Assistant practitioners: issues of accountability, delegation and competence

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Abstract

The NHS Modernisation Agenda, alongside workforce shortages in health care professions, has led to increasing interest in the role of assistant practitioners in the delivery of health and social care. This paper describes the introduction and evaluation of assistant practitioners in occupational therapy who were empowered to work independently in a limited number of interventions and services within an NHS Trust.

The evaluation involved focus groups with four groups of key stakeholders, the assistant practitioners, their supervisors, managers and service users.

Key themes included ambiguity about who takes responsibility for the outcomes of care and uncertainty about challenging the role of the ‘professional’ staff; there was a lack of clarity about how work is ‘delegated’ to the assistant practitioners; and it was difficult to determine levels of competence in the new workers because the existing staff did not recognize their qualifications.

These issues need to be addressed in order to optimise the relationships between staff, clarify the roles of team members, and ensure service users receive the most appropriate care from the most appropriate practitioner.
**Introduction**

Healthcare in Britain is undergoing a period of tremendous change as organisations restructure the delivery of services, in an effort to provide the most efficient and effective care to service users. This is resulting in transformations in the customary roles and practices of the health care workforce. Currently, significant changes to the employment patterns of support workers are occurring in both hospital and community settings. Support worker roles are growing both in terms of number and in the scope of activities being undertaken. Many of these roles have evolved within the context of the National Health Service (NHS) modernisation programme (Department of Health 2000, 2001, 2002).

The Changing Workforce Programme (CWP) established within the NHS Modernisation Agency to promote the development of new and extended roles, acknowledges the increasing importance of support workers. The introduction of “assistant practitioners”, higher level support workers who complement the work of state registered professionals, is one of the modernisation initiatives the CWP is promoting (CWP 2003). The CWP recommends that support workers should have access to nationally recognised qualifications and, consequently many forms of vocational qualifications are being developed including foundation degrees and updated National Vocational Qualifications (NVQ).

Until recently, the health service professions in partnership with Institutes of higher education identified the knowledge and skills that were required by employees in health care (Barnett 1994). With the competence based approach, it is employers who identify the competencies they wish to purchase.
In an environment characterised by rapid change and the disappearance of traditional unskilled jobs, competence based qualifications are considered the leading instrument in achieving the Governments aim of increasing participation and higher attainment in education.

LITERATURE REVIEW

There is little in the way of a substantive evidence base which explores the impact on care delivery of the introduction of assistant practitioner roles. A review of several databases including CINAHL, MEDLINE, AMED and the British Nursing Index, reveals a paucity of information on these new support worker roles. The small number of articles available are mainly descriptive accounts of where the new roles are being introduced, or opinion pieces. Warne and McAndrew (2004), reflecting on the introduction of mental health assistant practitioners, warn that the introduction of these new style workers is beset by organisational, cultural and professional concerns.

In another piece, the same authors raise concerns over the threat posed to professional identities by the new roles, and identify ethical concerns about whether members of the public will be informed as to who is providing care for them (Warne and McAndrew 2003).

Advocates of an extended role for support workers envisage that the role will enable professionally registered staff to spend more of their time carrying out profession specific and complex activities (Atkinson 1993, Kennerly, 1989). Workload studies have shown that many professionally trained health care staff, including nurses, doctors and the allied health professionals, spend a high proportion of their time performing tasks that do not require their expertise or experience (Richardson et al 1998). Consequently, support workers are now being encouraged to take on clinical work traditionally undertaken by professionally registered staff.
At present there is a lack of a national definition and perspective on the role of assistant practitioners. Little guidance exists on the development of such a role, its educational basis, its implementation or evaluation. Accountability for the scope of such new roles and the standards of practice which apply to them are still unclear. This leaves service managers the flexibility to create roles which suit local need. Consequently, the role is evolving within different models. This may change with statutory regulation as proposed by the Department of Health (2004).

Whilst it is acknowledged that different work areas may have differing definitions, for the purposes of this study, the definition of assistant practitioner is taken from Mackey (2004a).

“Assistant practitioners are support workers, who through extra education and training are able to practice autonomously, make decisions and instigate treatment based on those decisions and are accountable for their own practice”. (p26 – 262).

It is stressed that assistant practitioners can be empowered to function independently in a limited number of interventions and services, and are not intended to replace the state registered professionals role.

This paper is based on the findings of a qualitative evaluation of an assistant practitioner role within a Community Occupational Therapy Service. Issues of accountability, delegation and competence are discussed and issues raised which must be considered when introducing new style support workers into the workforce.

**Defining the Concepts**

**a) Accountability**

The concept of accountability is an elusive one, described by Day and Klein (1987) as a “chameleon word” (p 1). The focus of this paper is public accountability, which in its most simplified form “requires that public bodies give an account of their activities
to other people and provide a justification for what has been done” (Smith and Stanyer 1976 p 30 – 31).

Like other public bodies, the health service providers are accountable to both the criminal and civil courts to ensure that their activities conform to legal requirements. In addition health service employees are accountable to their employers to follow their contract of duty, and health service professionals are also accountable to their professional bodies in terms of standards of practice and codes of ethics. At present, assistant practitioners are not subject to professional registration and therefore are not professionally accountable although a recent consultation on regulation of support staff indicates that this will change (Department of Health 2004).

Shardlow (2000) reviews accountability and responsibility and believes that although in general usage the terms are synonymous, a difference does exist in that accountability relates to the position held within an organisation whilst responsibility is a personal concept and derives from being a member of society, and therefore responsible for one’s actions.

b) Delegation

There is a distinction between delegation, the transfer of responsibility for the performance of an activity from one person to another while retaining accountability for the outcome, and assignment, the downward or lateral transfer of both the responsibility and accountability of an activity from one individual to another (Barter and Furmidge 1994).

When delegating work to others, professionally qualified staff have a legal responsibility to have determined the knowledge and skill level required to perform the tasks required within the work area. The professional retains accountability for the delegation and the assistant practitioner is accountable for accepting the delegated task and for his/her own actions in carrying out the task providing that the assistant
practitioner has the skills, knowledge and judgement to perform the assignment, the
delegation of tasks falls within the guidelines and protocols in place within the work-
base and the level of supervision and feedback is appropriate. (Storey 2004).

e) Competence

Competence is arguably one of the most commonly used words in investigating the
extended roles of support workers but there are diverse views about what constitutes
and contributes to competent practice. Some definitions are clearly based on
behavioural outcomes but others are more holistic. Competence, in the behavioural
sense is “what people can do rather than what they know” (Unit for the Development

To Gonczi (1994) competence is relational, as it brings together the abilities of the
individual and the tasks that need to be performed in different situations.
For Benner (1984) competence is the third of five stages ranging from novice
practitioner to expert. During the competent stage, practitioners are able to function
capably with an increased capacity to view situations holistically, but are still lacking
the expertise to handle a whole range of situations proficiently.

Dependant upon which definition is taken there are different methods for the analysis
of competence, with no way of deciding which is best (Holmes 1994).

One of the ways in which competence is assessed is through the award of National /
Scottish Vocational Qualifications (N/SVQ). These qualifications use past and current
performance to adjudge future performance. The acquisition of an N/SVQ is not a
permit to practice, but identifies the holder as competent to undertake a range of
duties in a given care environment (Storey 2004). The state registered professional is
then able to use their judgement to determine the most appropriate person to deliver
care.
The Study

This study was commissioned by the Shropshire and Staffordshire Workforce Confederation during 2003 / 2004. The aim was to evaluate the impact of a skill mix project introduced into a large community based Occupational Therapy service.

The project involved the evaluation of the introduction of a new tier of Occupational Therapy support worker, an assistant practitioner, trained to NVQ level 4, to undertake some tasks traditionally performed by a professionally qualified Occupational Therapist.

The background to the introduction of the role rationale for the selection of grade and process of identifying the work areas and role is described elsewhere. (Mackey 2004 (b).

Method

A qualitative approach was used. Four Focus Group interviews were undertaken by one of the authors (S. N). The study population consisted of Occupational Therapy service providers and service users from the community based health Trust.

A purposive sampling method was used to ensure representation from each of the stakeholder groups involved with the introduction of the new role. Each focus group consisted of a different category of participant.

Group 1: Assistant Practitioners (n = 5)
Group 2: Supervising Occupational Therapists (n = 5)
Group 3: Team Managers (n = 4)
Group 4: Service Users (n = 3).

This sampling method was used in order to create groups that could maintain active, free flowing discussions and encourage the sharing of information.

All assistant practitioners, supervising Occupational Therapists and team managers were invited to attend the focus groups. Attendance was voluntary and staff did not
have to provide a reason for non-attendance. Interviews took place during normal working hours, in paid staff time.

Service Users were recruited via an “invitation to attend” letter sent to all Occupational Therapy users within a single week. Participation was voluntary. Service users had their travel costs reimbursed and were provided with refreshments. Before the interviews each participant was given a written information sheet describing the research aims and a written consent form. Ethics and Research Governance approval was obtained from the appropriate local committee. In compliance with ethics requirements, anonymity and confidentiality of the group members was assured and no identifying information used in the final report. All groups were given the same introductory background information. A semi-structured interview format was adopted and pre-identified themes discussed. The interviews were scheduled for two hours. The interviews were tape recorded and transcribed verbatim. Data was handled in accordance with ethics requirements. The methods employed were designed to obtain the breadth of views rather than consensus. The transcripts were analysed using the “framework” approach as described by Richie and Spencer (1995). This involves the sifting, charting and coding of data. The two researchers undertook this activity separately and then compared outputs to verify the results.

**Findings**

Seven major themes pertinent to the introduction and evaluation of the role of assistant practitioners within the Occupational Therapy Service emerged from the analysis (Mackey and Nancarrow 2004).

This paper is concerned only with the issues around accountability, delegation, and competence.
1. **Accountability**

1.a. **Confusion of accountability**

One of the most important issues around accountability within the service was the ambiguity about who is responsible for the outcomes of the work of the assistant practitioner. The supervising Occupational Therapists perceived that they were responsible for the outcomes of the assistant practitioners work, even though the assistant practitioners were managing their own caseloads autonomously.

“That’s one thing where I don’t agree because there’s numerous people who have gone into (the unit) or whatever and I’ve never seen them and I’ve got that professional accountability for people who I have never even seen” (Supervising Therapist 564).

The assistant practitioners were unclear about their own accountability. Initially, they said that the supervising Occupational Therapist was responsible for the patient outcomes. When pressed they said that they felt they were accountable themselves for the outcome of their intervention.

The supervising therapis highlighted the inconsistency in responsibility in that they cannot see patients if they do not have signed professional accountability through the Health Professions Council, but assistant practitioners can, despite having no regulatory recognition.

Team Managers acknowledged introduction of the new roles highlights a need to examine the existing models of professional accountability within the workplace.

“And now this new environment … well we aren’t talking about professional accountability as long as the structure is in place and the person is competent and … there’s the training, there’s the supervision, as long as the framework is in place, if the person makes
a mess then they’ve made the mess haven’t they”.

Manager 1205.

The confusion surrounding the management of accountability, the innovatory nature of the assistant practitioners role, the lack of guidance and an increasingly litigious public leaves the Occupational Therapy practitioners of all grades feeling vulnerable and unsure of their legal positions.

1. b. Power and Accountability

There was recognition by the participants that accountability was an important part of the supervising Occupational Therapists professional identity and status, and consequently, they felt uneasy with any challenge to it.

“I think for some of the qualified staff its to do with the culture that they’re in, and what they feel safe with, it’s a form of control this accountability thing, that’s their one way of having responsibility or power over, I don’t mean power that’s a horrible way of saying it, but a degree of control”.

Manager 1281.

And ...........................................

“I think it is about power….That some of the qualified staff feel very threatened by…..our extended role”.

Assistant Practitioner 86.

Thus professional accountability, as well as being a mechanism for public protection, has become a method of preserving the prestige and power of the Occupational Therapists. It is an important difference between the two groups of workers and may be used to persuade others of the special qualities of the professionals.
2. **Delegation**

2. a. **Delegation or Assignment**

A key area of ambiguity for supervising therapists and team leaders was whether assistant practitioners work would be considered “delegated” or assigned to the assistant practitioners.

“and I think its about delegation as well, this is the other thing that confuses me is that is this task delegated? Has the OT delegated this task to the support worker? In our situation I don’t think they are, it’s the support workers role and responsibility”.

Manager 1344.

This point was important. If work was delegated, for example during Annual Leave the Occupational Therapist was able to control the workload and had the ability to take the delegated tasks back under their own control.

“I know if I was on Annual Leave (the assistant practitioner) would do that and do that very well, but I think that when I’m there, there is that…..level of responsibility”.

Supervising Therapist 116.

With assignment, however,

“There’s no control, you can’t pull it back can you, so you’ve lost that control over the (assistant practitioners)”.

Manager 78

This ambiguity created some concerns for the assistant practitioners who felt that their roles expanded and contracted according to the availability of the qualified staff. They felt that if they are deemed competent to deliver roles when the qualified staff are not available, then they should be able to continue that role when the qualified staff
member is present. The managers reinforced the notion that the assistant practitioners should be able to sustain a consistent level of responsibility.

2. b. Training Needs

Some Occupational Therapists reported that they felt unprepared for the task of delegating work to, and supervising assistant practitioners.

“maybe I need more training in that because I don’t feel I ….Actually when I talked to (My Manager) about it and I said I wasn’t happy with my supervision skills for supervising (the assistant practitioner) she said it was (the assistant practitioner) who should be bringing things to supervision not me supervising across to (the assistant practitioner) but I don’t feel comfortable about that”.

Supervising Occupational Therapist 676.

It was the change in the working relationship that supervising therapist felt most unprepared for. Their role changed from controller to facilitator. It was acknowledged that it takes time to train and change attitudes. The Assistant Practitioners felt that the supervising therapists needed training to develop their own roles

“I don’t think that the senior therapists really know what they should be doing if they have got this assistant practitioner”.

Assistant Practitioner 189

Participants identified a need to establish systems both to support assistant practitioner supervision and give the Occupational Therapists skills to supervise, delegate and initiate new service developments.
2. c. **Conflicts of Interest**

There was a perception that in some cases, Occupational Therapists were reluctant to delegate work to the assistant practitioners because they did not want to lose the job satisfaction associated with treating patients.

“Some of the qualified staff have not felt happy about really letting go of that as well, because often it is delegation of work and they lose the job satisfaction of actually seeing that patient through themselves”. Manager 424.

And ............................................................

“I think that’s what I went to university for, for those juicy bits, for the treatment plan, for the whole relationship with the client, everything, and in that respect I do feel threatened. Not because I don’t think they’re competent to do that, but I feel that that’s part of my job, that was the whole reason I went into it in the first place and its been taken from me”.

Supervising Therapist 782.

This reluctance was heightened by the perceived lack of opportunities for professional staff to advance in clinical roles. Both supervising therapists and assistant practitioners believed the qualified staff’s progression was into more management activities. The Team Managers, on the other hand, saw that the professional staff now had opportunities for career advancement whilst retaining the clinical focus of their work.
2. d. What Roles to Delegate

Ongoing tensions existed between supervising therapists and the assistant practitioners about which tasks should be delegated. Participants had difficulty in clearly articulating which roles could be delegated and which should remain with the Occupational Therapists.

“our Senior 1…..openly said to us that she was not threatened was she? She was a bit dubious as to what we did because she had never worked with assistant practitioners before and what part of the role should we do as assistant practitioners and where does she fit in?”.

Assistant Practitioner 94.

For the Occupational Therapy profession this is particularly difficult issue as everyday activities are used as therapeutic interventions. The participants reported that the assistant practitioners could perform most of the tasks undertaken by the qualified Occupational Therapists but not in all circumstances. The State Registered Therapist accepted this because they could defend their own role as more than the completion of clearly defined tasks, and talked of their own use of judgement and clinical reasoning skills in relation to patient care. There was however, concern that other health and social care workers, particular those in management roles, could not distinguish between tasks suitable for a qualified therapist and those able to be carried out by an assistant practitioner. This was felt to make Occupational Therapy vulnerable to lobbying by other workers and managers for more Occupational Therapy tasks to be delegated.
3. **Competence**

3. a. **Defining Competence**

Participants had difficulty in articulating professional and legal interpretations of competence. It was acknowledged that personal characteristics were often as important as technical skills and knowledge.

“I see a knowledge base as being important and the training is important. You start off with a personal qualification but I think you have to have a professional set of qualifications at whatever level it is”. Service User 330.

Confusion existed surrounding whether competence was a description of being able to do something or whether it was a state of being, involving attitudes and values. Whichever criteria was accepted, there was little agreement about how holistic competence could be inferred.

3. b. **Verification of Competence**

The importance of measuring competence arose as both a supervisory and as a training need. The supervising therapists reported that they were reluctant to let go of work until they ‘trust’ the assistant practitioner.

“Its almost a matter of sometimes the relationship of trust that you have with that person, the way that your two characters combine. That can almost – its kind of an unsaid thing isn’t it but sometimes it can just be a matter of how well you get on with somebody and how well you communicate, how well you feel like you can trust each other, which can help or hinder”. Supervising Therapist 706.

Supervising therapists did not place intrinsic value on the NVQ qualifications of the assistant practitioners.
“But we’ve also got issues where people don’t know NVQ’s, don’t know what the contents are, don’t know what the person has had to do, and therefore don’t class it as a qualification, they only see their degree education or A levels and if it isn’t that then you haven’t got one”. Manager 330.

When the supervising therapist was an NVQ assessor, they tended to have a greater faith in the competence demonstrated by the qualification and a greater awareness of the content of that training. There was also a perception across all levels of staff that there is a great deal of inconsistency in the quality of NVQ’s. Assistant Practitioners felt cheated that the Occupational Therapists qualifications are accepted at face value as an indicator of competence but NVQ’s are not.

The lack of trust of the assistant practitioner had implications for them personally.

“When I first became an assistant practitioner I spent many sleepless nights wondering if I had done absolutely everything for this client because I felt I had so much to prove and it was awful I was stressed after just a few weeks”. Assistant Practitioner 352.

It was difficult to determine how to measure competence. Service users said that they had trust in the employing organisation to ensure that the practitioner had the necessary skills to deliver the care that they required.

**Discussion**

While the findings are not necessarily generalisable to other settings, they highlight a number of factors that need to be considered in the development of assistant practitioner roles. These include perceived legal vulnerability due to confusion around accountability, lack of clarity over what might be viewed as a delegated task and difficulties with the definition and verification of competence.
National policy directives are leading to wide ranging interpretations and applications of the assistant practitioner role. It would be useful to revisit and clarify the role in the context of how services have evolved. As the activities which health professionals are involved in change there is the need for a wide ranging, national debate on the extent to which traditional activities should be retained or delegated. Leaving this debate to local organisations will continue the diversity and confusion illustrated. Ideally these changes in practice should be evidence based and investment in research about the effect of such changes on patient care and outcomes is much needed. This would allow professional staff to confidently move forward with new developments around an extended role for support workers but also hold back in areas where it is suggested that extended roles are detrimental to client care.

The introduction of an assistant practitioner role results in a redesign of both professional and support workers jobs. This process is unlikely to be a smooth one as the assistant practitioners, whose work roles are being created, engage in some form of “turf battle” with the supervising professionals whose roles are being modified. The problems of defining the tasks and authority of each role and dealing with the conflict arising from real or perceived overlaps create real challenges to the historical and prevailing hierarchical system within the NHS Trust and is an integral part of role redesign and the delegation process. There is a need to acknowledge the evolving nature of workforce redesign. It takes time to train and change attitudes. Relationships develop over time and sharing, co-operation and communication enable professional staff and assistant practitioners to clarify and feel comfortable and confident with each others role. A care delivery model which allows staff to be placed together consequently allows this to occur.
What will prove crucial in the development of assistant practitioner roles is not only the skills of the individual assistant practitioner, but whether professional groups embrace the changes. There is an increased need for professional staff to be skilled in the care co-ordination activities of supervision and delegation, and for them to be educated in the reconceptualisation of their role. Reinforcement of the professionals’ role in the evaluation of patient care activities must be given on a regular basis, and undergraduate training needs to prepare students for the new look workforce.

Professional staff working with assistant practitioners have professional and legal obligations to train them adequately and to delegate responsibly. Regular supervision and clear record keeping is a necessity, as is periodic competence verification, which can occur via a number of methods including personal development, reflective diaries and observation. Service Users have the right to expect that those who provide their care are knowledgeable and competent. There is a need to increase the scope and relevance of training for assistant practitioners that has national standards and status, and for professional staff to be educated in the content of this training.

It is to be hoped that clarification around the issues of accountability, delegation and competence of assistant practitioners will enable the professional staff to develop their own roles and to create a model of service delivery, which allows all staff to deliver the care their qualifications and experience, permits.
Conclusion

It is apparent that we can expect to see continued development of new roles and responsibilities for support workers. The dual demands of innovation in workforce design and safe practice require educational and management strategies, to ensure public protection is optimised and professional vulnerability minimised.

At a national level, there is urgent need to clarify the supervisory and accountability relationships of assistant practitioners. Supervising professionals need to be trained in how to prepare for and facilitate the role of assistant practitioner as well as developing an awareness and knowledge of the content of assistant practitioner education and training. This will assist with delegation and the verification of competence.

There is a need to increase the scope and relevance of training that is accessible to assistant practitioners. In addition, there is a need for career advancement opportunities for professional staff so that the new service models can be welcomed as opportunities rather than seen as threatening professional practice. Consequently, it is essential that managers recognise and address the issues surrounding accountability, delegation and competence in any new service developments concerning assistant practitioners.
**Key Points**

- At a national level, there is an urgent need to clarify the supervisory and accountability relationships of assistant practitioners.

- The dual demands of innovation in workforce design and safe practice require educational and management strategies, to ensure public protection is optimised and professional vulnerability minimised.

- Supervising Therapists need to be trained in how to prepare for, and facilitate the role of assistant practitioner. Educational Programmes must clarify changes in the Therapists role and emphasise the importance of indirect care co-ordination.

- Supervising Therapists need an awareness and knowledge of the content of assistant practitioner education and training to assist with delegation and the verification of competence.

- There is a need for professional security and scope for career advancement for professional staff in order to optimise the introduction of assistant practitioners.

- There is a need to increase the scope and relevance of training that is accessible to assistant practitioners.
References


