

*Staffing matters;
funding counts –*
**Pressure point:
Associate nurses**

Can the planned new ‘associate nurse’ role
make a difference?

About this supplement

This supplement is produced to accompany the report *Staffing matters; funding counts: Workforce profile and trends in the English NHS*.

During the research to inform the report, six particular pressure points were identified for the workforce of the NHS in England. The pressure points were chosen based on feedback from a stakeholder roundtable, held in October 2015, and analysis of recent policy reports.

The pressure points are:

- the proposed changes to nurse bursaries
- international recruitment to fill vacancies
- the recruitment and retention of GPs
- the potential of physician associates
- the potential of nursing associates
- the use of temporary and agency workers.

These pressure points need to be addressed if the health service is to have access to the staff it needs to deliver high quality care.

In addition to the discussion in *Staffing matters; funding counts*, more detailed information and analysis about each of these pressure points is available as part of a series of supplements, from www.health.org.uk/publication/staffing-matters-funding-counts.

Please note: While the focus of this supplement is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

Can the planned new ‘associate nurse’ role make a difference?

Associate nurses: The issue

In December 2015, the government announced plans to create a new nursing support role. The new role is ‘expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve’.¹ Nursing associates ‘will support nurses to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care’.

It is reported that it will be up to individual NHS employers to decide how many nursing associates they need in their organisation. However, subject to the outcome of a consultation, it is anticipated that up to 1,000 nursing associates could be trained each year from 2016. The government remains committed to training the right number of staff and will maintain nurse training places as the scheme goes forward; 23,000 more nurses should be available by the end of this parliament’.

Earlier this year there was a consultation on this new role, with respondents asked to consider the potential for a new role ‘to sit between a Care Assistant with a Care Certificate and a graduate Registered Nurse’, to consider ‘whether or not the proposed role should be regulated’ and to agree the title of this new role.² At the end of the consultation phase in late May, Health Education England (HEE) announced that the new role would be established.³ Test sites will recruit 1,000 students to start training in 2017. In the first instance this would involve developing a scope of practice for the new role, based on workshops to be scheduled this summer, before testing it next year. Issues that remain for examination include how the role will be supervised, if the role may have supervisory responsibilities for care assistants, and whether nursing associates should be regulated.⁴

Associate nurses: The evidence

The UK is in a minority of high income countries in only having one level of qualified/registered nurse.⁵ Many high income countries educate and employ two levels, a ‘first-level’ nurse with three or more years of training, often to degree level, and usually termed a registered nurse; and a ‘second-level’ nurse with one or two years of technically focused training, variously titled enrolled nurse, licensed practical nurse and licensed vocational nurse in different countries.

The UK did have a second-level (‘enrolled’) nurse, but this role was phased out in the 1990s. This was in response to the demand from the nursing profession to end role overlap and uncertainty and to focus on one, higher, level of registered nurse educated in colleges and universities rather than in schools of nursing affiliated with hospitals. Part of the move to this new supernumerary status for the single level of student nurse was the introduction of the role of vocationally qualified health care assistant (HCA) to fill some of the care gap created by the ending of enrolled nurse (EN) training.

The numbers of ENs in the UK subsequently dropped as those in the workforce either retired or were converted to registered nurses. There were more than 70,000 ENs working in the NHS in the mid-1980s – one third of the qualified nursing workforce at the time⁶ – now there are only about 3,000.

The ‘replacement’ HCAs were introduced in the late 1990s, and while initial numbers were small, there has been steady growth over the last two decades, and there are now about 60,000 (full-time equivalent – FTE) working in the NHS – about 30,000 more than 10 years earlier. But numerical growth in HCAs has been mirrored by decline in the number of auxiliary nurses – there are now about 50,000 (FTE), some 30,000 less than 10 years ago. So in crude numerical terms, the growing number of HCAs has not compensated for the reduced numbers of ENs, but has covered for the reduction in auxiliaries.

In other countries the second-level nurse continues to be a substantial source of care in health systems that have retained the role. Australia deployed about 60,000 ENs in 2014⁷ (20% of the qualified nurse workforce) and the EN role has been extended, with some now educated to administer drugs and supervise other staff and students;⁸ in the US there were approximately 730,000 licenced practice nurses (LPNs) active in 2012⁹ (again, about 20% of the qualified nurse workforce). New Zealand ended enrolled nurse training during the early 1990s, but subsequently reintroduced training.¹⁰

The absence of a second level of nurse in the UK has raised debate about constraints on the flexibility of workforce deployment and appropriate skill mix, with some policymakers and managers identifying a skills ‘gap’ to be filled, between the HCA role and the registered nurse role. Counter arguments in favour of the single level have focused on the benefits of higher skills and improved outcomes when only one, higher level of nurse is deployed.¹¹ The debate also needs to have a labour market perspective. The EN role had a different recruitment pool, was a stable part of the workforce and, at its height, comprised about one-third of the nursing workforce in England (and is currently one in five of the workforce in Australia and the US). The phasing out of the role in the UK has in effect reduced the overall size of the registered nursing workforce.

The announcement of the associate nurse role in the UK could be perceived as a move to, in part, fill the gap left by the ending of the EN role, as well as provide scope to recruit from broader labour markets to achieve a numerical scale up in the broader nurse workforce. The role could also be used to extend the current career ladder and give aspirational HCAs a next step in career development.

However there is also a risk of role confusion, as the NHS already employs a few thousand ‘assistant practitioners’. When introduced last decade, this new role was intended to deliver protocol-based clinical care that was previously associated with registered practitioners, while under the direction and supervision of a registered practitioner; the role descriptor was published by Skills for Health almost 10 years ago.¹² This ‘old/new’ role appears to have some of the characteristics promoted in the ‘new’ role of associate nurse, but in terms of numerical growth, the assistant practitioner cannot be cited as an example of rapid scale up.

Although introduced 10 years ago, the assistant practitioner role has only been separately identified in NHS data since the beginning of 2011, and current data suggest there are only about 4,000 (FTE) recorded as working in the NHS in England. An early review of the assistant practitioner (AP) role highlighted role confusion, a plethora of job titles, and unclear career prospects, concluding that ‘it is still not clear what managers and workforce planners want from the AP role as it does not have a clearly defined position in the clinical hierarchy, despite being located at level four on the Skills for Health (2008) framework’.¹³

The NHS in England has tried out various new roles in the last 10 years or so. Not all have been successful, in terms of achieving a prominent profile in the overall workforce. Some have been promoted and then marginalised, when funding tightened or when demand proved to be much lower than anticipated. The HCA has been a success in numerical terms (but took 10 years or more to reach significant numbers, while only requiring a few week training). As noted above, some other ‘old/new’ roles, such as the physician assistant, which were first piloted around 10 years ago, remain almost invisible in terms of national numbers. Along with the AP role, these no longer appear to excite much policy interest (although as noted above, another ‘new’ role of physician associate has also been recently promoted, but does not appear to differ from the ‘old’ role of physician assistant*).

Associate nurses: Conclusions

The proposed introduction of the associate nurse appears to risk confusion in two directions. Firstly most of the debate and review has been about the role: how it should be regulated, whether it will supplement, or substitute, for registered nurses, or if it will be a ‘new’ EN. The quality impact of any skill mix change is important, but will have to be considered beyond the simple ‘regulate or do not regulate’ debate. Relatively little attention has been paid to how training of the new role will be funded, how many nurses are required (other than an arbitrary training target) and to what timeline.

Secondly, it must be noted that the track record of the NHS with the introduction of new roles is mixed, and far from encouraging. The lesson here is that a new role is never a quick fix. Even if it does receive unwavering policy attention (by no means a given), it will probably take at least a decade to have significant numerical impact. It will also require sustained investment in training (funding and capacity), and preparation of recipient health systems and existing workforces. Recent experience in the NHS suggests that the sustained policy involvement and national funding required to enable a new role to mature may be found wanting.

At a time when the NHS is trying to control a rapid increase in staffing costs, the fiscal space to support any rapid large-number scale up of a ‘new’ role is just not evident. Unless there was to be either a determined effort to scale up the new role by switching scarce training funds from current allocations to other established roles, or earmarked central funding to kick start training capacity and scale up, it is unlikely that the associate nurse will become a salient and integral part of the broader health workforce much before the middle of the next decade.

* For more information about this role, see the pressure point supplement ‘Can the physicians associate become a significant part of the workforce?’. Available from www.health.org.uk/publication/staffing-matters-funding-counts

References

1. Department of Health. *Nursing associate role offers new route into nursing*. Department of Health, 2015. www.gov.uk/government/news/nursing-associate-role-offers-new-route-into-nursing
2. Health Education England (HEE). *Nursing associate consultation: frequently asked questions*. HEE, 2015. www.hee.nhs.uk/sites/default/files/documents/Nursing%20associate%20FAQs_0.pdf
3. Health Education England (HEE) *A new support role for nursing*. HEE, 2016. www.hee.nhs.uk/our-work/developing-our-workforce/nursing/new-support-role-nursing
4. Merrifield N. 'Green light' given for nursing associates, says HEE, as consultation results revealed. *Nursing Times*, May 26 2016. www.nursingtimes.net/news/education/associate-role-supervision-to-be-debated-over-summer/7005152.article?blocktitle=today's-headlines&contentid=18932
5. Robinson S, Griffiths P. *Nursing education and regulation: international profiles and perspectives*. Kings College London, 2007. <http://eprints.soton.ac.uk/348772/1/NurseEduProfiles.pdf>
6. Seccombe I, Smith G, Buchan J, Ball J. *Enrolled nurses. A study for the UKCC*. Report 344. Institute for Employment Studies, 1997. www.employment-studies.co.uk/system/files/resources/files/344.pdf
7. Australian Institute of Health and Welfare. *Nursing and midwifery workforce*. Available from: www.aihw.gov.au/workforce/nursing-and-midwifery (accessed 6 July 2016)
8. Keast K. Taking enrolled nurses into a new era. *Australian Nursing and Midwifery Journal*, 2016 23(8) 21-25.
9. Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. *The future of the nursing workforce: national- and state-level projections, 2012-2025*. US Department of Health and Human Services Health Resources and Services Administration. HRSA, 2014. www.hrsa-report-nursing-projections.pdf
10. Department of Health, Australia. *Review of Australian government health workforce programs: nursing and midwifery education*. DOH, Canberra, 2013. www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc--chapter-7-nursing-midwifery-workforce%E2%80%93education-retention-sustainability--chapter-7-nursing-midwifery-education
11. National Nursing Research Unit, Kings College London (KCL). Is there a case for the UK nursing workforce to include grades of qualified nurse other than the registered nurse? *Policy plus evidence, issues and opinions in healthcare issue, October 2009*. KCL, 2009. [http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare\(roles\)/PolicyIssue21.pdf](http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare(roles)/PolicyIssue21.pdf)
12. Skills for Health. *Key elements of the career framework: assistant practitioner*. Skills for Health, 2007.
13. Wakefield A, Spilsbury K, Atkin K, McKenna H. What kind of work do assistant practitioners do and does this reflect the policy aspirations? *Nursing Times* 2010, 106: 12. www.nursingtimes.net/roles/practice-nurses/what-work-do-assistant-practitioners-do-and-where-do-they-fit-in-the-nursing-workforce/5013113.fullarticle

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