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RESEARCH

Healthcare assistants in general practice: a qualitative study of their experiences

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Aim: To explore the experiences of healthcare assistants (HCAs) working in general practice (GP). **Background:** HCAs increasingly play an important role in UK GP teams. The role is relatively new and little is known about how HCAs feel about their work in GP, and the challenges that they face. **Methods:** Semi-structured interviews were undertaken with 14 HCAs from two Primary Care Trusts in the West Midlands, United Kingdom. Transcriptions were analysed using the framework analysis approach. **Findings:** Overall, HCAs reported that they enjoyed their work, and particularly appreciated the patient contact and positive feedback gained. Attitudes to the role were affected by previous position, experience, and length of time working within the practice. The HCAs felt accepted and supported by GP team members and valued the support they were receiving. Key sources of frustration included the poor salary, the lack of initial clarity with regard to role definition, and the constraints of their scope of practice. Role boundaries between HCAs and practice nurses were experienced as well defined, and no perceptions of role ambiguity were reported. HCAs considered their work to be of relatively low status, with its main purpose being to ease the practice nurse's workload. Although many had the desire to train as nurses, few saw it as a realistic possibility. **Conclusions:** Although HCAs appear to be satisfied overall, the elements of dissatisfaction relate to status, pay, and career progression, which may limit the retention of individuals in this role. Practices should consider the importance of recognising and valuing the work of HCAs and of providing protected time and resources for mentorship and career progression.

Key words: general practice; healthcare assistants; job satisfaction (MeSH); nurses aides (MeSH); primary health care (MeSH); skill mix

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Introduction

Healthcare assistants (HCAs) have contributed to the UK National Health Service (NHS) workforce for many years, but only recently did their employment become widespread within general practice (GP; Working in Partnership Programme, 2007). Approximately half of the GPs in England are estimated to employ one or more HCAs (Andrews and Vaughan, 2007). Although in many healthcare systems individuals performing similar auxiliary roles are employed in secondary care and home settings, the employment of HCAs in GP appears to be limited outside the United Kingdom (Bosley and Dale, 2008).

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Within GP in the United Kingdom, HCAs have been employed to relieve practice nurses and GPs of less complex tasks (Working in Partnership Programme, 2007) and to directly contribute to the achievement of health promotion and disease prevention targets (Royal College of General Practitioners, 2007). Improving patients' access to appointments, reducing waiting times, and the more effective use of the skills of the GP workforce have been reported as benefits associated with their employment (Wright, 2002; Joels and Benison, 2006; Longbottom *et al*., 2006).

The significance of assistant roles within the UK public sector has increased with the reform of public services (Kessler *et al*., 2006). There has been a recent rise in the number of teaching assistants within UK schools (Bach *et al*., 2006), and within the social care sector the role of the social work assistant has been explored (Kessler *et al*., 2006). Within the NHS, changing the skill mix in the workforce has been identified as key to achieving the vision of a high-quality health service (Wanless, 2002). The Wanless report suggested that in order to achieve the standards set within the review by the year 2022, 12.5% of nurses' workload will need to shift to HCAs, and consequently 74 000 additional HCAs would be needed (Wanless, 2002). Other factors such as the development of patient-led services, the growing importance of preventive health care, GPs' increased flexibility in managing their own budgets, and the introduction of financial rewards to GPs for achieving quality and outcome targets have all led to an increasing emphasis on employing HCAs in GP (Bosley and Dale, 2008).

The HCAs' experience of working in GP is largely unexplored. To our knowledge, only two published studies have explored their experiences in this setting (Carlisle *et al*., 2007; Brant and Leydon, 2009). Journal publications on this topic tend to be descriptive/reflective accounts concerning individual practices or individual HCAs' personal accounts (Walters, 2005; Burns, 2006; Smith, 2008). The limited evidence that is available suggests that HCAs in GPs enjoy the responsibility and status associated with their role (Carlisle *et al*., 2007), that they have high job satisfaction (Burns, 2006), feel accepted as part of the nursing team (Walters, 2005), and that other members of staff are supportive of the role (Smith, 2008). The challenges that were identified included a lack of available space to work, an initial lack of clarity about the HCA role, and patients' negative reaction to the dual HCA/receptionist role (Walters, 2005; Smith, 2008).

Research suggests that within hospitals, HCAs undertake a predominantly clinical role, involving direct 'bedside' care, with the nature of the role being actively influenced by negotiation between HCAs and registered nurses (RNs; Spilsbury and Meyer, 2005). A study investigating HCAs' perceptions of their role in a general hospital setting (Workman, 1996) found that they viewed their role as similar to that of a qualified nurse, and that they experienced role ambiguity. Role theory (Handy, 1993) assumes that the scope of a person's role (role definition) is defined primarily by the expectations of the members within the team (role set). Role ambiguity occurs when there is uncertainty within either the role set or the individual (the focal person) about what the role entails, and this can cause dissatisfaction and inefficiency.

Introducing new roles and extending existing ones changes the scope of traditional staff responsibilities and therefore challenges professional boundaries. Professional boundaries between nurses and HCAs have been explored within secondary care, with research showing variation in the type of role undertaken by HCAs as a consequence of 'differing assumptions' within the nursing workforce (Bach *et al*., 2008). Thornley (1996), in describing the NHS workforce, distinguished between traditional, professional, and radical models of nursing, which Bach *et al*. (2008) applied to HCAs working in hospital care. The *traditional model*, as interpreted by Bach *et al*., views the role of HCAs as that of a 'substitute' for a RN. Beyond this, little value is placed on the contribution of HCAs and the boundaries between RNs and less qualified staff remains unacknowledged. Within the *professional model*, the HCA is viewed as a 'relief' worker who can ease the nurse's workload by taking on less complex tasks. The role is restricted and controlled by RNs. The *radical model*, which has grown in importance since the 1980s, is consistent with HCAs being seen as 'apprentices' rather than 'helpers' or 'substitutes'. Emphasis is placed on the development of the HCA as a practitioner and role development is encouraged. The extent to which this model applies to HCAs working in GP is unknown.

The current study aimed to build on the limited evidence base and gain further insight into HCAs' perceptions of their role and their experiences of working within GP. It had two main objectives: (1) to explore the nature of the HCA role within GP, as perceived by HCAs (2) to uncover the positive aspects and the challenges associated with the role. The study was part of a larger feasibility study in which the views of GPs and practice nurses about HCAs were also investigated (Petrova *et al*., 2010).

Methods

Recruitment

We aimed to recruit HCAs working at GPs within two Primary Care Trusts in the West Midlands, United Kingdom. In the absence of centrally collected data on GP employment of HCAs, practices that employed HCAs were identified through purposive sampling, a strategic sampling method that involves identifying individuals that are relevant to the proposed research (Bryman, 2004). We approached GP contacts, Primary Care Trust (PCT) and Working in Partnership Programme contacts, HCAs' trainers and assessors, members of practice managers' forums, and individual practice managers and nurses to request their help in identifying potential participants. In addition, we attempted to use snowball sampling, which involves using research participants as 'informants' (Robson, 2002). At the end of the interviews respondents were asked to identify other GP HCAs that they were aware of. In all, 35 practices were identified as employing HCAs, of which three declined to participate due to time constraints, insufficient interest and previous negative experience with research participation. The remaining 32 practices were sent detailed information about the study and reply slips. Information was sent to practice the managers, which was then passed on to the HCAs. From the scoping exercise, 24 HCAs were identified as potential participants, of which 13 returned consent forms. The characteristics (size and location) of practices, which contained the non-responders, did not appear to differ from those containing responders. A researcher contacted those who consented to participate and an interview time was arranged. We continued to recruit participants until we were no longer gaining new information from the interviews; this point was reached after 14 interviews.

Data collection

Semi-structured interviews with HCAs, lasting 20 min on average, were conducted between May and September 2007. Depending on the preference of the participant, the interviews were conducted by telephone (six interviews) or at the participant's place of work (eight interviews). The interview guide (see Table 1) was largely based upon findings from previous literature concerning HCAs in secondary care settings (Thornley, 2000; Spilsbury and Meyer, 2004; 2005) and was developed by S.B. Due to the constraints on the interviewers' availability, data collection was undertaken by three interviewers. A research assistant and S.B undertook two interviews each, and the remainder were conducted by L.V. (10 interviews). All the interviews were audio-taped and transcribed verbatim. Each transcript was checked and anonymised by L.V.

Data analysis

Transcripts were analysed using the 'framework approach', which was developed specifically for policy-relevant qualitative research (Pope *et al*., 2000). Analysis involved five main steps: familiarisation, creating a thematic framework, indexing, charting, and mapping and interpretation. Immersion into the data involved reading and re-reading the transcripts, and also listening to audio recordings of interviews. A thematic framework was created by drawing upon issues reported within the literature looking at the HCA role in secondary care, and also from emerging issues within the transcripts. Indexing (applying the thematic framework to transcripts) was carried out using Atlas.ti5. Interpretation of the data was guided by the aims and objectives of the study and also emergent themes arising from the data. Common themes running through the transcripts were explored in relation to HCA characteristics and deviant cases were scrutinised. One researcher coded the data (L.V.). Two researchers (S.B. and M.P.) validated the coding and made further suggestions.

Table 1 Interview guide

1. How old are you?
2. How long have you been working as an HCA in this practice?
3. Are you employed by your practice or by the PCT?
4. Do you have a dual role as a receptionist or in another capacity?
5. Approximately how many hours a week do you work as an HCA in this practice?
6. Where did you work/what did you do before working as an HCA in this practice?
7. What attracted you to this role?
8. What does your job involve?
9. What do you like/enjoy about working as an HCA in general practice?
10. What do you dislike/find frustrating?
11. What experience, qualities and skills do you think you need to do an HCA's job in this practice?
12. How were you prepared and trained for your role as an HCA?
13. What is your view of this preparation and training?
14. How might preparation and training be improved?
15. What opportunties do you think there are for training and development in this job?
16. What type of support and supervision do you receive?
17. What tasks, if any, do you do without supervision?
18. How have patients responded to you in this role?
19. How do you think your role has affected other staff and their roles?
20. How do you think your role has affected the way things are done in this practice?
21. How, if at all, could you/would you like to develop your role?
22. What training and development do you think you would need to develop your role?
23. What advantages would you gain from developing your role in this way?
24. What challenges might you face?
25. How would you like to develop your career?
26. Are there any other comments/points you would like to add?

HCA = healthcare assistants.

Results

Characteristics of participants

The 14 HCAs interviewed worked in a total of 13 practices set within urban (seven practices) and rural settings (six practices). The size of the practices, in terms of the number of partners, varied from two to seven (mean: five). Eight participants had been employed by their practices prior to becoming an HCA (either in an administrative role or as a phlebotomist or care worker). The other HCAs had come mainly from secondary care settings. All interviewees had experience in either GP or a caring role before being appointed. Although a number of the participants had initially undertaken a dual HCA/receptionist role, only one was undertaking such a role at the time of interview. The characteristics of the participants are shown in Table 2.

Table 2 Characteristics of HCAs

Age	Range = 24–57 years Mean age = 38 years
Previous role	Community care worker: 1 Receptionist/admin role: 6 Child minder: 1 Phlebotomist in secondary care: 3 Auxiliary/support worker in secondary care: 3
Length of time employed as an HCA in general practice	Less than one year: 3 Between one and three years: 5 Over three years: 6 Mean = 2.5 years
Sex	13 Female 1 Male

HCA = healthcare assistants.

HCA role

The HCAs in our sample were undertaking a range of tasks, with the most common being taking blood, measuring blood pressures, and performing ECGs (see Table 3 for a comprehensive list of the tasks). Just under half of the interviewees were undertaking administrative/clerical duties as part of their HCA role (eg, patient recall) whereas the other half were undertaking a predominantly clinical role, involving little or no administration or clerical work. Examples of tasks that were rarely mentioned (only by one interviewee) were flu vaccinations, audiograms, peak flow measurements, and chaperoning.

The participant's previous experience and/or length of time in the post appeared to determine the exact nature of the role, and the tasks that they undertook. The three participants who had only recently started working as HCAs in GP (two weeks, two months, and six months before interview) were all performing well-developed roles, involving a wide range of clinical tasks

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Table 3 Tasks performed by the interviewees

Type of task	Specific task	Number of HCAs carrying out task
Routine procedures	Blood pressures	11
	New patient medicals	6
	Height/weight measurements and BMI calculations	5
Technology-based investigations	Audiograms	1
	ECG readings	10
	Peak-flow measurements	1
	Spirometry	5
	Urinalysis	4
Invasive procedures	Phlebotomy	11
	Flu vaccinations	1
Wound care	Removal of sutures	5
	Applying simple dressings	9
Monitoring of drugs and patients with chronic conditions	Diabetes and coronary heart disease checks (including warfarin, IRN Service, and glucose tolerance testing)	4
Health promotion	Smoking cessation and obesity clinics	4
	Distributing lifestyle literature and advice	1
Administrative/clerical duties	Patient recall	4
	Summarising paper notes onto computer	1
	Cost comparisons	1
Assistance	Assisting with minor operations	3
	Chaperoning	1
	Assisting with chronic disease clinics	2
Maintenance of practice premises/supplies	Cleaning/sterilising	2
	Setting up minor operations	1
	Stock ordering (including vaccines) and restocking clinical area	4

(all three had extensive experience of working within secondary care settings).

> Because I worked in A and E I've got the minor injury experience. I do minor injuries (HCA6, in post two months).

> I worked at the hospital, which is where really all my training comes from and my knowledge to know this role (HCA11, in post for six months).

To a certain extent, the role was influenced by the individual preferences of the HCA, as they were given the autonomy to seek out training for new tasks, and to refuse tasks that they were not comfortable with doing. Tasks were also determined by the needs of the particular practice in which they were working, as many were employed in response to an increased need for care in the community (eg, carrying out blood tests and undertaking health promotion clinics).

The HCA toolkit, a web-based resource designed to support the development of the role within GP, outlines the potential range of duties for HCAs working in GP. The toolkit was developed by the Working in Partnership Programme (WiPP, 2007) in collaboration with Staffordshire University, with the main function being to 'establish and optimise the role of the HCA in GP' (Vaughan, 2007: 20). Developing the toolkit involved a rapid review of the literature, which was followed by the development and testing of new resources with GP organisations. Tasks that were mentioned by the HCAs in our sample, which were not included in the task list provided by the Working in Partnership Programme, were wound care (removal of sutures and applying simple dressings), warfarin monitoring, glucose tolerance testing, cost comparisons, and flu vaccinations. In total, nine HCAs were performing tasks not specified within the toolkit. In the case of wound care, there appeared to be a relationship with previous experience: all except one of the HCAs undertaking wound care (in five cases – removal of sutures and applying dressings, in four cases – applying dressings only) had experience

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within a secondary care environment. Undertaking warfarin monitoring, glucose tolerance testing, and making cost comparisons were less common, and did not appear to be related to HCA or practice characteristics. At the time of interview, flu vaccinations were a relatively new task for HCAs in GP, which may explain why only one interviewee reported them as part of their current role. However, four stated that there were plans for them to attend a training course in the near future. Areas of clinical practice that were included in the toolkit, but not mentioned by our interviewees, were helicobactor testing and nurse triage.

Attitudes towards being an HCA

Overall, the HCAs were largely positive towards their role, with many claiming that they 'loved' their job and that they were 'happy' working within GP. Half of the participants appeared extremely positive, and although the other half were also positive and claimed to enjoy their role, they were clearly less enthusiastic and spoke more often about the challenges associated with it. The differences in attitudes appeared to be related to the age of the HCA, their previous position, and the length of time that they had been working within the practice. The HCAs who appeared to be the most satisfied with their role were those who had come from administration posts (within the same practice), and/or those who had been working within the practice for a long period of time (either as an HCA or within a previous position such as a receptionist or a visiting phlebotomist/support worker).

> [I]t's a dream job for me (HCA1; previous community care worker, 5 years within practice).

> I just think it's fantastic. It's a fantastic job (HCA9; previous reception worker, 14 years in practice).

> [I]t's a lovely role … It's a lovely practice. The patients in general are lovely and it's … you know, it's great (HCA2; previous reception worker, 13 years in practice).

The less enthusiastic participants had come mainly from secondary care environments and/or were younger (under the age of 30 years). Although the three youngest HCAs were positive about their role and claimed to enjoy it, they spoke more often about negative aspects of the job, such as low pay and the lack of opportunities to progress.

> I think we should be on more money … we're at risk from needle stick injuries and infections and all the rest of it. And we're on fourteen and a half thousand [pounds]. …… I don't understand how they got to that figure … I think we're undervalued for the skills that we've got (HCA5, age 24).

> I do get frustrated because there's only a certain amount I can do without my general nursing qualification. I'm actually hoping to go to University … I'd like to learn more and do more (HCA14).

> [T]here's no way you can advance up the [salary] bands so you'll actually earn more money. So then you think, Where's the incentive to do any training?, I could just do what I was doing last year, which was not very much, and stay on the same money (HCA12, age 27).

Positive aspects of the role

Having contact with patients was by far the most valued aspect of the role. Just over half of the HCAs stated that they enjoyed interacting with patients on a day-to-day basis and liked receiving their positive feedback.

> [Y]ou get the variety of different people coming through. It's really nice when you just listen to somebody and think, and you do a test on them, and it comes back positive, and they come up and say, well, if it wasn't for you, I'd have never have known that. So it's nice (HCA13).

> I get job satisfaction in what I do. The amount of people that … the thank you cards, the hugs at the end of the day when people have lost weight because they've struggled, so, you know …. So it's all rewarding stuff (HCA9).

For those who had come from secondary care settings, working in primary care provided the opportunity to 'get to know' patients and develop long-term relationships with them.

> It's patient contact mainly. I quite like the relationship you can develop with them. Because you didn't get that at the hospital

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> either. You had some regulars, but (…) it's not the same as here. You get to know the patients (HCA12).

After patient contact, the variety of the role was the second most common benefit, as stated by our participants. HCAs appreciated the varied nature of the role – the wide range of tasks to undertake each day, and also its unpredictability, which they felt prevented boredom.

> [W]hether you're taking somebody's blood or you're checking a urine sample, it's going to be different every time … you don't know what's going to walk through the door … So I suppose it's the unpredictability of it. (HCA8).

> [Y]ou're not just stuck with doing, say, phlebotomy all day every day. You're not just doing smoke intervention all day every day. Each clinic's different … So you could have, say, smoking patients about fifteen minutes, and then fifteen minutes later … you're doing your ECGs, and so it's a good variety of work as well (HCA10).

Having autonomy was also a valued aspect of the role for some HCAs, but was less frequently cited than having variety and patient contact.

> I love the responsibility. Because I run my own clinics, I don't get told what I do day-to-day (HCA9).

> I like knowing what I've got, working on my own initiative and sorting out what comes along … (HCA1).

Despite being less enthusiastic about the HCA role in general, those that had come from secondary care environments were appreciative of the benefits associated with working in GP, such as greater flexibility and lack of shift work.

> I like the flexibility of the job. But I also like not having to work shifts. Not having to do nights in the hospital and … gone are the days when all the heavy lifting on the wards and things. And, I mean, I did that for a long time. So I've had that, been there … that's one thing I wouldn't even dream of, is going back into a hospital role (HCA10).

> The hours suit better. I don't have to do shifts or weekends or bank holidays or anything like that. So, you know, the hours are better. Much better (HCA5).

Infrequently reported benefits of the role were working within a team (mentioned by two interviewees) and learning new things (mentioned by one interviewee).

Challenges and sources of dissatisfaction

The most common source of dissatisfaction with the role was the low pay. Half of the interviewees stated that they were dissatisfied with their salaries and felt that they should be paid more. As noted previously, the issue of low pay was commented on frequently by the younger interviewees, and also others who had come from secondary care environments. Most of the participants who had progressed from an administrative role to that of an HCA were extremely positive about the role and did not state that low pay was an issue for them.

Although not a common theme, two of the participants (both of whom had been working in the role for over four years) stated that they were frustrated by the limitations of the HCA role: they felt that they had 'got as far as they could' and could not progress any further within GP.

> [I]t's being not able to go further and get that extra knowledge that you want, you know, when you get so far and you just … you're hungry for it and you can't get it (HCA3).

A lack of awareness and understanding within the GP team about the HCA role was another source of frustration. Two of the interviewees, both of whom had come from practices in which the role was new, reported that their colleagues were initially unaware of what tasks could be delegated to them.

> Here was a little bit frustrating for me when I first started because they were … they were unaware of what I was and what I could do … because they'd never had a health care assistant before (HCA11).

The perceived status of the HCA role

Over half of the HCAs commented on their role being of minor importance within the GP team. The interviewees often referred to their tasks as 'menial', 'silly', and 'mundane', and implicitly or explicitly

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compared them to the 'more important' responsibilities of the nurses. Many felt that the main purpose of their role was to provide help for the nurses.

> I think I take the pressure off the nurses because I can do little jobs for them, which means that they can move on and do other things that are more important (HCA2).

> Obviously, I'm not allowed to give injections and do smears and that, but just silly little things like doing a leg dressing or stitch removal (HCA1).

> I don't think you could do without … well, I couldn't go as far as to call it a Girl Friday, but somebody that will do blood tests and urine tests and, you know … probably jobs that are for nurses quite mundane things. Because they're more qualified to do things like dressings and immunisations and that type of thing … But if it's what you call a basic skill, you know, we can do that (HCA8).

Only two of the participants emphasised that more recognition and respect was needed for their role.

> [I]t needs to be recognised more for what it is, I think … It should be a recognised position and paid accordingly (HCA7).

> I mean, just if you get the opportunity, let everybody know, just because we *choose* to be like this, we have got a brain. Don't judge us because we've got the title 'health care assistant' (HCA3).

Role boundaries between HCAs and practice nurses

Role boundaries between HCAs and practice nurses appeared to be well defined. The HCAs often commented on the differences between their own role and that of the practice nurse. They also appeared certain of the tasks that they could and could not undertake. Tasks outside of the HCA remit, which were commonly cited, were smears, injections and '*anything to do with medication*'.

> I know there's a lot I can do, but I am aware. I know my role and I know obviously what I can't do … I know I'm not a practice nurse. I never pretend to be. I am a health care assistant (HCA11).

> [O]bviously, because there's so much she (the practice nurse) can do, that I can't (HCA5).

> I wouldn't change any doses. I mean, that's up to a doctor or a health professional. I mean, I just do the actual test (HCA8).

Only one of the HCAs stated that they considered their role to be very similar to that of the practice nurse.

Perceived acceptability to patients

HCAs had experienced patients as being mainly positive about their role, and patient acceptance was felt to have increased over time. Whereas interviewees who had previously worked in caring roles in the community felt that the patients had accepted them readily, those who had made the transition from an administrative role within the practice reported that initially patients questioned their capability and were sceptical about the 'secretary' taking their blood.

> [S]ome of them were a bit dubious at first because a lot of them (…) because it's a village and a lot of them know me anyway, they're sort of thinking Well, hang on a minute. How can somebody that's been a secretary take on a job like this? …. Surely you have to be a qualified nurse to take blood? (HCA8).

Tensions had also arisen when the HCAs performed a dual role as receptionist/HCA.

Most of the participants who had initially worked within a dual role reported that the patients' response improved when they progressed to working solely as an HCA.

> Now I'm not on the reception or in the dispensary, they've responded a lot better. When I first started, because I was doing part job of each, some of them didn't like it because they'd see you on reception one minute and then taking their blood pressure another (HCA2).

The participants felt that many patients were confused by the title 'healthcare assistant' and often could not differentiate between them and more qualified staff, such as a nurse, a health visitor, or 'something marvellous like some high up doctor' (HCA11).

Acceptability with the GP team

All but one of the HCAs reported that they had good working relationships with colleagues, especially practice nurses. GPs, practice managers, and reception staff were also recognised as being 'helpful' and 'supportive'. Almost all of the HCAs were complimentary about the practice, the team, or individual staff members.

> They're very, very organised here. Before I even started, I had a welcome-to-the-company pack with everything. And they made me feel really welcome. Yeah, it's a good environment to work in (HCA5).

> [S]he's (the practice nurse) been fantastic. And [name] the nurse practitioner here. In fact, even the doctors have been very supportive … The back up's there (HCA9).

> [I]f you want help, there's always help. They don't mind how often you ask. And they never say, 'Oh, for goodness sake, we've done it with you once, can't you do it?!'. They never say that here (HCA8).

Feeling fully supported by colleagues (both day-to-day support and also in relation to role development) was related to experiencing fewer difficulties and challenges within the role. Six of the participants felt that they had experienced few difficulties in their current role, which they attributed mainly to their supportive colleagues.

> [I]'m very well supported, so if I have any difficulties, there's people around me that are always very supportive. So I can't see that there is really much of a problem (HCA7).

> I honestly haven't come across any problems as such … If there's any problems with an individual patient, then I've always got support around … I've got two nurses right next door to me. And a doctor like, you know, the door after (HCA10).

The HCA who was not complimentary towards the practice or her colleagues stated that she sensed that her colleagues were not supportive of her developing her role.

> [T]hey (colleagues within the practice) don't want to develop us … I sometimes get the feeling they don't want to develop you too much in case then you think, I want to go and leave and do nursing or something. Then they don't want to have wasted all this training and money on you and you just leave … I'll be told we'll support you, but only so far. So you always think, well, what does that mean. And that's quite negative really (HCA12).

With regard to extending their competencies, the majority felt that their colleagues were keen for them to develop their role and would support them in undertaking further training, which was appreciated.

> [E]very time you ask whether you can do something or be trained on something, the practice manager certainly goes out of her way to try and find out and see if there's a course (HCA8).

> [T]hey are more than ready to send me on anything I want to go on … and I like that aspect. They're behind you, you know? They look after you really (HCA11).

Only two HCAs mentioned practice nurses' resistance towards their role.

> [W]hen I very first started, it was quite hard from one nurse … she couldn't get her head around me, it was very hard for her to let go with certain things … I think she was quite frightened that I was here to take her role (HCA13).

> [T]here's an awful lot of trained nurses that feel as though their toes are being stepped on (HCA10).

Future plans and role development

Although most of the participants did not directly state that the limitations of the HCA role were an issue for them, half did report that they would like to pursue nurse training. The main reasons for not undertaking nurse training included financial constraints and family commitments.

> [I] have thought about going into nursing, but with the financial situation at the moment it's not feasible, but never-say-never … I've got a young family and I've got a mortgage, so I've got to think about all that before I sort of take three years out of my life basically, to do the training (HCA1).

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> [H]opefully, like I say, eventually go to Uni and do nurse training … I've got a baby on the way … so it's affording to take the pay cut. Because it's a bursary, you're talking about four/five hundred pounds a month. I couldn't afford to live on that. …. I've got a house to run and I've got a family to bring up. So I couldn't afford to take that pay cut. So, you know, if circumstances changed or … if they brought out a new scheme … then maybe I would (HCA5).

> She (the NVQ assessor) wanted me to go on to do my nursing and I felt very frustrated because personal circumstances didn't allow … I'm a single mum, so I couldn't take the risk of leaving here and having to, you know, drop my wages (HCA9).

Others reasoned that they did not want to give up working within primary care, as they were settled within the GP team, and appreciated the working conditions associated with it. Five of the HCAs were happy in their present role and wanted to stay working within GP for the foreseeable future. These participants tended to be within the older age group (over 40 years of age), with family commitments or else near to retirement. Two of the HCAs had definite plans to develop their career – one to undertake nurse training and the other an assistant practitioner foundation degree course.

In terms of extending or developing their current role, attitudes varied. Four of the HCAs felt that they were already being used to their full potential (in terms of their paid hours within the practice) and so did not want or feel the need for any further development. The participants that were frustrated by the limitations of the role felt that there were no new tasks that they could undertake, as they had already reached the 'ceiling' of the HCA post. Others outlined various tasks that they would like to take on, such as spirometry, dressings, ear syringing, assisting with minor operations, and wound care.

Discussion

Summary of main findings

This study has produced new insights into the experiences of HCAs working within GP. It appears that the role of the GP HCA includes both clinical and administrative tasks, with role definition being determined by the needs of the practice and the experience and preferences of the individual HCA. In this study, attitudes to the role appeared to be related to the age of the HCA, previous employment and experience, and length of time that they had been working within their practice. HCAs who had progressed from an administrative post and/or had been long-standing staff members, appearing to be the most satisfied with the role. Although HCAs appreciated the variety, patient contact, autonomy and flexibility of their role in GP, many were dissatisfied with their salary and the limited scope for career progression. Role boundaries between HCAs and practice nurses appeared well defined, and HCA perceptions of their role did not reveal role ambiguity. They considered their role to have low status and to be primarily one of a 'substitute' or 'helper' to nurses.

Limitations of the study

The study has a number of limitations. First, given its small scale, its findings need to be interpreted cautiously and cannot be assumed to apply to HCAs outside the region studied. Second, the interviews were relatively short in length and, consequently, the range of topics discussed and the depth of their coverage were relatively limited. Third, the study did not involve patients, and the findings about patient acceptability are thus drawn from the HCAs' perceptions only. Lastly, the majority of interviewees were well established in their role and had been in the post for over a year. Therefore, the findings may not fully portray the experiences of newly appointed HCAs.

Comparison with previous literature

The findings here contrast with Bach *et al.*'s (2008) finding that HCAs in secondary care generally rejected the idea that they were the nurses' 'assistant' or 'helper' and perceived themselves as having their own duties to fulfil, which were separate from nurses' tasks. They found that such HCAs were generally more satisfied with their role, although still feeling that their work was unrecognised and undervalued. Compared to this, our study found tendencies that were more typical of the traditional or professional workforce

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models, in which the role is viewed as either a 'substitute' or 'relief' worker to qualified nurses. It is plausible that this reflects a difference of phase in the development of the HCA role, with it being much less established in GP.

Role boundaries between practice nurses and HCAs were reported as well defined in our study, and most HCAs appeared certain about the tasks that they could and could not undertake. Role ambiguity was thus not identified as an issue. However, there was some vicarious evidence of it: a few of the HCAs did say that other staff members were initially unaware of what tasks to delegate to them. Our findings contrast those of Workman (1996), who found that HCAs in secondary care directly experienced role ambiguity, as they found it difficult to ascertain the differences between their own role and that of qualified nurses, and also expressed uncertainty about role expectations and suitable activities for HCAs.

One of the main sources of frustration concerning the role was the poor salary, as is the case for support workers and HCAs in other settings (Thornley, 2007). HCAs, support workers and nursing auxiliaries are among the poorest workers in the UK economy, with most earning just half the current national average (Thornley, 2007). A recent survey by UNISON (UNISON, 2008), the biggest public sector union in the United Kingdom, has shown that nearly two-thirds of HCAs have considered leaving the NHS in the past year, mainly because of their income. Our findings are consistent with this widespread dissatisfaction, which is likely to have implications for the recruitment and retention of staff (Thornley, 2007).

The HCAs in this study felt that patients were generally accepting of their role, particularly where they came from phlebotomist/caring backgrounds. Those who had previously worked as part of the practice administration team felt that patients were less accepting of HCAs and were mistrusting of the dual HCA/receptionist role. They found that sometimes patients were confused by the term HCA, and often mistook the HCA for a nurse. This concurs with other reports (Gear and Jackson, 2003; Walters, 2005; Burns, 2006; Longbottom *et al*., 2006; Burns and Blair, 2007; Smith, 2008). A parallel can be drawn with the emergence of the practice nurse in the 1980s and the difficulty patients at the time had in distinguishing between the role of a practice nurse and a doctor (Drury *et al*., 1988). It is likely that as the role of the HCA becomes more established in GP, patients will increasingly gain familiarity with their role.

On the whole, the HCAs in our sample felt that practice team members, especially practice nurses, had been helpful, supportive, and encouraging. It has previously been recognised that GP team members tend to welcome the introduction of the HCA role (Burns and Blair, 2007), although some practice nurses initially had concerns (Gear and Jackson, 2003). Tension between HCAs and RNs in secondary care has been described, and some HCAs have expressed negative feelings and resentment towards RNs (Spilsbury and Meyer, 2005; Bach *et al*., 2008).We did not find any evidence of such negative feelings in GP. Instead, the interviewees reported having good working relationships with practice nurses.

Although several of the HCAs had considered the possibility of undertaking nurse training at some point in the future, some were frustrated by the lack of a definite career pathway or felt they could not undertake nurse training due to family commitments and/or financial constraints. Similar reasons have been reported by HCAs in other settings with many having been 'blocked' from entering RN training (Thornley, 2000). Although undertaking nurse training was frequently mentioned, becoming an assistant practitioner was rarely recognised as an option. There seems to be little awareness of the assistant practitioner role, which is fairly new and sits 'between that of an HCA and a RN at level four' (Longbottom, 2006). Assistant practitioners work in a variety of settings, including primary, secondary and community care. The exact nature of the role varies according to the nature of the post, and the context that they work in.

Implications for policy, practice, and future research

There appears to be a need for greater awareness of the HCA role among practice team members in order that the potential benefits of the role can be fully realised. Practices, therefore, need to ensure that their wider workforce is fully prepared when taking on an HCA for the first time. HCAs in this study appreciated their colleagues' support and encouragement on both a day-to-day basis and also in relation to role development. This indicates the importance of providing

protected time and resources for mentorship, for ensuring that HCAs feel valued in their role, and for supporting their career development. Furthermore, this highlights the significance of effective interprofessional working for ensuring that HCAs are satisfied within their role.

In terms of implications for policy, the findings highlight the need for support in relation to the career development of HCAs. A number of participants expressed the desire to undertake nurse training but felt that they were constrained by their financial or domestic circumstances. Therefore, in line with the report by Lord Darzi (Department of Health, 2008), future policy should recognise the importance of providing appropriate and feasible pathways for HCA career development.

Much remains unknown about how HCAs encounter working as part of GP teams. Further research is needed to investigate the generalisability of the experiences reported here, and to understand how best to promote this new and fast developing role.

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Ethical approval

This study was approved by Warwickshire Research Ethics Committee (reference: 07/Q2803/23).

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Conflicts of interest

none.

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