

Healthcare assistants in general practice: practical and conceptual issues of skill-mix change

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ABSTRACT

The emergence of healthcare assistants (HCAs) in general practice raises questions about roles and responsibilities, patients' acceptance, cost-effectiveness, patient safety and delegation, training and competence, workforce development, and professional identity. There has been minimal research into the role of HCAs and their experiences, as well as those of other staff working with HCAs in general practice. Lessons may be learned from their role and evidence of their effectiveness in hospital settings. Such research highlights blurred and contested role boundaries and threats to professional identity, which have implications for teamwork, quality of patient care, and patient safety. In this paper it is argued that transferability of evidence from hospital settings to the context of general practice cannot be assumed. Drawing on the limited research in general practice, the challenges and benefits of developing the HCA role in general practice are discussed. It is suggested that in the context of changing skill-mix models, viewing roles as fluid and dynamic is more helpful and reflective of individuals' experiences than endeavouring to impose fixed role boundaries. It is concluded that HCAs can make an increasingly useful contribution to the skill mix in general practice, but that more research and evaluation are needed to inform their training and development within the general practice team.

Keywords

family practice; healthcare assistants; health personnel; nursing assistants; nursing staff; primary healthcare; skill mix.

INTRODUCTION

Developed countries are experiencing increasing pressures on their primary and secondary healthcare services.¹ Causes include extended longevity and the consequential demographic shift to an ageing population; technological and pharmaceutical developments resulting in more sophisticated medical treatments; spiralling costs; increased patient expectations; and shortages of skilled healthcare professionals. One way of addressing these issues is through changing role boundaries between staff groups by extending, delegating, substituting existing roles, or by introducing new ones.² In the UK, for example, nurses are taking on tasks that were previously the preserve of doctors.³ In turn, more support staff may be needed to relieve nurses of routine healthcare tasks, and it has been suggested that an additional 74 000 healthcare assistants (HCAs) will be needed over the next 20 years.⁴ In other developed countries, such as the US,⁵ Finland,⁶ and Hong Kong (prior to its acquisition by China),⁷ staff are employed in equivalent support roles, although more commonly in hospital settings and in home care rather than in primary care centres.

In the UK, four strands of healthcare policy are challenging traditional roles and responsibilities in primary care. First, 'patient-led' services have shifted funding and delivery from secondary to localised primary care.^{8,9} Second, the increased emphasis on public health, health promotion, and disease prevention requires responses at local level.¹⁰ Third, the new General Medical Services contract provides financial rewards to GPs for achieving quality and outcomes targets,¹¹ and requires the routine collection of patient data. Fourth, practice-based commissioning increases GPs' flexibility in allocating their budgets. The development of the HCA role in general practice is emerging as a response to meeting the demand for extra staff in primary care to address these challenges.

ENUMERATING AND DEFINING THE HEALTHCARE ASSISTANT ROLE

In the UK, 'healthcare assistant' is the title officially applied to staff working at National Vocational Qualification (NVQ) level 2 or 3 in healthcare,¹² which

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equates to GCSE and A level respectively. HCAs may be recruited from among existing unqualified support staff, and in hospitals they commonly engage in nursing duties and direct patient care, such as bathing, monitoring, and observing patients, and talking to and reassuring patients and their relatives.¹³ Their contribution was formally recognised in October 2005 with their admission as associate members to the Royal College of Nursing (RCN).¹⁴ An indication of the growing importance of this role is the publication in April 2007 of the first issue of the *British Journal of Healthcare Assistants*.

Inconsistent use of the 'healthcare assistant' title and the use of alternative titles for the same category of staff, preclude accurate identification of the number currently employed.¹⁵ One estimate suggests that in 2005, 39 522 HCAs were employed across different NHS settings in England, along with a further 128 325 nursing auxiliaries or assistants.¹⁶ However, the distinction between these groups is unclear, as all staff with little healthcare training and who work under the supervision of a healthcare professional can sometimes be termed 'healthcare assistants'.¹⁷ Information about the number of HCAs employed specifically in general practice is more elusive. One recent estimate, based on extrapolating from a survey of GP practices, suggests that around 6700 HCAs are employed across the 8451 general practices in England.¹⁸

HEALTHCARE ASSISTANTS IN HOSPITAL SETTINGS

Published research focuses on the training,^{19–21} and/or role of HCAs in hospital settings.^{22–29} The literature identifies the value of HCAs' contribution and a number of tensions and concerns around the nursing care skill mix. HCAs have been shown to provide practical nursing care such as bathing,^{25,28,29} and emotional support,²⁵ freeing nurses to concentrate on therapeutic tasks,²⁶ medication, and paperwork.²⁵ Nurses appreciate being relieved of these routine tasks,²³ and often rely heavily on HCAs.²⁵

By working at the bedside, HCAs may cultivate closer relationships with patients than nurses do,^{21,28} and gather useful information about patients.²⁵ HCAs often identify little difference between their role and that of nurses, with the exception of drug administration, paperwork, and professional accountability.²⁶ Role boundaries are blurred,³⁰ socially negotiated, and are dependent more on contingency and culture^{21,25} and the relationship between HCAs and nurses, than on primary care trust (PCT) policy²⁸ or individual HCAs' willingness to take on responsibility.²⁶ For example, HCAs may be allocated technical tasks at times of increased workload and nurse shortage, but this work is

How this fits in

Healthcare assistants (HCAs) are an emerging group in general practice with the potential for improving patient access and releasing highly qualified staff to concentrate on treating and managing more complex conditions. However, there are concerns around preparation and training for this role and the place of HCAs in the general practice workforce. These issues need consideration within the wider discourse about skill mix in primary care.

withdrawn once professional staffing levels are restored.²⁷ HCAs have been found to exceed their remit by doing systematic observations and electrocardiogram tracings,³¹ monitoring blood glucose levels without supervision,²⁸ taking blood and dressing wounds,³² administering drugs while unsupervised, and running clinics without a nurse.¹³ In addition to these high-level clinical tasks, they have been found to communicate with doctors,²⁹ and informally instruct nursing students and newly-qualified nurses.²⁸ The dynamic nature of the role may be rewarding or a source of frustration for HCAs. Undertaking tasks for which they feel inadequately trained may cause considerable anxiety and may compromise patient safety and quality standards.³¹ The issue of delegation is discussed later in this paper.

BOUNDARY DISPUTES AND PROFESSIONAL IDENTITY

The nursing profession may be perceived as under threat, as nurses take on medical tasks and the HCA role is extended into the domain of traditional nursing.³³ Nurses claim professional identity on the basis of holistic, patient-centred care,³⁴ as distinct from the task-oriented approach they attribute to HCAs.²³ However, this distinction is contested by many HCAs who interact with and relate to patients in a way that nurses are increasingly unable to do.^{25,26} Nurses report experiencing 'role deprivation' at the loss of relationships with patients and hands-on care.^{25,26} Some defend their identity by treating HCAs as subordinates, highlighting professional credentials, and referring to professional accountability and their knowledge as the basis for a different approach to activities that are also performed by HCAs.²⁵ Nurses may undervalue HCAs' experience, skills, and knowledge of local community and organisation, and restrict their involvement in higher-level activities.²⁸ Despite their less-powerful position, there is evidence that HCAs also engage in boundary-work,³⁵ by exerting influence over inexperienced staff and choosing whether to share or withhold patient and organisational knowledge depending on their relationship with individual

nurses.²⁸ Such activities are not conducive to effective teamwork or patient care.

Evidence about the role of HCAs cannot be easily transferred from hospital settings to general practice because of differences in context and activities. General practices are more business oriented and community based than acute hospitals. Although culture is likely to vary considerably between practices, teams are more close-knit and relatively stable. Support staff are more likely to live locally and be well-known in the local communities they serve. Despite limited research on this topic, the NHS Working in Partnership Programme³⁶ and some small-scale studies (S Burns, unpublished data, 2007)³⁷ indicate that some general practices recruit HCAs from existing reception, administrative, or clerical staff, rather than seeking people with experience in clinical support roles. Responsibilities are likely to vary between practices and are largely determined by the delegating GPs or practice nurses.

In general practice, HCAs are commonly trained to undertake specific clinical procedures, such as blood pressure and new patient checks, health promotion, urinalysis, weight and height recording, ordering supplies, equipment sterilisation, and phlebotomy.³⁶⁻³⁸ Some work as both receptionist and HCA in the same practice (S Burns, unpublished data, 2007).³⁶ However, such visible mixing of roles may confuse patients and challenge their confidence in HCAs' capabilities. Patients who have longstanding, trusting relationships with their GP and practice nurse may be uncertain about the HCA role, or fail to differentiate between roles, while HCAs, unlike their counterparts in hospitals, may feel isolated without interaction with, and support of, colleagues in the same role.

SKILL MIX IN PRIMARY CARE

Literature on the skill mix in general practice or primary care,³⁹⁻⁴⁵ regarding practice nurses,^{46,47} and nurse practitioners,⁴⁸⁻⁵⁰ the new mental health worker role in the UK,^{51,52} and physician assistants in the US,⁵³⁻⁵⁵ raises pertinent issues around the contribution of non-physicians, quality of care, patient acceptance of new and extended roles, role boundaries, and cost-effectiveness. Practice nurses^{46,49} and physician assistants can improve patient access and save physicians' time.⁵⁵ Research evidence, albeit limited, shows that GPs and appropriately-trained nurses provided similar quality of care and achieved good health outcomes,^{44,49} as did physician assistants and nurse practitioners working on similar problems.^{54,55} Patient acceptance of practice nurses depended on the reason for the consultation.⁴⁶ Some patients were

confused about the relative roles of the nurse practitioner and GP, opposed to the deployment of nurse practitioners, and concerned about their lack of diagnostic skills.⁴⁸ However, patients found nurse practitioners easier to talk to,⁴⁸ and were more satisfied with nurse consultations⁴⁹ in terms of the length of consultation, explanation, and skills.⁴⁴ In the US, patients were willing to accept nurse practitioners and physician assistants, and were satisfied with the care they provided.^{54,55}

In the 1970s, some GPs were initially resistant to the emergence of practice nursing, and the nursing profession was concerned about a potential erosion of the nursing role.⁴⁷ While an early discussion paper indicated that physicians accepted the physician assistant role,⁵⁴ more recent opposition may be due to the over-supply of physicians in the US.⁵³ Tensions between physician assistants and nurses over differences in philosophical approaches have also been reported.⁵³

A US-based study found inconclusive evidence for lower salaries converting into lower costs per visit, in part, because less-qualified staff see fewer patients per hour than their more-highly qualified colleagues.⁴³ In the UK, lack of evidence about the cost-effectiveness of multidisciplinary primary healthcare teams precludes any decisive conclusions.⁴² While nurses are less expensive to employ than GPs, overall costs need to take into account the setting up of delegation systems,⁴⁴ length of nurse consultations,⁵⁰ and the larger number of tests that nurses may request.⁴⁹ Importantly, cost-effectiveness may depend on whether non-physicians provide an enhanced service rather than a substitute for existing GP-delivered care.^{45,54}

In summary, increasing the skill mix in primary care can save GP time, improve patient access, and provide enhanced services without compromising patient care, but is not necessarily more cost-effective than more traditional models of care. Patients may be initially concerned about new roles but are likely to become more accepting and satisfied with the care they receive over time. Improving access and patient satisfaction may be sufficient goals in themselves aside from cost-effectiveness. Initial threats to professional identity may recede as healthcare professionals redefine their roles.

HEALTHCARE ASSISTANTS IN GENERAL PRACTICE

Evidence on the impact of HCAs in UK general practice is scant, reflecting the relative novelty of this role.^{36,37} An extensive literature review identified five studies that focused on the role or training of HCAs

(S Burns, unpublished data, 2007),^{37,38,56,57} and a rapid review of the role and impact of nurses and HCAs in general practice.⁵⁰ Of the studies of HCAs specifically, only one is currently published.⁵⁷ Together, this evidence indicates that HCAs can contribute to improvements in patient care, but it also raises questions around acceptability and cost-effectiveness, patient safety and delegation, training and competence, and the development of the primary workforce.

Practice managers and nurses generally report that HCAs bring great benefits to their practices,³⁸ including reduced waiting times (S Burns, unpublished data, 2007),³⁷ easier access to appointments, and more time for more-highly qualified staff to concentrate on patients with complex needs (S Burns, unpublished data, 2007),^{38,57} such as mental health, palliative care,³⁹ and long-term conditions.⁵⁶ HCAs may enable continuity of care and extended GP consultation times (S Burns, unpublished data, 2007).⁵⁸ They may also take on tasks such as collecting patient data to meet the requirements of the Quality Outcomes Framework (QOF),³⁸ and initial patient screening. Practice managers thought that HCAs could extend their role into areas such as smoking cessation, diet, and exercise advice (S Burns, unpublished data, 2007), while nurses and HCAs agreed that the role could include applying dressings and taking blood pressure.⁵⁶ By being established in their local communities, HCAs may have a better understanding of the cultural and social context of patients than GPs and nurses who do not live locally.⁵⁷ These cultural and social resources are a valuable attribute in promoting rapport and communication, and building trust with patients.³⁶

COST-EFFECTIVENESS

General practice staff report that patients are initially hesitant about consulting HCAs,⁵⁶ and concerned about the dual HCA/receptionist role (S Burns, unpublished data, 2007). However, data gathered directly from patients shows that, despite some confusion, patients are generally positive about HCAs who take blood, and appreciate the benefits of shorter waiting times, continuity of care, and time spent with them (S Burns, unpublished data, 2007). The extent to which this applies to patients undergoing other procedures requiring referral to a doctor or nurse for interpretation, advice, and responses to patients' questions, is not known. Patient education about the HCA role, and raising awareness of the qualifications of the person administering care or treatment⁵⁹ may help to address patients' concerns. Studies of extended nurse roles suggest that satisfactory encounters with

staff are likely to improve patient acceptance.^{44,48,49} However, delegation to staff in new and unfamiliar roles may be viewed differently. There is a need for specific research on patient acceptance of the HCA role in general practice.

Evidence of the impact of employing HCAs in general practice is limited. Their employment is reported to improve practice capacity and efficiency,³⁵ as patients can be allocated to staff on the basis of cost-effectiveness.³⁹ As unregistered staff, HCAs are likely to require more ongoing supervision and mentoring, the cost of which needs to be taken into account,³⁸ but the advantages of achieving QOF targets and improved patient satisfaction may outweigh the longer appointment times HCAs may need.

Key factors for the successful introduction of the HCA role into general practice have been identified as effective mentoring,³⁷ support, including financial support from PCTs, and local education and training provision.⁵⁷ Initial investment in planning, delegation, training, and assessment needs to be weighed against the potential HCA contribution, a calculation that may need to be practice-specific for it to be meaningful. In more general terms, the relative costs and benefits of employing HCAs and changing the skill mix in primary care require more systematic attention.

PATIENT SAFETY AND DELEGATION

The key to promoting patient safety is to ensure that HCAs are trained and competent to undertake the tasks delegated to them, and that accountability is clear. The Working in Partnership Programme (www.wipp.nhs.uk) provides valuable guidance on these issues, but the emergent nature of the HCA's role means that some uncertainty among staff is inevitable. The RCN advises that decisions about delegation should be determined by patients' needs and interests.⁵⁹ Practice nurses are commonly responsible for delegating to HCAs, and accountable for the appropriateness of delegation. To make such decisions appropriately, they need to ensure that HCAs have the knowledge, skills, and competence to undertake the delegated tasks,⁶⁰ taking into account the individual's own confidence and experience. The RCN advises that HCAs should work according to defined protocols and procedures, and that they should not be asked to make clinical judgements. HCAs should be accountable to a registered healthcare professional and receive regular supervision.⁵⁹ In practice, HCAs may make decisions about treatment as members of a healthcare team. If the legal parameters of the role are unclear to staff who are delegating work, HCAs' skills may be under-utilised or, conversely, they may

be asked to work beyond their capabilities. Research suggests that in the pressured hospital environment, the latter is sometimes the case.²⁸ Busy staff in general practice also experience the conflicting demands of immediate patient need and remaining within the parameters of safety. While training can help to clarify professional and legal parameters,³⁷ power relationships between nurses and HCAs may make it difficult to challenge an instruction that is perceived to be inappropriate.

TRAINING AND COMPETENCE

The variation in tasks and the lack of regulation in the UK have given rise to training that is neither statutory nor standardised.³¹ HCAs usually work for NVQ level 2 or 3 in health and social care, by collecting evidence of competence and underpinning knowledge. To a variable extent, training is provided within general practices, although PCTs may also run off-the-job training, and support HCAs to enrol on distance learning courses such as those offered by the Open University and other universities.⁶¹ However, training provision is variable, and HCAs may have difficulty in accessing NVQ training that is appropriate to general practice.⁵⁰ Networks and support systems external to HCAs' employing practices are sources of informal learning and support (S Burns, unpublished data, 2007),³⁸ which may be particularly valuable to lone HCAs.

Although increasing confidence through training is important for individual HCAs,³⁷ this can be a double-edged sword if overconfidence blinkers them to their limitations. While competence to perform specific tasks is assessed by qualified NVQ assessors, the limited availability of such assessors and a lack of support for HCAs' training arising from pressure on PCTs' budgets in some areas, may hinder or suspend the development of the HCA role, or require GPs to fund training directly.

More fundamentally, the competence approach has been criticised for overlooking valuable soft skills, such as communication and advising.⁶² Regulation (which is currently the focus of a pilot project in Scotland)⁶³ should clarify the situation by standardising training and introducing professional accountability for HCAs. However, the associated formality and increased responsibility may reduce interest in the HCA role, an important consideration if development of the primary care workforce is among the aims of the skill-mix agenda.

DEVELOPING THE PRIMARY CARE WORKFORCE

The employment and development of HCAs offers benefits to the primary care workforce as a whole. Delegation from GPs to nurses to HCAs provides

development opportunities for staff, which in turn may increase job satisfaction and retention. However, role development of HCAs (and other staff) may not be attractive if they are inadequately rewarded for taking on new responsibilities.

Training may increase HCAs' desire for further development within the role,³⁷ and may encourage some to seek training as nurses. Skill development benefits individuals and the healthcare workforce as a whole, but may be perceived as less beneficial to individual practices if they lose a valuable team member in whom they have invested. Even in the short-term, developing the skills of HCAs may be perceived as counterproductive,⁵⁶ if they no longer undertake the routine work for which they were initially recruited, or wish to undertake training that is not available, funded, or required to meet their practice's needs.

The employment of dual-role staff presents particular challenges such as intrapersonal role conflict/confusion for HCAs moving between roles, and frustration if the need to staff reception restricts the use of newly acquired skills. Conversely, tensions between HCAs and dedicated reception staff are likely to occur if reception is inadequately covered as result of developing the HCA role.

Role-boundary issues, a major theme in studies on HCAs based in secondary care, are already apparent in general practice, albeit to a lesser extent than in secondary care. While HCAs tend to be clear about their role, other staff groups often are not.⁵⁶ Nurses are reported as resisting the delegation of some practical tasks, such as ear syringing, which they perceive to need broader knowledge than HCAs possess.⁵⁶ Nurses' reluctance to delegate, possibly due to a sense of threat, may hinder HCAs' role development (S Burns, unpublished data, 2007). While such unwillingness to delegate might reflect inappropriate caution arising from concerns about accountability, it could also be an appropriate response based on knowledge and experience of the HCAs concerned, or an attempt to protect professional identity and prevent loss or dilution of valued skills.

Even when other practice staff perceive HCAs as threatening nurses' professional identity, nurses themselves may not share this view.⁵⁶ Results from study on district nursing suggest that individual attitudes and the microculture of particular general practices may shape attitudes; the study also found that the development of the HCA role was affected by district nurses' attitudes, team culture, and the motivation of the HCAs, as well as nurses' perceptions of HCAs' competence.⁶⁴ HCAs saw themselves as undertaking a nursing role but felt their extended role was not recognised.

CONCLUSIONS

Research in hospital settings has found that HCAs make a valuable contribution to patient care. Studies also suggest that HCAs often work beyond their remit, the boundaries between the assistant and nurse role are unclear, HCAs and nurses use boundary-work to protect or extend their roles, and that the development of the HCA role challenges nurses' professional identity. Such concerns have implications for teamwork, quality of care, and patient safety, and may also apply to general practice. However, transferability cannot be assumed because of differences in setting, culture, and the HCA role. Despite very limited evidence of the impact or effectiveness of HCAs, the role is being advanced in general practice.

The limited, and largely unpublished, research on HCAs in general practice described above, indicates that employing HCAs is thought to reduce waiting times, enable easier access to appointments, and release more-highly qualified staff to concentrate on patients with complex needs and long-term conditions. The appropriateness of developing the HCA role in general practice may depend on a range of factors, such as patient need, existing skill mix, patient and staff attitudes, the culture and ethos of the practice, and having the staff, time, and financial resources to invest in appropriate training, mentoring, and supervision.

The emergent HCA role cannot be separated from wider questions relating to changing skill mix in primary care. The notion of fixed role boundaries in general practice is becoming less relevant, as flexibility can improve quality of care and provide development for staff with few qualifications whose opportunities have traditionally been very limited. In reviewing skill mix, the concept of role may be more valuable than job title. Role situates the healthcare practitioner in a social position, performing a set of functions in a web of relationships,⁶⁵ and bearing a set of characteristic behaviours.⁶⁶ The challenge is to facilitate dynamic, flexible roles while minimising boundary-work and protecting patient safety. Supportive conditions include fostering trust between staff groups, willingness to challenge inappropriate hierarchical structures in order to share knowledge and support team members, understanding members' strengths and limitations, provision of appropriate, timely training, and equitable remuneration for responsibility. Occupational identities can be retained by emphasising a philosophical approach and the values of different healthcare staff. However, further investigation is needed to explore these ideas, perhaps by comparing skill-mix models in different contexts, taking account of professional and practice

culture. Such investigation would identify and explore issues important to staff and patients, and develop models to inform and support effective skill-mix change, training, and regulation.

Competing interests

The authors have stated that there are none

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