Should healthcare assistants be performing annual diabetes reviews?

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I was prompted to write this comment piece when a colleague in one part of the country revealed to me that healthcare assistants (HCAs) were being asked to perform annual diabetes reviews independently, and often with little training.

I was shocked to hear this but after further investigation found several posts on an online practice nursing forum suggesting that this may not be an isolated case (available at: http://bit.ly/18wkaot [accessed 28.05.13]).

In one post an HCA wonders if other practices are asking their HCAs to carry out annual diabetes reviews, with patients not seeing a trained nurse at all. The HCA is, understandably, uncomfortable about this and goes on to express concerns, such as: "I don't feel confident […] the GPs have decided it's down to us and not the nurses […] we're not happy […] we don't have the appropriate training."

I find all of this deeply worrying. It compromises patient care and places HCAs in an invidious position.

The Government's drive to move the management of long-term conditions such as diabetes into primary care (Department of Health, 2006), coupled with the increasing demands placed on us by the Quality and Outcomes Framework (QOF), has resulted in huge additional workload. In my experience, there are many cases in which much of the additional chronic disease management has been taken on by practice nurses. Of course, there is only so much we can do in the time allocated and it makes sense to review skill-mix and delegate those tasks that may be safely transferred to unregistered practitioners.

The evolution of the HCA

HCAs can improve capacity and efficiency and as their role has evolved many HCAs have taken on higher-level tasks very successfully. Roland et al (2004) describe how "diabetes care technicians" expanded their role beyond traditional tasks of weight, blood pressure and urine testing to encompass foot examination, and Carlisle et al (2007) describe where HCAs have been responsible for protocol-based screening for diabetes.

HCAs are hugely valuable members of the primary healthcare team, performing tasks such as venepuncture with tremendous skill and competence. Their role in general practice has evolved rapidly in recent years, and training courses have been developed to support this. An example is the 6-month self-directed "Understanding Diabetes Care" course offered by the Primary Care Training Centre, which equips HCAs assisting in the management of people with diabetes (available at: http://bit.ly/130ygMX [accessed 28.05.13]). Courses such as these, however, are not designed to enable HCAs to make independent clinical management decisions. In my opinion, making clinical judgments is a fundamental element of the annual diabetes review.

The annual diabetes review

Arguably, there is no agreed definition of what constitutes an annual diabetes review. Those of us working in primary care are all too aware of the need to achieve the QOF indicator targets, but the annual review should not be a tick-box exercise for collecting QOF data. Diabetes UK (2012) describes 15 healthcare essentials, which include services people with the condition should have access to and key checks that should be performed at least once a year (this is a minimum standard). The organisation also points out that "a formal annual care planning review with a doctor or nurse experienced in diabetes" is what people with diabetes should expect (Diabetes UK, 2009).

A review can be defined as "a formal assessment of something with the intention

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of instituting change if necessary" (definition from: http://oxforddictionaries.com [accessed 28.05.13]).

Diabetes is a complex and dynamic condition. The annual diabetes review, if performed properly, is rarely a straightforward process. Clinical decisions need to be made in relation to multiple associated pathologies and risk factors, including blood pressure, lipid management, neuropathy and nephropathy – and, of course, glycaemic control. It should involve:

- A sharing of information between clinician and patient.
- A discussion about the meaning of test results and examination findings.
- An agreement over the preferred treatment options.

The HCA's role and responsibilities

The role and responsibilities of HCAs need to be clearly defined with protocols that outline procedures to follow. There also need to be clear definitions about who can do what to ensure that people with diabetes see the right people, in the right place, at the right time.

Of course, part of the problem with unregistered practitioners is that there is currently no statutory regulation. As Tanis Hand, HCA Adviser to the Royal College of Nursing (RCN), recently pointed out, there is an urgent need for statutory regulation for HCAs because "it brings with it a code of conduct, standards for education and training, a clear career pathway and definitions of the role" (Hand, 2012).

There may be areas of overlap between registered and non-registered nursing roles but a fundamentally distinguishing feature is that registered nurses make judgements and decisions based on the clinical circumstance, whereas HCAs have tasks delegated to them, possibly with supervision by a registered professional. HCAs should not be placed in situations where they are required to make such independent clinical judgements – that is the responsibility of appropriately trained registered practitioners. Instead, they should be guided by protocols, acting within that framework at all times and only performing tasks according to their competence level (Skills for Health, 2009).

But how do you determine competence? *Agenda for Change* (Department of Health, 1999) and the supporting *Knowledge and Skills Framework* (Department of Health, 2004) have promoted the employment of varying grades of staff to meet the needs of the service. Within general practice, however, few are employed under the terms and conditions of *Agenda for Change*. This raises the question of what measures are in place to guard against unregistered practitioners being used to perform higher-level tasks?

Interestingly the *Integrated Career and Competency Framework for Diabetes Nursing* (TREND-UK, 2011) defines what is expected for five levels of competency, including that of the "unregistered practitioner", across various aspects of diabetes care. These would provide a useful starting point to clearly define the role and responsibility of HCAs involved in diabetes care.

As Tanis Hand also recently stated: "to fulfil their role safely and effectively it is essential HCAs have clear role boundaries, appropriate competence-based training, protocols and procedures and a good understanding of accountability and delegation" (Hand, 2012).

Other organisations have also provided guidance in this area. The RCN (2012), for instance, published a briefing document titled "The nursing team: Common goals, different roles", which describes the role and responsibilities of HCAs as follows. They should:

- Have their nursing tasks delegated to them and be supervised by registered professionals.
- Be guided by protocols and act within these protocols at all times.
- Perform tasks according to their competence levels (Career Framework levels 2 and 3 [Skills for Health, 2009])
- Demonstrate competence supported with the required level of knowledge before being delegated particular tasks.
- Inform the delegating professional if they do not have competence to perform a task.

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- Should not be required to make "stand-alone" clinical judgements and plan care of patients based on those judgements.

There is no definitive list of tasks that an HCA can do and there is no statutory training, although the RCN has previously suggested that HCAs should be trained up to National Vocational Qualification level 3 in order to work independently (Hopkins and Young, 2003).

The Medical Protection Society's advice is that whatever task is delegated to an HCA, the healthcare professional must ensure that the HCA is trained and has the necessary knowledge, skills and competence to undertake the task and that accountability is clear (Wilson and Stacey, 2012). Similarly, the General Medical Council (2006) states: "When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised."

Finally, the Nursing and Midwifery Council (2009) observes: "The delegation of nursing or midwifery care must be appropriate, safe and in the best interests of the person in the care of a nurse or midwife. The decision to delegate would be judged against what could be reasonably expected from someone with their knowledge, skills and abilities when placed in those particular circumstances."

Concluding remark

So, should HCAs be performing annual diabetes reviews? I shall leave you to decide that for yourself. I hope that my comment piece helps to inform the debate and provokes further discussion. ■

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