Benefits and challenges of employing health care assistants in general practice: a qualitative study of GPs’ and practice nurses’ perspectives

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Background. Estimates suggest that over half of general practices in England currently employ a health care assistant (HCA) but there is little evidence of their impact, effectiveness and acceptability to patients and primary care team members.

Objectives. To explore the role of HCAs in general practice and the benefits and challenges associated with their employment.

Methods. Semi-structured interviews were performed with 6 GPs and 13 practice nurses as part of a larger qualitative study that also included HCAs. Interviewees were from 16 general practices from two Primary Care Trusts in the West Midlands. Transcripts were analyzed using thematic and framework analysis.

Results. HCAs were seen as a valuable addition to the primary care team. They were reported to accelerate, rather than extend services, allow more appropriate use of nurses’ skills and enable cost containment. Their training and supervision were felt as time intensive, demanding of time and commitment. Patient safety was raised as a concern, although no specific experience of it being compromised was reported. Nurses recognized the usefulness of HCAs, helped to make the role work, but were often anxious about the impact on their own roles and professional identity. Patients were perceived as being generally neutral or positive.

Conclusion. Cost-effectiveness, patient safety, quality of care, potentially contested role boundaries and patient attitudes are among the issues that policy-makers, commissioners and those responsible for workforce development and training need to consider in relation to HCAs in general practice. There is also a need for more in-depth evaluation of this role.

Keywords. Family practice, health personnel, nurses’ aids, nurses’ role, nursing, team.

Introduction

The health care assistant (HCA) role has existed in the UK for many years and is well established in hospitals, nursing homes and community nursing settings. In recent years, with increasing patient demands and incentives for GPs to provide extra services, general practices have also started to employ HCAs to ‘take on less complex, but important, tasks that have traditionally been performed by nurses. They also work around GPs so that GPs can spend more time focusing on the needs of their patients, and less time on administration and paperwork’. There is no definitive role specification for HCAs in UK general practices. The tasks they undertake vary according to the needs of each practice, the views of the delegating nurses and GPs on what is appropriate for them to do and the competences of the particular individual.

Although HCAs of various types and designations (nursing auxiliaries, nurses’ aides, nursing assistants, nurse extenders, etc.) contribute to the health workforce worldwide, their use in general practice in the developed world appears limited. Out of >3454 publications concerning nurses’ aides in MEDLINE (nurses’ aides is the generic indexing term for the database; search run January 2010), only eight were indexed as discussing their role in family/general practice, six of which came from the UK.

The emerging role of HCAs in UK general practices has parallels with the physician assistant role as established in some developed countries, most notably the
USA, Germany and the Netherlands. Nevertheless, there are substantial differences between the two roles. These concern primarily level of training and the associated differences in role remit, as well as the professional role (of nurse or physician) with which the assistive role is aligned. For example, US physician assistants study for around 2 years, either after a first degree (often in the life sciences) or after having worked as another type of clinical professional (e.g. paramedic). Their remit may cover more complex tasks such as prescribing and ordering and interpreting laboratory tests. In Germany, HCAs undergo a 3-year on-the-job training, which also includes weekly school sessions. Their major duties are administrative, with simple clinical tasks delegated by the supervising physician. The UK general practice HCA role, in contrast, seems to have developed primarily as a nursing support, hands-on role. There are no formal requirements for previous clinical experience. Training is arranged in accordance with the employing practice’s discretion.

It was recently estimated that ~55% of general practices in England employ an HCA and that there are ~7000 general practice HCAs. There is still no national regulation of HCAs, despite government plans to introduce this by 2007. The role is being advanced despite scarce evidence of impact and effectiveness. The limited evidence base (see Longbottom et al. and Bosley and Dale for reviews of the literature) suggests that HCAs in general practice may enable reduced waiting times and easier access to appointments, allow more highly qualified staff to concentrate on patients with complex needs and engage in preventive care, enable continuity of care, lead to extended GP consultation times and help meet Quality and Outcomes Framework performance targets.

**Objectives**

This study sought to explore the nature of the role of HCAs in UK general practices and the benefits and challenges of employing them, as perceived by GPs and practice nurses (PNs) who have had experience of working with HCAs. This was part of a larger study, which also included interviews with 14 HCAs (report under review and available from the authors).

**Materials and methods**

**Sampling**

A purposive sample of GPs and PNs who work with HCAs was selected from two Primary Care Trusts (PCTs) in the West Midlands. We approached general practice contacts, PCT and Working in Partnership Programme (WiPP) contacts, HCAs’ trainers and assessors, members of practice managers’ forums attached to the PCTs and individual practice managers and nurses in order to inquire about their willingness to participate in the study and/or request their help in identifying potential participants. Snowballing techniques, which involved asking interviewees to suggest other individuals who may be interested in the study, were also used.

Thirty-five practices were identified as employers of HCAs, of which three declined to participate. The reasons given were time constraints, insufficient interest and previous frustrating experience with research participation. The remaining 32 practices were sent detailed information about the study. In total, 9 GPs and 24 PNs expressed interest in participation. All those who returned their consent forms without further reminders were interviewed (except for one nurse whom we were unable to contact after a number of attempts), after which recruitment continued until data were saturated. As a result, interviews were conducted with 6 GPs and 13 PNs from 16 general practices between May and September 2007. Ten practices were urban, and six were rural. The number of partners within the practices ranged between one and nine (three-partner practices were the largest group—six).

**Data collection**

In line with participants’ preferences, most interviews were conducted over the phone. The topic guide for the interviews was based on issues arising from previous research. With participants’ permission all interviews were digitally recorded and transcribed verbatim. Transcripts were anonymized.

Interviews lasted on average 17 minutes for GPs (range: 9–31 minutes) and 21 minutes for nurses (range: 11–46 minutes). No differences were identified in the length or contents of interviews that could be attributed to mode of interviewing. Data were felt to have saturated quicker for GPs, as GPs appeared to interact much less with HCAs than did nurses.

**Data analysis**

Atlas.ti 5.2 was used to aid coding and retrieval. A thematic analysis approach was used, supplemented with techniques from framework analysis. An initial coding frame was developed by SB from reading a sample of transcripts. This was discussed with LV and revised accordingly. Both tested the revised coding frame with a fresh sample of transcripts. After further revisions, the coding frame was agreed. LV coded the majority of the data, while SB and MP verified the coding and made further suggestions. Tables of summary statements were prepared and used to explore relationships between challenges and benefits, the context within which they occurred (for instance, the team dynamics within a particular practice) and the staff group (GPs or PNs). Attention was paid to
nuances of language, contradictory statements within the same interview and untypical views. A draft of the paper was sent to the interviewees to inform them of the findings and request feedback on its contents and interpretations.

**Results**

We report on results concerning the following main topics: (i) tasks performed by HCAs; (ii) overall attitude towards the role; (iii) benefits of employing an HCA; (iv) challenges and demands of employing an HCA and (v) impact of team dynamics on attitudes towards and perceived impact of the role. Quotes are included in addition to the summary reporting where they were seen to provide necessary clarifications and telling nuances.

**Tasks performed by HCAs**

The tasks that were reported most frequently as performed by the HCAs in the interviewees’ practices were blood pressure checks, new patient medicals, height and weight measurements and body mass index (BMI) calculations, electrocardiogram (ECG) readings, spirometry, phlebotomy, removal of sutures, applying simple dressings, stock ordering and general administrative duties. Tasks that were seen as controversial, with some interviewees supporting their delegation to HCAs and others believing that they should remain strictly within the domain of the registered nurse, included: flu vaccinations, applying dressings, diabetic checks and spirometry. Tasks that were performed in the sampled practices but were not specified in the illustrative list of the WiPP Toolkit³ were flu vaccinations, removal of sutures, glucose tolerance testing, warfarin monitoring and INR service. (The WiPP Toolkit is the document of reference for employing, training and integrating HCAs in UK general practices. It is not, however, a legal document and is currently under review.) Table 1 provides further details of the tasks performed by HCAs.

**Overall attitude towards the HCA role**

General comments about employing an HCA ranged from unqualified enthusiasm to measured endorsement or conditional acceptance. If expressed, reservations applied to the suitability of the role for a particular practice, usually as compared to the option of employing a registered nurse:

I think everything about having a health care assistant is positive. I don’t think there are any negatives at all ... (PN7)

[Without an HCA] we couldn’t perform and provide the level of patient care and healthcare that ... we are asked to by the GMS contract, but, probably more importantly, that we want to ... (GP4)

I think there’s a good role ... for the HCA ... [I] really do, from the bottom of my heart, but not if all they can do is dress things, blood pressures and stitch removal because that doesn’t really help me. (PN1)

[O]bviously they employ them because they’re cheap. But have got to have training and back-up for them. But no, they definitely have their place. (PN10)

Yes, I would hope so, but ... we have found that she isn’t that busy, and whether the boss might think, ‘actually, does this pay?’ (PN3)

**Benefits of employing an HCA**

By far the most cited benefits of employing an HCA were more appropriate use of nurses’ skills, mainly through freeing up nurses to undertake chronic disease management, increased availability of appointments and an associated reduction in waiting times. Financial benefits to the practice were briefly mentioned or alluded to.

Atypical benefits concerned staff—reduced workload for nurses, reduced pressure on reception staff and increased opportunities for nurses to develop their own roles; improvements in the functioning and performance of the practice—facilitated achievement of targets and a streamlined, smoother process (‘it flows, it all flows’) and further benefits for patients—availability of new or extended services, such as weight management programmes or 24-hour ECG; improved care for specific patient groups, such as nursing homes patients; and a more relaxed and open type of relationship that sometimes developed between patients and HCAs.

**Challenges and demands of employing an HCA**

The interviewees discussed the challenges and demands associated with employing an HCA more extensively than they discussed benefits. All major issues raised are presented below. First, challenges are reported as related to three phases in the process of integrating the role within a practice (initial challenges, demands of an established HCA role and future challenges). We then report on a further set of challenges (associated with staff acceptance, patient acceptance and a range of unintended consequences) that have less clear or no temporal boundaries.

**Initial challenges and demands.** The in-house training of a new HCA was often singled out as a (or the) major challenge, demanding significant time and commitment. Predictably, these demands were felt to be greater where the supervising nurse had limited experience as a trainer, was not given adequate practice support and/or if the HCA had not worked in a health setting before.
Luckily, it was a reasonably quiet time, but I had underestimated the amount of time it would take me to prepare and to train her, to get all the necessary bits and pieces, and just supervise her and mentor her... (PN4)

We’ve all got our own roles to play... and our jobs to do, and it’s just having dedicated time to assist people as well, which isn’t always as easy as it sounds. (PN7)

External training was considered very useful. It reduced the dependence on in-house training, guarded against potential omissions in it and gave in-house training structure and impetus, by preventing it from going to the ‘backburner’. It was also seen as offering protection in cases of litigation, especially if it led to an accredited qualification. However, opportunities for external training were considered limited and difficult to identify:

[The PCT] should really put something into practice to say, ‘look, let’s send them away for a week, a group of health care assistants, so we can teach them what is expected of them.’” (PN5)

Probably not enough [opportunities for training and development], they’re quite hard to find, you know, you have to search for them. So you have to be motivated, you have to have the time to do that, and I know [Name] had a lot of problems with the NVQ assessors... [If she hadn’t] had been as motivated as she is, she would have given up long ago... (PN7)

In spite of the challenges, the quality of training was seen as high and reported as having been taken very seriously by the designated trainer and/or the team as a whole.

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**Table 1** Tasks performed by the HCAs in the sampled practices

<table>
<thead>
<tr>
<th>(Type of) task (boldface tasks were mentioned most frequently by interviewees)</th>
<th>Included in WiPP illustrative list?</th>
<th>Controversial? (divergence of opinions observed—delegation supported by some but opposed by others)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure checks</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>New patient medicals</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Height and weight measurements and BMI calculation</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Technology-based investigations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiograms</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>ECG readings</td>
<td>✓</td>
<td></td>
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<tr>
<td>Peak-flow measurements</td>
<td>✓</td>
<td></td>
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<tr>
<td>Spirometry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>✓</td>
<td></td>
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<tr>
<td><strong>Invasive procedures</strong></td>
<td></td>
<td></td>
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<tr>
<td>Phlebotomy</td>
<td>✓</td>
<td></td>
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<tr>
<td>Glucose tolerance testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu vaccinations</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Wound care</td>
<td></td>
<td></td>
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<tr>
<td><strong>Removal of sutures</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Applying simple dressings</strong></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Monitoring of drugs and patients with chronic conditions</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease checks</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetic checks</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Warfarin monitoring</td>
<td>✓</td>
<td></td>
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<tr>
<td>INR service</td>
<td></td>
<td></td>
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<tr>
<td><strong>Health promotion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distributing lifestyle literature</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Obesity clinics</td>
<td>✓</td>
<td></td>
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<tr>
<td>Smoking cessation clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance of practice premises and supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning and sterilizing</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Monitoring vaccine storage and ordering vaccines</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Stock ordering</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restocking clinical area</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Setting up for minor operations</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Administrative duties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General administrative duties</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Patient recall</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Summarizing paper notes onto computer</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cost comparisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assistance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting with minor operations</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Chaperoning</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

[The PCT] should really put something into practice to say, ‘look, let’s send them away for a week, a group of health care assistants, so we can teach them what is expected of them.’” (PN5)

Probably not enough [opportunities for training and development], they’re quite hard to find, you know, you have to search for them. So you have to be motivated, you have to have the time to do that, and I know [Name] had a lot of problems with the NVQ assessors... [If she hadn’t] had been as motivated as she is, she would have given up long ago... (PN7)

In spite of the challenges, the quality of training was seen as high and reported as having been taken very seriously by the designated trainer and/or the team as a whole.
Another early challenge involved the wider general practice team becoming familiar with the limits of the HCA and beginning to assign appropriate tasks to her. This problem was reported as concerning receptionists but also some GPs who did not always appreciate that ‘they are not dealing with trained nurses’.

It was quite hard initially for the receptionist to understand what was the health care assistant’s role and what it wasn’t, and so initially … there were a little bit of antagonism and difficulty in trying to sort out what actually was suitable … (PN9)

[S]ome of us, GPs, perhaps wanted her to do more initially … ‘well, why isn’t she doing this, why isn’t she doing the other?’. Then, of course, the practice nurse was saying, ‘well, she’s not trained for that yet …’ (GP1)

A third early challenge concerned the need to overcome concerns, fears and resistance from existing staff members. Although these usually allayed over time, some anxieties and tensions persisted (discussed further below).

Demands associated with an established HCA role. On a day to day level, employing an HCA placed demands on staff time and practice’s resources for ongoing training, supervision and mentoring and also on the processes of planning and organization of the work within the practice. Support for the HCA had to be constantly available to ensure patient safety. This was felt as burdensome to a varying extent. Interviewees from practices where the role was well integrated and/or whose HCA was seen as ‘committed’, ‘capable’, ‘trustworthy’ and ‘knowing her limitations’ did not seem to be conscious of such a challenge.

Challenges associated with the future development of the role. Attitudes to the future extension of the HCA role varied from clear opposition to different types of conditional endorsement. The main challenge was seen in defining the boundaries of the HCA role without compromising patient safety. For nurse interviewees, concerns about the safety and quality of care were often coterminous with concerns about the extra burden of responsibility for them as supervisors and about the preservation and respect for their own roles and professional identity:

[I]t’s possible to say you can train anybody to do anything … but I think you’ve got to be very aware of all the legal aspects surrounding some things … [I]t’s good to develop roles, but know where a more qualified nurse should take over. (PN6)

[W]ho is going to be responsible for her if there is a mistake? If it’s myself or [Name of nurse], we’re not happy about that, about our numbers being at risk if the health care assistant has not had adequate training to do injections. (PN8)

A further perceived challenge of developing the role was the potential conflict of interest between the HCA and the practice. Some interviewees thought that their HCA would feel pushed beyond her comfort zone if asked to undertake more complex tasks. Others focused on the danger of losing the main benefits of employing an HCA if the role was overextended.

Most interviewees felt a high level of uncertainty about the remit of HCAs in general practice and the need for more information, guidance and policies, both national and practice specific. None circumscribed the role’s possible extension in a specific task-by-task way, although some gave examples of tasks that they were unwilling to allow HCAs to perform (see Table 1).

Acceptance by practice staff. As already indicated, most nurses reported having experienced concerns, doubts, worries and fears when an HCA was first employed. Initial worries and insecurity related both to the nurse’s own role and whether the person would be ‘up to scratch’. In some cases, the feeling was more persistent and deep-seated and associated with a general sense of devaluation of the nurse’s role. However, other nurse interviewees felt that the employment of an HCA was ‘long overdue’ and/or it was them who had instigated it.

[O]riginally, if I’m being honest, myself and the other nurse did [have concerns], because we didn’t know how it would affect our role … [W]e seemed to manage very well, and we didn’t know if there was an actual … role there for her. But obviously there is, so … our fears have been sort of allayed … (PN8)

[W]e’re not anything special anymore. Years ago we were treated with respect and everything, but that’s gone out of the window, unfortunately. So I think we’re pretty much equal really. Although we’re not, we are, so you’ve got to get on with it, haven’t you? (PN1)

[I’ll] probably feel, yes, a little bit scared and a little bit intimidated by the fact that the health care assistants are probably catching up with me and I can’t progress any further because there’s no funding … (PN5)

On a few occasions, tensions were reported between the HCA and the practice’s administrative team. This was related to some form of role overlap—either in cases where the HCA currently performed a dual role...
or where she had previously been a member of the receptionist or administrative team:

[B]ecause there’s a dual role for them ... sometimes the receptionists might feel that the health care assistants prefer their role and get a bit bored in reception sometimes, which I think is a bit of a problem ... (PN6)

The only thing I would say, being completely honest, is I still think there are some people that ... if people come in and say they want to see the nurse and say [Name] is a nurse, I still do hear occasionally people almost pulling it down, ‘no she’s not a nurse, she’s a healthcare assistant’ ... (PN13)

The GPs made far fewer comments about actual or potential tensions between their practice’s HCAs and members of the nursing and/or administrative teams. They tended to deduce a positive, appreciative attitude on behalf of members of the nursing team because the HCAs were providing support for nurses and easing their workload. Some of the GPs were cautious in their statements [‘theoretically, they [the nurses] should be positive’ (GP2); ‘I certainly haven’t been aware of any difficulties’ (GP4)].

Patients’ acceptance. Only a few interviewees reported having experienced any problems with patients’ acceptance of an HCA. These related to the HCA being expected to do more than she could or concerns about her skills arising from the co-performance of an HCA and a receptionist role. The majority of interviewees either reported that there had been ‘no problems at all’ with their patients’ response to the HCA or that they had been very positive, with some patients even starting to self-refer to her (‘yes, I need to come and see the health care assistant for that, don’t I?’).

Unintended consequences. Unanticipated negative effects of the introduction of HCAs were also described. These included a potential deskilling of other members of staff; the undesirable changes to the nurses’ role, which might become too intense, with only the ‘difficult jobs’ left for the nurses and the vulnerability of a practice’s system to the loss of a ‘tailor-trained’ HCA. The most notable of those concerns was that the new role might contribute to increased needs and expectations on the part of patients and their increased dependence on the service:

[May]be you’ll call me a cynic. Sometimes I think there’s too much access ... [If] a person comes in, ‘Oh, I can’t see the doctor. OK, I can’t see the practice nurse. OK, I’ll see the nurse’. And that, sort of, has got a very subliminal message that we’re not being valued, if you like. (GP5)

[I]t creates a need in the patients, as in the weight reduction programmes ... people used to go to Weight Watchers before. So now the NHS is funding them, so there’s that issue. And there’s the dependence issue, as in people like coming to see us. They like getting their blood pressure checked and they probably overdo it, and actually they wouldn’t come and see us as often for it. (GP3)

Impact of team dynamics on attitudes towards the HCA role. The overall attitude towards the HCA role and the perceptions of specific benefits and challenges often seemed to reflect characteristics of the employing practice rather than essential characteristics of the role. Interviewees who saw themselves as working in ‘close’, ‘tight-knit’ teams, where ‘everybody was prepared to share knowledge’, and/or described an inclusive decision-making process concerning the employment of an HCA were more enthusiastic about the role. They would ‘definitely’, ‘certainly’ employ an HCA again and tended not to report initial tensions and insecurities. Interviewees in whose practices involvement in the decision to employ an HCA was only partial (e.g. consultation with the nursing staff only after the decision had been made by the GPs), or where personality difficulties were identified or alluded to, tended to report initial apprehension, some ongoing or background tensions and a more measured positive attitude. Interestingly, the interviewees in whose practices the decision was made in a clearly top-down manner, which left them feeling ‘a bit annoyed’ and ‘a little bit put out’, appeared highly supportive of the role, more supportive than interviewees from practices where consultation was partial. However, they made more comments about the devaluation of the nurse’s role and identified cost as the primary reason for employing an HCA.

Discussion

Summary of main findings

This study found that overall, HCAs were seen as a valuable new member of the general practice team. In line with previous research, the HCA role appeared almost exclusively as an extension to the nurse’s role and primarily as a hands-on role. This and the fact that HCAs in UK general practices are trained according to a practice’s discretion, sometimes only in-house and not to report initial tensions and insecurities. Interviewees in whose practices involvement in the decision to employ an HCA was only partial (e.g. consultation with the nursing staff only after the decision had been made by the GPs), or where personality difficulties were identified or alluded to, tended to report initial apprehension, some ongoing or background tensions and a more measured positive attitude. Interestingly, the interviewees in whose practices the decision was made in a clearly top-down manner, which left them feeling ‘a bit annoyed’ and ‘a little bit put out’, appeared highly supportive of the role, more supportive than interviewees from practices where consultation was partial. However, they made more comments about the devaluation of the nurse’s role and identified cost as the primary reason for employing an HCA.
delegation was seen as inappropriate by interviewees from other practices, included: flu vaccinations, applying dressings, warfarin monitoring, diabetic checks and spirometry.

The main benefits of employing an HCA were perceived to be in accelerating existing services, allowing more appropriate use of nurses’ skills, and enabling cost containment. The majority of interviewees recognized or alluded to the benefits of cost containment, but a concern was also raised that when indirect costs are taken into account, the role may not be as cost-effective as perceived. The benefits of a more appropriate use of nurses’ skills and reduction in waiting times appeared uncontentious.

The main challenges identified by the interviewees concerned the time commitment required for training and supervision and patient safety, with the associated issue of protection against litigation. Although patient safety was raised as a concern, no specific experience of it being compromised was reported. Anxieties were frequently shared by nurses about the impact of HCAs on their own roles and professional identity. These were often interwoven with concerns about patient safety. Nevertheless, nurses recognized the usefulness of HCAs and helped to make the role work. Patients were perceived as having a generally neutral or positive attitude towards the new role.

**Strengths and limitations of the study**

This study along with Brant and Leydon’s focus-group based study are, to our knowledge, the only two detailed and methodologically sound qualitative studies exploring the perceptions of GPs and PNs of employing HCAs in UK general practices. Detailed data were collected from staff of 16 general practices representing a varied mix of size, location, management practices and team dynamics. Rich descriptions were obtained, particularly with regard to nurses’ concerns about the future of their own role. In interpreting the study’s findings, however, a number of methodological limitations need to be considered. Firstly, the approach taken to practice recruitment may have resulted in capturing interviewees with a generally more positive attitude towards HCAs and practices with atypical characteristics affecting the uptake of HCAs. Secondly, the interviewed GPs and nurses were generally from different practices, which precluded intra-practice comparisons of perspective. Thirdly, while interviews are a reliable source of evidence about explicit attitudes to the HCA role, they are an imprecise source of information on issues such as impact on service improvement, quality of care, cost reduction and implicit attitudes.

**Comparison with previous research**

In the rest of the discussion, we will focus on the boundaries of the HCA role and their future extension, which received much attention from the interviewees in this study, and compare our findings with findings from previous research.

Tasks that were perceived as involving a greater degree of risk (e.g. flu vaccinations) or as verging on diagnosis and clinical decision making (e.g. warfarin monitoring and wound dressings) were seen by some as overstepping the boundaries of acceptable practice. Reports from 30 years ago, when GPs were beginning to delegate tasks to nurses, suggest a very similar controversy. Procedures whose delegation was seen as problematic at the time (e.g. vaccinations, ear syringing and smear taking) are raising controversies once again.

This study also demonstrated clearly the intensity of nurses’ anxieties, their feelings of being devalued and their fears associated with the introduction of the HCA role. Interestingly, neither the GPs interviewed in this study nor the HCAs themselves (as interviewed in its complementary arm) recognized the extent to which nurses were concerned about their own roles and felt devalued. Such emotions will inevitably have an effect on nurses’ motivation and job satisfaction. They may also drive some nurses to behave in ways that undermine the HCA’s role.

Identical emotions have been found in skill-mix research in secondary care and in relation to other new roles in primary care. Ward, in describing the introduction of the dental therapist role in general dental practice, distinguishes between ‘structural context’ difficulties related to job loss fears, with members of the new occupational group perceived as competitors in the job market, and ‘cultural context’ difficulties related to issues of professional ethos and interests and perceptions of challenges to a group’s identity and sphere of exclusive activity. In a UK context, where staff shortage in the National Health Service has been a long-standing concern, job market fears are probably unlikely to materialize. Fears concerning role identity and nature of the job, however, may have stronger grounds. Research suggests that introducing HCAs in secondary care has contributed to nurses experiencing work intensification; increased administrative and managerial duties, along with training and supervision responsibilities; an erosion of patient contact time; pressure to develop new skills and competences; perceptions of compromised quality of care and perceptions of being devalued and easily replaceable. On the positive side, their introduction may enable nurses to experience satisfaction with gaining extra skills and their motivation, authority, status and contribution to the service may increase. The introduction of HCAs seems to be contributing to a shift in the remit of general practice nurses in the UK. What the nature and extent of the effect will be, however, is still unclear.
Implication for future research and practice organization

More methodologically robust research on the role and impact of HCAs in general practice is needed to inform health service policy, decisions about commissioning and workforce training and development, as well as individual general practices’ decisions about skill mix. Among the research priorities are cost-effectiveness, patient safety, and the wider impact of the role—in terms of its effect on other roles, the pros and cons of increased access, and duplication of services (such as smoking cessation and weight loss clinics) and the addition of a link in the lines of communication. Patient satisfaction, factors promoting HCAs’ satisfaction with their role as well as HCAs’ acceptability to other members of the general practice team (such as practice managers and receptionists) also need urgent investigation. More broadly, literature reviews providing cross-national comparisons will also be valuable.

Based on current evidence, GPs and practice managers are best advised to take a decision following a structured assessments of the practice’s needs and resources (the WiPP manual3 offers some tools to that effect; a summary of a wider range of methods used to review skill mix are summarized in reference13); consult team members most likely to be affected early in the process; recognize that many of the promoted benefits of the HCA have little evidential support and, in cases of a positive decision, address the challenges of implementation in a strategic, well planned and genuinely consultative way.

Conclusion

HCAs are playing an increasingly important role as members of the general practice teams in the UK. This study has indicated a range of issues associated with their employment that need to be considered if the role is to become successfully integrated. The ‘quiet revolution’28 of introducing HCAs needs more detailed research in view of the projected expansion of HCAs so that this innovation in skill mix occurs in an evidence-based manner and through facilitated sharing of effective practices.

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References

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33 Buchan J, Ball J, O’May F. If changing skill mix is the answer, what is the question? *J Health Serv Res Policy* 2001; 6: 233–8.