriate action is taken in response to anticipated or manifest patient anxiety or distress.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
6.#D Patient receives explanation and verbal reassurance when needed.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
7.#D Patient receives attention from nurses with neither becoming involved in a non-therapeutic way.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
8.#D / *ID Patient is given consideration as a member of a family and society.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Psychosocial Care: Individual Actions directed towards meeting psychosocial needs of individual patients:

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
9. #D / *ID Patient receives attention for his spiritual needs.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
10. #D / *ID The rejecting or demanding patient continues to receive acceptance.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
11. #D Patient receives care that communicates respect and dignity.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
12. #D / *ID The health aspects of the patient's personality are utilised.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Psychosocial Care: Individual Actions directed towards meeting psychosocial needs of individual patients:

Patient: **A B C D** (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
13.#D An atmosphere of trust, respect and acceptance is created rather than one of power, prestige and authority.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
14.#D Appropriate topics for conversation are chosen.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
15.#D The unconscious or non-oriented patient is cared for with the same respectful manner as the conscious patient	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Physical Care Actions directed towards meeting physical need of patients. [15 items]

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
24.#D Nursing procedures are adapted to meet needs of individual patient for treatment.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
25.#D Patient's daily hygiene needs for cleanliness and acceptable appearance are met.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
26.#D Nursing procedures are utilised as media for interaction & communication with patient.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
27.#D Physical symptoms and physical changes are identified and appropriate action taken.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Physical Care Actions directed towards meeting physical need of patients.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
28. #D Physical distress evidenced by the patient is responded to quickly and appropriately.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
29. #D / *ID Patient is encouraged to observe appropriate rest and exercise.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
30. #D / *ID Patient is encouraged to take adequate diet.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
31. #D / *ID Action is taken to meet patient's needs for adequate hydration and elimination.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Physical Care Actions directed towards meeting physical need of patients.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
32. #D / *ID Behavioural & psychological changes due to medication are observed & appropriate action taken.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
33. #D / *ID Expectations of patient's behaviour are adjusted & acted upon according to the effect the medication has on the patient.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
34. #D Medical asepsis is carried out in relation to patient's personal hygiene & immediate environment.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
35. #D / *ID Medical asepsis is carried during treatments & special procedures.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Physical Care Actions directed towards meeting physical need of patients.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
36. #D Environment is maintained that gives the patient a feeling of being safe and secure.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
37. #D Safety measures are carried out to prevent patient from harming him/herself or others.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
38. #D Established techniques for safe administration of medication & parenteral fluids are carried out.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

General Care Actions that may be directed towards meeting either psychosocial or physical need of patients or both at the same time. [15 items]

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
39. #D Patient receives instruction as necessary.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
40. #D / *ID Patient and family are involved in planning for care and treatment.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
41. #D Patient's sensitivities and right to privacy are protected.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
42. #D Patient is helped to accept dependence/in-dependence as appropriate to his/her condition.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

General Care Actions that may be directed towards meeting either psychosocial or physical need of patients or both at the same time.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
43. #D Resources within the milieu are utilized to provide the patient with opportunities for problem solving.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
44. #D Patient is given freedom of choice in ADL[1] whenever possible & within patient's ability to make choice.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
45. #D / *ID Patient is encouraged to take part in ADL that will stimulate his/her potential for positive psychosocial growth and movement towards physical independence	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

General Care Actions that may be directed towards meeting either psychosocial or physical need of patients or both at the same time.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
46.#D / *ID Activities are adapted to physical and mental capabilities of patient.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
47.#D Nursing care is adapted to patient's level and pace of development.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
48.#D Diversional and/or treatment activities are made available according to the patient's capabilities & needs	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
49.#D Patient with slow or unskilled performance is accepted and encouraged.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

General Care Actions that may be directed towards meeting either psychosocial or physical need of patients or both at the same time.

Patient: **A B C D** (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
50. #D / *ID Nursing care goals are established & activities performed which recognize & support the therapist care plan	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
51. #D Interaction with the patient is within the framework of the therapeutic plan.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
52. #D Close observation of the patient is carried out with minimal disturbance.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
53. #D Response to the patient is appropriate in emergency situations.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Communication Communication on behalf of the patient. [8 item].

Patient: **A B C D** (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
54. #D Ideas, facts, feelings & concepts about the patient are communicated clearly in speech to medical & paramedical staff.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
55. #D / *ID Family is provided with the opportunity for reciprocal communication with the nursing staff.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
56. *ID Ideas, facts and concepts about the patient are clearly communicated in charting.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
57. *ID Well-developed nursing care plans are established and incorporated into nursing assignments.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Communication Communication on behalf of the patient.

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
58. #D / *ID Pertinent incidents of the patient's behaviour during interaction with staff are accurately reported.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
59. #D Staff participate in conferences concerning patient care.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
60. #D / *ID Good & effective communication & relationships with other disciplines in & outside the hospital are established for patient's benefit.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
61. #D / *ID Patient's needs are met through the use of referrals, to departments in the hospital & to other community agencies.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Professional Implications Care given to patients reflects initiative & responsibility indicative of professional's expectations. [7 item].

Patient: A B C D (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
62. #D / *ID Decisions made by staff reflect knowledge of facts & good judgment.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
63. #D / *ID Evidence (spoken, behavioural, recorded) is given by staff of insight into deeper problems and needs of the pts.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
64. #D / *ID Changes in care & care plans reflect continuous evaluation of results of nursing care.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
65. #D / *ID Staff is reliable: follow through with responsibility for the patient's care.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Professional Implications Care given to patients reflects initiative & responsibility indicative of professionals' expectations. [7 item].

Patient: **A B C D** (please circle appropriate letter)		1	Grade	2	Grade	3	Grade	4	Grade	5	Grade	6	Grade	7	Grade	8	Grade	9	Grade	10	Grade
66.#D Assigned staff keep informed of the patient's condition and whereabouts.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
67.#D / *ID Care given to the patient reflects flexibility in rules and regulation as indicated by individual patient needs.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				
68.#D / *ID Organisation & management of nursing activities reflect due consideration for patient needs.	Best care																				
	Better than average care																				
	Average																				
	Poorer than average care																				
	Poorest care																				
	Not applicable																				
	Not observed																				

Appendix 9 Stage 1 structured instrument for recording patient dependency (personal correspondence with Sue Cooper, St George's Health Care NHS Trust, 2007)

NURSE DEPENDENCY SCORING

One score per category row, dependency is cumulative score

CATEGORY	SCORE 0	SCORE 1	SCORE 2	SCORE 3
PERSONAL CARE & HYGIENE	• Independent, no supervision required.	• Some assistance required.	• Constant supervision/teaching during bath/wash.	• Dependent and requires full assistance.
FEEDING, NUTRITION & ELIMINATION	• Patient able to eat independently.	• Some assistance required with eating and drinking. • Formal fluid balance chart and special diet. • Urinary catheter in place	• Close supervision and recording of nutritional intake. • Naso-gastric or parental feeding. • Requires help with toileting	• Nurse managed colostomy or 24hrs post colostomy • Continual vomiting/ diarrhoea/incontinence • Patient requires constant supervision.
MOBILITY	• Independent and can mobilise safely without help	• Requires one nurse to assist with mobilisation. • Requires some pressure ulcer prevention care.	• Two nurses to assist with mobilisation. • Pressure ulcer care and monitoring • Able to mobilise but needs supervision as confused/or wanders	• Totally dependent for mobility. • Requires a hoist or two nurses or more to assist with mobilisation. • Constant pressure ulcer prevention care.
NURSING ATTENTION	• Minimal involvement; *completion of routine nursing documentation, daily vital sign observations, oral medication.*	• Nurse required to give some treatments e.g. *nebulizers, pre-operative care for elective surgery or procedure.* • Routine IV fluids • Specific procedure e.g. *lumbar puncture or biopsy.* • Patient is confused and might have some challenging behaviour • New Admission assessment • Vital signs 4 hrly or less, but more than daily observations	• Requires above average nursing intervention *IV drugs, large dressing, frequent cannulation, insulin sliding scale, traction etc.* • Extensive health education/counselling • Other time consuming nursing interventions that requires frequent contact • Vital signs 2-3hrly • 24 hrs post surgery/procedure	• Requires maximum nursing care. • Non –invasive ventilation (CPAP/BIPAP) • Complex daily or more frequent dressing • 24hours discharge from ICU/HDU • 24 hours post complex surgery • New tracheostomy tube • Vital signs 1hrly or more frequent. • Constant cardiac or other monitoring • Emergency event, cardiac/respiratory arrest, haemorrhage • Patient unstable and undiagnosed • Patient requires constant supervision or 'special' due to condition/behavioural or cognitive problems • Any other time consuming and constant invasive nursing procedures related to patient in an unstable condition. E.g. Trauma patient requiring care to multiple pin sites

No of Admissions in last 24 hours = :
No of discharges in last 24 hours =
No of transfers in last 24 hours =

Score 0-2= Dependency 1
Score 3-4 = Dependency 2
Score 9-12 = Dependency 4
Score 5-8 = Dependency 3

Note: All patients who have severe behavioural problems/need constant supervision/require a 'special nurse' will automatically default to a grade 4 dependency

Appendix 10 Stage 2 national survey of ward-based assistant practitioners in acute hospitals

THE UNIVERSITY of York

Trust reference:

Assistant Practitioners: A survey about your work

Why have I received this questionnaire?
This is a national survey of assistant practitioners. You have received this questionnaire because you are called an assistant practitioner (AP) or have an equivalent role (such as associate practitioner or Lead Healthcare Assistant).

What is this survey?
This is a survey about your job as an AP. We want to know your personal views on the job that you do. ***This is not a test. There are no right or wrong answers.***

Who will see my answers?
The information you give is totally confidential. Only the research team will handle the questionnaire (University of York working with Acton Shapiro Consultancy). The Trust where you work will not have access to any of the questionnaires completed by you or your colleagues. We will be writing a report of our findings, but this will be written in such a way that it is not possible for individuals, or their place of work, to be identified. Survey findings will be made available to all.

How long will it take?
The questionnaire will take about 20 minutes to complete.

How do I fill in this survey?
Please complete the questionnaire for your current job (the job you do most of the time). You can complete this paper copy and return in the pre-paid envelope or complete the survey online http://www.actonshapirosurveys.co.uk/v.asp?i=14594hxoto It is entirely up to you. We have provided paper and electronic copies of the questionnaire to make it as easy as possible for you to take part.

What is covered in this survey?
The questionnaire is divided into 2 sections:

Section A:	The first section asks for background details about you and the work you do. This information is important and means, when presenting our findings, we can say something about how characteristics (such as clinical speciality, qualifications or age) might influence opinions of assistant practitioners
Section B:	This section is concerned with your views about your job and opportunities for developing your role.

How should I respond?
Please read each question carefully. Most questions are made up of statements. You are asked to tick one response which best represents your views. For some questions you are required to write your answer in the space provided. There are instructions for each question. Please answer all questions as openly and honestly as possible. Respond according to your first reaction. Do not spend too long on one question. As an example, the question below asks about the extent of your involvement in the delivery of care to patients/ clients. If you consider that you are involved in the delivery of care quite a lot, you would answer like this:

Each week my role involves...	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
...Delivery of care to patients/ clients	☐1	☐2	☐3	☑4	☐5

Now that you have read the instructions, please begin the survey. Please read every question carefully before responding and answer every question. Thank you.

SECTION A. BACKGROUND DETAILS

It is important that we know some of your background details. This will enable us to compare the views of assistant practitioners working in Acute Hospital (NHS) Trusts in England.

About your job

1. Is your current job title 'assistant practitioner'?

Yes (tick here) ☐$_1$ → Please answer Q2

No (tick here) ☐$_0$ → Please insert your current job title below and then answer Q2

_____

2. What is your current Agenda for Change Pay Band? ***Please tick one answer***

AfC Band 4 ☐$_1$ → Please answer Q3

AfC Band 3 ☐$_2$ → Please answer Q3

AfC Band 2 ☐$_3$ → Please answer Q3

3. Prior to your current job, did you work in another health care position (for example as a Healthcare Assistant)?

No (tick here) ☐$_0$ → Please answer Q4

Yes (tick here) ☐$_1$ → Please insert your previous health care job titles below, then answer Q4

_____

_____

4. What type of ward do you currently work in? ***Please tick one answer and move on to Q5***

☐$_1$ **Medical**
☐$_2$ **Care of the Elderly Medicine**
☐$_3$ **Rehabilitation**
☐$_4$ **Surgical**
☐$_5$ **Intensive care**
☐$_6$ **Accident & Emergency**
☐$_7$ **Out patient departments**
☐$_8$ **Maternity**
☐$_9$ **Theatres**
☐$_{10}$ **Other department** → Please insert the name of your current speciality/place of work below

_____

5. In your current role as an AP, do you solely support nursing work or are you also trained to do other work, for example physiotherapy? ***Please tick one answer***

☐$_1$ **Nursing only** → Please answer Q6

☐$_2$ **Nursing + another discipline** → Please insert the other discipline below, then answer Q6

_____

_____

Project 08/1619/159

6a. How long have you worked **in total** as an employee in the NHS?

Please insert number of years/ months:

_____years_____months

6b. How long have you worked **in your current post** as an assistant practitioner?

Please insert number of years/ months:

_____years_____months

7. We would like to know whether you have completed a health care qualification to prepare you for your clinical role as an assistant practitioner. You may have, for example, completed a NVQ or Foundation Degree. Please indicate whether you have completed a health care qualification in Q7a and if you have provide detail of your highest level health care qualification and the year you obtained the qualification (or hope to complete the qualification) in Q7b.

7a. ☐$_0$ I have not studied for any Health Care Qualification → Please go to Q8

☐$_1$ I have studied for a Health Care Qualification → Please insert detail at 7b (below)

7b. ***Insert name*** of highest level health care qualification (and level, such as NVQ Level 2 or 3):

_____

_____

and insert the year you obtained qualification/ hope to complete qualification: _____

8. ***Please tick one box*** to indicate your shift/ rota systems/ normal working hours:

☐$_1$ Permanent day duty which includes early and late shifts

☐$_2$ Permanent night duty

☐$_3$ Internal rotation (mix of day and night shifts)

☐$_4$ Permanent day duty with regular hours (e.g. 8am to 4pm or 9am to 5pm)

9. Do you work full-time or part-time? ***Please tick one answer:***

☐$_1$ Full-time → Please go to Q10

☐$_2$ Part-time → ***Please insert your hours here*** and then go to Q10 _____ (hours)

10. For your current job as an AP, did you have to apply for your position or was your position guaranteed upon completion of some training? ***Please tick one answer:***

☐$_1$ I completed an application process and was interviewed and appointed as an AP

☐$_2$ I was guaranteed an AP position in my organisation upon completion of training

☐$_3$ Not applicable – still in training

Project 08/1619/159

About you

11. What was your age on your last birthday?

Please insert age in years: _____(years)

12. Are you…? ***Please tick one answer:***

☐1 Male ☐2 Female

13. How would you describe your ethnic origin? ***Please tick one box***:

White:

☐1 British ☐2 Irish ☐3 Other

Mixed:

☐4 White and Black Caribbean ☐5 White and Black African ☐6 White and Asian ☐7 Other

Asian or Asian British:

☐8 Indian ☐9 Pakistani ☐10 Bangladeshi ☐11 Other

Black or Black British:

☐12 Caribbean ☐13 African ☐14 Other

Chinese:

☐15 Chinese

Other ethnic group:

Please write here:_____

SECTION B. YOUR JOB

The following questions ask you to describe your job. Please answer all the questions, ticking ☑ the answer which best describes the job you do *most of the time*. There is space at the end of the questionnaire for any additional comments about any of the questions.

14. Listed below are activities which your job might involve. Please estimate how much your present work role involves these activities each week.

Each week my role involves:	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
a. Delivery of care to patients	☐1	☐2	☐3	☐4	☐5
b. Delivery of treatments to patients	☐1	☐2	☐3	☐4	☐5
c. Carrying out examinations of patients	☐1	☐2	☐3	☐4	☐5
d. Assessing and planning the delivery of care to patients	☐1	☐2	☐3	☐4	☐5
e. Assessing and planning the delivery of treatments to patients	☐1	☐2	☐3	☐4	☐5
f. Assessing and planning for carrying out examinations of patients	☐1	☐2	☐3	☐4	☐5
g. Planning for the discharge of patients from hospital	☐1	☐2	☐3	☐4	☐5
h. Supervising and supporting other assistants delivering care to patients	☐1	☐2	☐3	☐4	☐5
i. Supervising and supporting newly appointed or junior RNs delivering care to patients	☐1	☐2	☐3	☐4	☐5
j. Supervising and supporting student nurses delivering care to patients	☐1	☐2	☐3	☐4	☐5
k. Supervising others delivering treatments to patients	☐1	☐2	☐3	☐4	☐5
l. Supervising others carrying out examinations of patients	☐1	☐2	☐3	☐4	☐5
m. Discussions with patients about their concerns about treatment or condition	☐1	☐2	☐3	☐4	☐5
n. Discussions with relatives	☐1	☐2	☐3	☐4	☐5
o. Providing continuity of care to patients	☐1	☐2	☐3	☐4	☐5
p. Administrative duties/ data entry	☐1	☐2	☐3	☐4	☐5
q. Attending meetings	☐1	☐2	☐3	☐4	☐5

Continue next page

r. Report writing	☐1	☐2	☐3	☐4	☐5
s. Delivering a verbal handover of patient care to nursing staff on the subsequent shift	☐1	☐2	☐3	☐4	☐5
t. Participating in a medical ward round to communicate patient conditions with medical staff and allied health care professionals	☐1	☐2	☐3	☐4	☐5
u. Taking a caseload/ team/ bay of patients	☐1	☐2	☐3	☐4	☐5
v. Administering medications	☐1	☐2	☐3	☐4	☐5

15. To what extent do you agree or disagree with the following?

The AP role….	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. …was developed in my organisation to fill a skills gap in the nursing team (between RNs & HCAs)	☐1	☐2	☐3	☐4	☐5
b. …was developed in my organisation to reward long serving assistant staff	☐1	☐2	☐3	☐4	☐5
c. …is all about meeting patient need	☐1	☐2	☐3	☐4	☐5
d. …provides an opportunity for career progression for assistant staff	☐1	☐2	☐3	☐4	☐5
e. …provides an opportunity for staff that are not able to undertake RN training	☐1	☐2	☐3	☐4	☐5
f. …is successful when the assistant has worked in the organisation for many years and is an 'insider' (rather than being appointed from outside the organisation)	☐1	☐2	☐3	☐4	☐5
g. …provides an opportunity for staff that do not want to undertake RN training	☐1	☐2	☐3	☐4	☐5
h. …is suitable for all clinical specialities	☐1	☐2	☐3	☐4	☐5
i. …is better suited to some specialities	☐1	☐2	☐3	☐4	☐5
j. …provides support and relief for RNs	☐1	☐2	☐3	☐4	☐5
k. …frees up time for RNs to focus on more complex patients	☐1	☐2	☐3	☐4	☐5
l. …can replace/ substitute for a RN during a shift	☐1	☐2	☐3	☐4	☐5
m. …has knowledge and skills that can be easily transferred and used across a variety of settings	☐1	☐2	☐3	☐4	☐5
n. …has knowledge and skills that are particular to a clinical setting and not easily transferable	☐1	☐2	☐3	☐4	☐5

16. To what extent do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I always know what my responsibilities are	☐1	☐2	☐3	☐4	☐5
b. I am consulted about changes that affect my work	☐1	☐2	☐3	☐4	☐5
c. I do not have time to carry out all my work	☐1	☐2	☐3	☐4	☐5
d. I get clear feedback about how well I am doing my job	☐1	☐2	☐3	☐4	☐5
e. I can decide on my own how to go about doing my work	☐1	☐2	☐3	☐4	☐5
f. I often feel pulled in many directions because of my workload demands	☐1	☐2	☐3	☐4	☐5
g. I have fluctuating responsibilities depending on the shift I am working and numbers of other nursing staff on duty	☐1	☐2	☐3	☐4	☐5
h. What I do, depends on which RN I am working with	☐1	☐2	☐3	☐4	☐5
i. What I do, depends too much on what other nurses say I can do	☐1	☐2	☐3	☐4	☐5
j. I have a clear job description for my role as an AP	☐1	☐2	☐3	☐4	☐5
k. Staff that I work with in my ward understand my role as an AP	☐1	☐2	☐3	☐4	☐5
l. Staff in the wider organisation understand my role as an AP	☐1	☐2	☐3	☐4	☐5
m. Patients understand my role as an AP	☐1	☐2	☐3	☐4	☐5
n. Relatives and visitors to the ward understand my role as an AP	☐1	☐2	☐3	☐4	☐5

17. The following questions ask about the extent to which other people provide you with help or support.

To what extent can you:	Not at all	Just a little	Moderate amount	Quite a lot	A great deal
a. Count on your colleagues to listen to you when you need to talk about problems at work?	☐1	☐2	☐3	☐4	☐5
b. Count on your colleagues to back you up at work?	☐1	☐2	☐3	☐4	☐5
c. Count on your colleagues to help you with a difficult task at work?	☐1	☐2	☐3	☐4	☐5
d. Really count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?	☐1	☐2	☐3	☐4	☐5

18. How satisfied are you with each of the following areas of your job?

	Very dissatisfied	Moderately dissatisfied	Not sure	Moderately satisfied	Very satisfied
a. The recognition I get for good work	☐1	☐2	☐3	☐4	☐5
b. The support I get from my immediate manager	☐1	☐2	☐3	☐4	☐5
c. The freedom I have to choose my own method of working	☐1	☐2	☐3	☐4	☐5
d. The support I get from my work colleagues	☐1	☐2	☐3	☐4	☐5
e. The amount of responsibility I am given	☐1	☐2	☐3	☐4	☐5
f. The number of APs working in my clinical ward/ department	☐1	☐2	☐3	☐4	☐5
g. The opportunities I have to use my abilities	☐1	☐2	☐3	☐4	☐5
h. The extent to which my Trust values my work	☐1	☐2	☐3	☐4	☐5

19. To what extent do you agree with the following statements about your immediate (ward-based/ department-based) manager?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My immediate manager…					
a… encourages those who work for her/ him to work as a team	☐1	☐2	☐3	☐4	☐5
b… can be counted on to help me with a difficult task at work	☐1	☐2	☐3	☐4	☐5
c… gives me clear feedback on my work	☐1	☐2	☐3	☐4	☐5
d… asks for my opinion before making decisions that affect my work	☐1	☐2	☐3	☐4	☐5
e… is supportive in a personal crisis	☐1	☐2	☐3	☐4	☐5

20. The following questions ask for your opinion on registration for the role of assistant practitioners. To what extent do you agree or disagree that…

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. The AP role should be registered and regulated	☐1	☐2	☐3	☐4	☐5
b. Registration would enable APs to expand their practice	☐1	☐2	☐3	☐4	☐5
c. Registration would increase AP responsibility for their own actions	☐1	☐2	☐3	☐4	☐5
d. Registration would protect patients	☐1	☐2	☐3	☐4	☐5
e. Registration would protect APs	☐1	☐2	☐3	☐4	☐5
f. Registration would increase RN confidence in the AP role	☐1	☐2	☐3	☐4	☐5
g. Registration would increase other health care professionals confidence in the AP role	☐1	☐2	☐3	☐4	☐5
h. All assistant staff (regardless of agenda for change banding) should be registered and regulated	☐1	☐2	☐3	☐4	☐5

21. Do you currently have a mentor? ***Please tick one answer***

No ☐2 → Please go to Q22

Yes ☐1 → Please insert the job title of your mentor below then got to Q22:

_____

22. To what extent do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I often think about leaving this Trust	☐1	☐2	☐3	☐4	☐5
b. I will probably look for a new job in the next 12 months	☐1	☐2	☐3	☐4	☐5
c. As soon as I can find another job, I will leave this Trust	☐1	☐2	☐3	☐4	☐5
d. If I leave my current job, I would want to stay in the NHS	☐1	☐2	☐3	☐4	☐5

23. If you are considering leaving your job (and therefore answered 'agree' or 'strongly agree' to Q22a, b or c), then please indicate why you are considering leaving. ***Please tick all boxes that apply***. If you are not considering leaving your job, please go to Q24.

Career development	☐1	Unhappy with current job	☐2	Don't want to work in NHS	☐3
Change of career	☐4	Family or personal reasons	☐5	Retirement	☐6
Would like more pay	☐7	Entering full time education	☐8	Other reason	☐9

24. Have you had an appraisal or development review in the last 12 months?

Yes ☐1 → Please answer Q25, Q26 & Q27

No ☐2 → Please go to Q28

The following questions ask you about performance reviews and training. Please answer all the questions, ticking ☑ the answer to indicate your response.

25. Appraisal or development review	Yes	No
a. Was your appraisal or performance development review useful in helping to improve how you do your job?	☐1	☐2
b. Did you agree clear objectives for your work during the appraisal/ review?	☐1	☐2
c. Did the appraisal or performance development review leave you feeling your work is valued by your Trust?	☐1	☐2

26. In the past 12 months, as part of your appraisal or performance development review, did you agree a Personal Development Plan?

Yes ☐1 → Please answer Q27 (a-b)

No ☐2 → Please go to Q28

27. Personal development plans	Yes	No	Too early to say
a. Have you received the training, learning and development that was identified in the plan?	☐1	☐2	☐3
b. Has your immediate manager supported you in accessing this training, learning and development?	☐1	☐2	☐3

28. Thinking about training, learning or development provided by the Trust, please indicate how much you agree with the following statements:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. The training I received fully prepared me for my role as an AP	☐1	☐2	☐3	☐4	☐5
b. The skills of staff are developed so that they can improve their job performance	☐1	☐2	☐3	☐4	☐5
c. The Trust strongly believes in the importance of training	☐1	☐2	☐3	☐4	☐5
d. People are not properly trained in the Trust when new procedures are introduced	☐1	☐2	☐3	☐4	☐5
e. Staff are strongly encouraged to develop their skills in the Trust	☐1	☐2	☐3	☐4	☐5
f. Staff can only develop skills if they're prepared to do it in their own time	☐1	☐2	☐3	☐4	☐5
g. The Trust only gives people the minimum amount of training they need to do their jobs	☐1	☐2	☐3	☐4	☐5
h. There are plenty opportunities for my continuing development	☐1	☐2	☐3	☐4	☐5

29. Thinking of any training, learning or development that you have done in the past 12 months (paid for or provided by your Trust), please indicate how much you agree with the following statements:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. Your training, learning and development has helped you to do your job better	☐1	☐2	☐3	☐4	☐5
b. It has improved your chances of promotion	☐1	☐2	☐3	☐4	☐5
c. It has helped you stay up-to-date with the job	☐1	☐2	☐3	☐4	☐5
d. It has helped you stay up-to-date with professional requirements	☐1	☐2	☐3	☐4	☐5

If you have any further comments to make about your work or role then please feel free to write them in the space below. Please insert extra pages if you need extra space for your comments.

Thank you for completing this questionnaire. It will be a valuable contribution to our study. Please place the questionnaire in the pre-paid envelope provided, seal it, and return it to us in the post.

Don't forget to enclose the separate reply slip if you would like to receive a copy of the findings. This will be separated from your questionnaire immediately. Alternatively, email Dr Karen Spilsbury (ks25@york.ac.uk) with your request for a copy of the report.

If you have any questions or concerns about the questionnaire, please contact:

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Thank you again for your co-operation.

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Appendix 11 Stage 1 Analysis of case site questionnaires: Tables of responses (case sites combined)

Table 1: Characteristics of respondents

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number of respondents	Total responses Count (% within case site)	141 (52%)	17 (6%)	49 (18%)	29 (11%)	33 (12%)	269 (100%)
Age	Mean age (SD)	41 (10)	42 (8)	40 (12)	41 (9)	41 (10)	41 (10)
Gender	Number (%) female	128 (91%)	11 (65%)	42 (88%)	29 (100%)	29 (91%)	239 (90%)
Years worked in the NHS	Mean (SD)	14.7 (11.6)	14.3 (8.9)	9.1 (7.1)	14.3 (6.5)	11.4 (7.0)	13.2 (10.0)
	Quartiles: 25	4.8	7.4	4.5	8.6	7.2	5.4
	50 (median)	10.2	10.0	7.0	14.8	10.0	10.0
	75	25.1	19.2	12.7	18.8	16.2	19.0
	Range (min-max)	0.17-47.0	4.7-34.0	0.25-32.0	4.4-30.0	1.1-27.2	0.17-47
Ethnic group (no., %)	British white	117 (83%)	17 (100%)	42 (89%)	28 (97%)	30 (97%)	234 (88%)
	Other white	8 (6%)	-	2 (4%)	-	1 (3%)	11 (4%)
	Asian British	6 (4%)	-	2 (2%)	-	-	8 (3%)
	Black British	10 (7%)	-	1 (2%)	1 (3%)	-	12 (5%)
Highest level of qualification (no., %)	Degree	25 (18%)	-	-	-	-	25 (10%)
	Diploma	70 (50%)	-	-	-	-	70 (27%)
	Pre-diploma / EN	39 (28%)	-	-	-	-	39 (15%)
	Foundation degree	1 (1%)	14 (82%)	-	14 (50%)	16 (52%)	45 (17%)
	Certificate of Higher Ed	-	3 (18%)	-	13 (46%)	10 (32%)	26 (10%)
	NVQ (S or G)	-	-	27 (60%)	-	3 (10%)	30 (12%)
	Other	4 (3%)	-	12 (27%)	1 (4%)	2 (6%)	19 (7%)
	No health care related	-	-	6 (13%)	-	-	6 (2%)

Table 2: Respondents' working week

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Contracted hours	Overall mean hours (SD)	33.2 (6.6)	36.3 (2.8)	32.9 (7.0)	34.9 (4.7)	34.2 (6.3)	33.6 (6.4)
	Number (%) part time (<35 hours per week)	51 36.2%	2 11.8%	20 40.8%	7 24.1%	8 25.0%	88 32.8%
Part timers	Mean hours (SD)	25.9 (6.1)	29.0 (1.4)	26.5 (7.1)	27.4 (3.7)	25.3 (8.4)	26.1 (6.3)
	Median hours Range (min-max)	28.0 (7.5-34.5)	29.0 (28.0-30.0)	29.0 (13.0-34.5)	28.0 (20.0-30.8)	30.0 (7.5-32.0)	28.0 (7.5-34.5)
Overtime working	Number (%) of FTs working any overtime in the last week	34 39%	5 33%	10 35%	6 30%	7 30%	62 35%
	Number (%) of PTs working any overtime in the last week	15 29%	1 50%	6 30%	2 29%	1 13%	25 28%
	Mean (SD) paid overtime hours*	4.7 (6.4)	9.4 (4.8)	8.5 (7.1)	3.9 (5.7)	3.2 (3.6)	5.5 (6.3)
	Mean (SD) unpaid overtime hours*	1.0 (1.3)	-	0.3 (0.9)	1.1 (1.9)	0.3 (0.9)	0.7 (1.3)
	Mean (SD) overtime hours given as time off*	0.9 (1.9)	-	0.6 (2.0)	0.2 (0.6)	0.9 (1.2)	0.7 (1.7)
	Mean (SD) total overtime hours*	6.6 (5.8)	9.4 (4.8)	9.5 (6.5)	5.2 (4.8)	4.3 (2.5)	7.0 (5.6)
Notice given before overtime*	< 24 hours – no. (%)	30 (67%)	1 (17%)	4 (29%)	3 (43%)	3 (38%)	41 (51%)
	24 hours – 1 week – no. (%)	11 (24%	3 (50%)	4 (29%)	3 (43%)	2 (25%)	23 (29%)
	> 1 week – no. (%)	4 (9%)	2 (33%)	6 (43%)	1 (14%)	3 (38%)	16 (20%)
	Choice given – number (%)	24 (60%)	5 (100%)	9 (69%)	5 (71%)	4 (57%)	47 (65%)

*for those with any overtime stated in the last week

Table 3: Respondents' contracts and working patterns

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Shift or rota systems / normal working hours	Permanent day duty including early and late shifts – no. (%)	37 26%	3 18%	6 13%	13 45%	10 30%	69 26%
	Permanent night duty – no. (%)	17 12%	0 0%	10 21%	0 0%	0 0%	27 10%
	Internal rotation (mix of day and night shifts) – no. (%)	82 58%	13 77%	28 60%	15 51%	3 9%	141 53%
	Permanent day duty with regular hours – no. (%)	5 4%	1 6%	3 6%	1 3%	20 61%	30 11%
Contract type	Number (%) on fixed term contract	9 6%	0 0%	2 4%	1 4%	0 0%	12 5%

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Table 4: Respondents' work role and activities

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
	Delivery of care to patients / clients	127 90%	17 100%	46 94%	27 93%	24 73%	241 90%
	Delivery of treatment to patients / clients	124 88%	14 82%	15 31%	20 69%	18 55%	191 71%
	Carrying out examinations of patients / clients	75 53%	9 53%	6 12%	12 41%	12 36%	114 42%
	Planning the delivery of care to patients / clients	120 85%	14 82%	12 25%	13 45%	10 30%	169 63%
	Planning the delivery of treatments to patients / clients	99 70%	9 53%	2 4%	9 31%	8 24%	127 47%
	Planning for carrying out examinations of patients / clients	67 48%	8 47%	2 4%	8 28%	14 42%	99 37%
	Supervising others delivering care to patients / clients	98 70%	12 71%	11 22%	11 38%	9 27%	141 52%
	Supervising others delivering treatments to patients / clients	86 61%	10 59%	7 14%	4 14%	6 18%	113 42%
	Supervising others' carrying out examinations of patients / clients	63 45%	7 41%	7 14%	5 17%	6 18%	88 33%
	Discussions with patients / clients about concerns relating to their treatment or condition	108 77%	14 82%	15 31%	15 52%	20 61%	172 64%
	Discussions with relatives	104 74%	11 65%	5 10%	15 52%	10 30%	145 54%
	Administrative duties / data entry	79 56%	12 71%	10 20%	10 35%	25 76%	136 51%
	Attending meetings	28 20%	6 35%	7 14%	4 14%	12 36%	57 21%
	Report writing	110 78%	16 94%	5 10%	11 38%	11 33%	153 57%

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Table 5: Job clarity and autonomy, and staff relationships and support

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) agreeing or strongly agreeing with these statements	I always know what my responsibilities are	133 94%	15 88%	45 92%	24 83%	23 70%	240 89%
	I am consulted about changes that affect my work	87 62%	15 88%	36 74%	18 62%	16 49%	172 64%
	I do not have time to carry out all my work	91 65%	5 29%	26 53%	10 35%	10 30%	142 53%
	I get clear feedback about how well I am doing my job	63 45%	10 59%	26 53%	15 52%	16 49%	130 48%
	Relationships at work are strained	46 33%	2 12%	11 22%	9 31%	9 27%	77 29%
	I can decide on my own how to go about doing my work	93 66%	13 77%	35 71%	15 52%	16 49%	172 64%
Number (%) answering 'quite a lot' or 'a great deal' to the question 'to what extent can you...'	Count on your colleagues to listen to you when you need to talk about problems at work?	96 68%	16 94%	31 63%	19 66%	19 58%	181 67%
	Count on your colleagues to back you up at work?	83 59%	14 82%	25 51%	18 62%	13 39%	153 57%
	Count on your colleagues to help you with a difficult task at work?	107 76%	15 88%	37 76%	23 79%	24 73%	206 77%
	Really count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?	101 72%	15 88%	33 67%	21 72%	20 61%	190 71%

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Table 6: Job satisfaction

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) moderately or very satisfied with these areas of their job	The recognition I get for good work	82 58%	12 70%	31 63%	19 66%	14 42%	158 59%
	The support I get from my immediate manager	109 77%	14 82%	38 78%	20 69%	20 61%	201 75%
	The freedom I have to choose my own method of working	104 74%	12 71%	34 69%	18 62%	17 52%	185 69%
	The support I get from my work colleagues	124 88%	14 82%	40 82%	24 83%	22 67%	224 83%
	The amount of responsibility I am given	111 79%	15 88%	34 69%	19 66%	21 64%	200 74%
	The opportunities I have to use my abilities	119 84%	15 88%	36 74%	20 69%	15 46%	205 76%
	The extent to which my Trust values my work	35 25%	5 29%	23 47%	7 24%	12 36%	82 31%
Number (%) that agree or strongly agree with these statements	I often think about leaving this Trust	34 24%	2 12%	6 12%	10 35%	10 30%	62 23%
	I will probably look for a new job in the next 12 months	34 24%	2 12%	5 10%	4 14%	11 33%	56 21%
	As soon as I can find another job, I will leave this Trust	12 9%	1 6%	2 4%	1 3%	4 12%	20 7%
	If I leave my current job, I would want to stay in the NHS	81 57%	9 53%	27 55%	13 45%	21 64%	151 56%

87 individuals answered 'agree' or 'strongly agree' to one or more of the questions about leaving the Trust and looking for another job. The most frequently given reasons were because of career development (n=40), 'unhappy with current job' (n=29), 'more pay' (n=21), 'change of career' (n=18), 'family or personal reasons' (n=13), and 'other' reasons (n=19).

Table 7: Perceptions of support from line manager

	Statement: 'My immediate line manager ...	Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) agreeing or strongly agreeing with these statements	'... encourages those who work for her/him to work as a team'	116 82%	16 94%	39 80%	21 72%	17 52%	209 78%
	'... can be counted on to help me with a difficult task at work'	102 72%	16 94%	35 71%	17 59%	17 52%	187 70%
	'... gives me clear feedback on my work'	77 55%	9 53%	31 63%	12 41%	13 39%	142 53%
	'... asks for my opinion before making decisions that affect my work'	65 46%	10 59%	25 51%	16 55%	9 27%	125 47%
	'... is supportive in a personal crisis'	76 54%	13 77%	24 49%	13 45%	15 46%	141 52%

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Table 8: Performance review, appraisal and personal development

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
	Number (%) who have had an appraisal or development review in the last 12 months	99 71%	13 77%	37 77%	19 66%	25 78%	193 73%
Of those who had an appraisal or development review	Number (%) who found it useful in helping to improve how they do their job	77 79%	9 82%	27 73%	13 68%	15 63%	141 75%
	Number (%) who agreed clear objectives for their work	94 96%	11 91%	31 86%	16 84%	19 79%	171 91%
	Number (%) whose review left them feeling their work is valued by the Trust	47 49%	7 64%	25 68%	13 68%	8 33%	100 54%
	Number who have agreed a personal development plan	92 94%	12 100%	32 87%	15 79%	22 92%	173 91%
Of those who agreed a personal development plan	Number (%) who have received the training, learning and development identified in the plan	50 53%	7 58%	12 38%	8 53%	9 41%	86 49%
	Number (%) whose manager supported them in accessing the training	57 61%	9 75%	17 53%	10 67%	8 38%	101 58%

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Table 9: Training, learning and development received

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) having received training, learning or development in these areas	Equal opportunities	27 19%	3 18%	9 18%	3 10%	5 15%	47 18%
	Race awareness	38 27%	7 41%	13 27%	7 24%	17 52%	82 31%
	Gender awareness	30 21%	6 35%	15 31%	6 21%	16 49%	73 27%
	Disability awareness	37 26%	6 35%	15 31%	9 31%	18 55%	85 32%
	Harassment and bullying awareness	46 33%	8 47%	18 37%	7 24%	17 52%	96 36%
	Religious and faith awareness	35 25%	6 35%	14 29%	7 24%	15 46%	77 29%
	Cultural competence	29 21%	6 35%	13 27%	5 17%	15 46%	68 25%
	Age awareness	24 17%	4 24%	14 29%	11 38%	13 39%	66 25%
	Other	20 14%	3 18%	9 18%	7 24%	6 18%	45 17%

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Table 9: Training, learning and development received (continued)

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) having received training, learning or development in these areas	Health and safety	116 82%	14 82%	40 82%	26 90%	28 85%	224 83%
	Handling a major incident or emergency	65 46%	8 47%	24 49%	15 52%	21 64%	133 49%
	Preventing/handling violence and aggression	56 40%	8 47%	27 55%	17 59%	13 39%	121 45%
	Infection control	132 94%	17 100%	45 92%	27 93%	32 97%	253 94%
	Computer skills	74 52.5%	13 77%	23 47%	15 52%	21 64%	146 54%
	Handling confidential information about patients/clients	91 65%	12 70%	37 76%	20 69%	28 85%	188 70%
	Asking patients/clients about their use of alcohol or drugs	15 11%	2 12%	6 12%	4 14%	3 9%	30 11%
	Handling patients/clients who are drunk or under the influence of drugs	15 11%	1 6%	7 14%	2 7%	4 12%	29 11%
	Providing information to patients/clients on diagnosis, medication, side effects etc.	51 36%	2 12%	5 10%	3 10%	4 12%	65 24%

Table 10: Attitudes towards training, learning and development

		Registered nurses	Ward-based band 4 workers	Health care assistants	Assistant practitioners (nursing)	Assistant practitioners (other)	Total
Number (%) that agree or strongly agree with these statements	The skills of staff are developed so that they can improve their job performance	24 17%	5 29%	14 29%	3 10%	8 24%	54 20%
	The Trust strongly believes in the importance of training	82 58%	13 77%	37 76%	22 76%	26 79%	180 67%
	People are not properly trained in the Trust when new procedures are introduced	58 41%	3 18%	13 27%	9 31%	5 15%	88 33%
	Staff are strongly encouraged to develop their skills in the Trust	78 55%	7 41%	31 63%	15 52%	25 76%	156 58%
	Staff can only develop skills if they are prepared to do it in their own time	65 46%	4 24%	11 22%	7 24%	4 12%	91 34%
	The Trust only gives people the minimum amount of training they need to do their jobs	70 50%	6 35%	16 33%	8 28%	6 18%	106 39%
Number (%) that agree or strongly agree with these statements with regard to training in the past 12 months	Your training, learning and development has helped you to do your job better	19 14%	3 18%	14 29%	8 28%	8 24%	52 19%
	It has improved your chances of promotion	29 21%	5 29%	12 25%	15 52%	11 33%	72 27%
	It has helped you to stay up-to-date with the job	108 77%	13 77%	35 71%	22 76%	26 79%	204 76%
	It has helped you to stay up-to-date with professional requirements	108 77%	12 71%	34 69%	21 72%	24 73%	199 74%

Appendix 12 Detailed breakdown of all activities performed by each practitioner group across all three case sites

	Nurse - n (%)	AP - n (%)	HCSW - n (%)
Direct care			
Direct unseen	23 (0.3)	5 (0.2)	17 (0.5)
Medical proc	160 (1.8)	32 (1.3)	22 (0.6)
Comm patients	407 (4.5)	140 (5.6)	174 (4.6)
Nutrition	48 (0.5)	29 (1.2)	63 (1.7)
Hygiene	668 (7.4)	362 (14.4)	838 (22.4)
Elimination	114 (1.3)	73 (2.9)	147 (3.9)
Medication	1085 (11.9)	35 (1.4)	16 (0.4)
Movement	146 (1.6)	92 (3.7)	191 (5.1)
Vital signs	278 (3.1)	122 (4.9)	230 (6.1)
Specimens	75 (0.8)	21 (0.8)	20 (0.5)
Nursing proc	461 (5.1)	151 (6.0)	194 (5.2)
Esc/Adm/Disch	270 (3.0)	90 (3.6)	96 (2.6)
Teaching staff bed	40 (0.4)	9 (0.4)	3 (0.1)
Assisting drs	220 (2.4)	19 (0.8)	2 (0.1)
Assit others	7 (0.1)	3 (0.1)	1 (0.0)
Indirect care			
Charting	512 (5.6)	121 (4.8)	61 (1.6)
Reporting	1301 (14.3)	246 (9.8)	217 (5.8)
Comm staff	206 (2.3)	29 (1.2)	20 (0.5)
Comm relatives	134 (1.5)	25 (1.0)	28 (0.8)
Teaching staff	63 (0.7)	6 (0.2)	0
Associated			
Cleaning	223 (2.5)	113 (4.5)	192 (5.1)
Meals and drinks	104 (1.1)	99 (3.9)	250 (6.7)
Clerical	348 (3.8)	94 (3.7)	95 (2.5)
Admin comm	1161 (12.8)	264 (10.5)	339 (9.0)
Errands	59 (0.7)	34 (1.4)	46 (1.2)
Supplies	40 (0.4)	18 (0.7)	38 (1.0)
Meetings	151 (1.7)	4 (0.2)	7 (0.2)
Supervising	57 (0.6)	13 (0.5)	17 (0.5)
Non-productive			
Personal	57 (0.6)	24 (1.0)	44 (1.2)
Unoccupied	70 (0.8)	16 (0.6)	35 (0.9)
Breaks	516 (5.7)	176 (7.0)	313 (8.4)
Other	85 (0.9)	53 (2.1)	32 (0.9)

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.