Torbay and South Devon NHS
NHS Foundation Trust

Supervision, Accountability and Delegation of Activities to Skilled Not Registered Staff

A Guideline for Registered Practitioners and Support Workers

Date: August 2015

This policy is based on an intercollegiate information paper developed by the CSP, RCSLT, BDA and the RCN, a result of collaboration between different organisations and individuals. Contributions gratefully received from: RCSLT, Royal College of Speech and Language Therapists – Jenny Pigram BDA, British Dietetic Association – Rosemary Simpson RCN, Royal College of Nursing – Susan Hopkins, Jenny Brown and Helen Caulfield CSP, The Chartered Society of Physiotherapy – Catherine Smith and Sue Hayward Giles Trent RDSU University of Sheffield – Susan Nancarrow, Senior research fellow

Document Information

Date of Issue:	5.1.10	Next Review Date:	August 2017
Version:	4	Last Review Date:	04/08/2015
Author:	Tina Mitchell, Linda Gibson and Bev Glanville-Geake		
Directorate:	Torbay and Southern Devon Health and Care Trust		
Approval Route			
Approved By:		Date Approved:	
Care and Clinical Policies Group			
Links or overlaps with other strategies/policies:			
Delegation of Level 3 Tasks to SNRs not employed by Torbay Care Trust			
TSDHCT medicines Policy for Skilled Not Registered (SNR) Staff			
TSDHCT Percutaneous Endoscopic Gastrostomy (PEG) Tube Feeding and Medication Administration for Adults in a Community Setting			
TSDHCT Medicine Administration Records (MAR) in Care Homes and Domicilliary Care			
TSDHCT Choice, Control and Risk Enablement Policy			
TSDHCT Clinical Guideline for the Assessment of Clinical Competence in Registered Nurses			

	Please select	
	Yes	*No*
Does this document have training implications? *If yes please state:*	*x*	
Does this document have financial implications? *If yes please state:*		*x*
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*		*x*

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Ratified	5.1.10	Ratified and formatting re-checked	Sue Ball and Julie McHenry
2		28.2.12	Additions from Medications Management	Sue Ball and Julie McHenry
3		10.4.12	Additions and comments from Michelmores LLP	Sue Ball and Julie McHenry
4		June 2014	2 yearly Review	Bev Glanville-Geake

5		August 2015	Amended to link with all other relevant policies listed	Tina Mitchell, Linda Gibson and Bev Glanville-Geake

Contents

1. Introduction

This paper was originally developed by a working group of Torbay Care Trust representatives from the pharmacists, allied health, social care and nursing professions*.See Preface

1.1 Many terms have been used to describe the practitioner who is responsible for delegating a task. This is a professional who is on a register for that particular profession, i.e. the Health and Care Professions Council (HCPC) or the Nursing and Midwifery Council (NMC). The code: Standards for Conduct, Performance and Ethics for Nurses and Midwives (2015), states *"You must establish that anyone you delegate to is able to carry out your instructions." "You must confirm that the outcome of any delegated task meets the required standards." "You must make sure that everyone you are responsible for is supervised and supported."*

1.2 The terminology used to describe groups of support workers and their management, varies within and across professions and so for the purposes of this policy, the following terms have been used:

Skilled Not Registered (SNR)
There is currently no national policy that determines a single name for this group of workers. Numerous titles exist to reflect the many and varied roles carried out. For the purposes of this policy the term 'SNR' describes the worker who has a role or task delegated to them.

Registered Professional
This is the professional who is on a register for that particular profession, e.g. Registered Nurse (RN)

Service user
Any individual requiring care provision from the Trust

2. Statement/Objective

2.1. The purpose of this policy is to encourage Trust staff engaged in the delivery of health and social care to work collaboratively on tasks proposed for delegation, in order to ensure that clients receive safe and effective care from the most appropriate person.

2.2. Health and Social Care in the UK is undergoing rapid change as organisations restructure the delivery of services in order to provide the most efficient and effective care to service users. A wide range of drivers has led to SNR roles growing both in terms of number and in the scope of activities being undertaken. This has prompted an increasing number of enquiries to professional bodies and trade unions about their management and support. This paper has therefore been developed to help clarify the delegation process for registered practitioners and SNRs and the associated issues of accountability and supervision.(Appendix 4)

2.3. Research and anecdotal evidence shows that SNRs throughout the UK can be working at a very wide range of levels of practice as a result of delegation[1] [2]. Torbay Care Trust guidelines for role and band competencies are available on the Trust's internet website *icare. http://icare/Pages/Default.aspx*

2.4. The issue of delegating tasks to SNR staff is increasing in significance, due to current consultation on the registration and regulation of this group. This document is aimed at:

• Individuals who manage SNR staff either through line management or by providing clinical support

• SNR staff

• Any registered professional or manager who delegates an activity or role

• Service managers

• Individuals who deliver services from a multi-disciplinary team that has a mix of registered and SNR staff

• All settings where registered professionals are called upon to delegate tasks to SNR staff – education, social service, NHS, independent sector etc.

3.0 Competence

There are two key questions to be answered when considering delegation of activities.

1. Does the registered professional consider the SNR worker competent to carry out the tasks?
2. Does the SNR worker feel competent to perform the activity?

Competence is an individual's ability to effectively apply knowledge, understanding, skills and values within a designated scope of practice. It is evidenced in practice by the effective performance and understanding the specific role and its related responsibilities. Competence also involves individuals in critical reflection about, and modification of, their practice. The following summary may help to clarify related terms and their meanings:

Term	Basic meaning
Competence	General, overall capacity; holistic; rests on consensus view of what forms good practice
Competency	Specific ability that makes up competence
Competencies	Abilities to undertake specific tasks that relate to specific ability.
Capability	Potential competence
Performance	Competence in action

Capability is a step further than competence and relates to the individual's full range of potential and may go beyond their current scope of practice

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3.1 Staff Competencies

There are various guidelines concerned with identifying the relevant competency levels required for job roles within the NHS. These are available in the TSDHCT public internet site www.**torbaycaretrust**.**nhs**.uk/contact_us/Pages/Default.aspx

3.2 Roles and Responsibilities

Although SNR's are not currently regulated by statute they remain accountable for their actions in several ways, including:

- **To the service user – civil law (duty of care):** The SNR is accountable for their actions and omissions when they can reasonably foresee that they would be likely to injure people, or cause further discomfort or harm, e.g. If an SNR failed to report that a patient had fallen out of bed.

- **To the public – Criminal Law e.g.** If an SNR were to physically assault a patient, then they would be held accountable and could be prosecuted under criminal law, as well as being in breach of their contract of employment.

4. Deciding on Delegation

The question of who should carry out which activity depends on a number of factors. and must be based on a risk assessment to include:

- The skills, competence, confidence, attitude and experience of the SNR worker
- The requirements of the service user /group.
- The nature of the task in the specific circumstance.
- Mental capacity of the service user (see mental capacity assessment Appendix 3)
- The particular setting e.g. hospital or home.
- If the service users 'condition stable and safe to be allocated to SNR's.
  If a Registered Professional has any concerns about delegation of a task, they should refer to Appendices 1 and 2 at the end of this document

4.1 Principles of Delegation

- The primary motivation for delegation is to serve the interests of the Service User

- The registered professional must undertake appropriate assessment, planning, implementation and evaluation of the role to be delegated.

- The person to whom the task is delegated must have the appropriate role, level of experience, competence and confidence to carry it out.

- The SNR worker must be aware of the extent of his/her expertise at all times and seek support from available sources, when appropriate.

- The organization must ensure it has well defined lines of accountability and SNR workers are clear about their own accountability.

- The SNR must feel able to refuse to accept a delegation if they consider it to be inappropriate, unsafe or they lack the necessary competency.

- The Registered practitioner must refuse to delegate a task if they have any concerns about the SNR's competence.

- The employer must ensure that the necessary training is provided including competency assessment with updates provided at intervals defined by policy or the individuals needs.

- Regular supervision time must be appropriate, agreed, and adhered to. Documented records must be kept in line with Trust policies

- The SNR worker shares responsibility for raising any issues in supervision and may initiate discussion or request additional information and/or support

- Documentation must be completed by the appropriate person and within employers' protocols and professional standards

5. Accountability

Like other public bodies, health service providers are accountable to both the criminal and civil courts to ensure that their activities conform to legal requirements. In addition, employees are accountable to their employer to work within the requirements of their contract of employment. Registered professionals are also accountable to regulatory and professional bodies. At present, SNR workers are not subject to professional registration[5 6].

When delegating work to others, registered professionals have a legal responsibility and accountability to have determined the knowledge and skill level required to perform the delegated task.

The registered practitioner is accountable for delegating the task and the SNR is accountable for accepting the delegated task, as well as being responsible for his/her actions in carrying it out.

6. Assessment of service users

The initial holistic patient assessment, due to its complexity (relies on professional reasoning) requires the assessor (registered professional), to determine a programme of treatment or care that reflects the service users need. It is expected therefore, that it will be a registered professional who makes the clinical diagnosis, analyses and interprets assessment results, and generates possible therapeutic options in discussion with the service user.

- All SNR workers who have been delegated a task must be competent to continually monitor changes in the service users care requirements. This must be reported back to the registered professional(s) with minimal delay for advice and re-direction if necessary.

- It is essential that the role and specific activities of the SNR worker are made explicit in the design of new protocols for specific user groups e.g. stable diabetics needing monitoring or administration of insulin

7. Experienced SNR workers

Senior SNR workers at a more advanced level e.g. Assistant Practitioner (AP) should be able to plan and implement a therapy/ treatment programme or care plan within the scope of their skills and training.

- If an Assistant Practitioner (AP) has had training to provide a skill, they can undertake this skill for other service users. This means that an Assistant Practitioner can be allocated a group of patients. e.g. an AP trained to undertake female catheterisation, can do this skill for more than one patient, but they must report to the Registered Practitioner if the patient's condition changes and the Registered practitioner must then review the service user.

- Junior SNR's, e.g. Healthcare Assistants (HCA's) must remain patient specific and be assessed undertaking the skill for each patient they care for.

- Only service users whose condition is stable should be allocated to an SNR

8. Newly Employed Staff Training

New healthcare assistants from another Trust or area, must attend all mandatory and clinical skills training, and must be assessed as competent using the Torbay and Southern Devon Health and Care Trust's (TSDHCT) competency assessment documents prior to undertaking any clinical skills, or being delegated to do a task.

- Assistant Practitioners or senior SNR's in other professions, who have been doing a skill regularly in their previous role, and have documented evidence of a certificate/competency assessment, can continue using this skill under the Registered Professional's discretion. E.g. if an Assistant Practitioner has been regularly undertaking venepuncture in their previous workplace, with no break in practice, they would not need to re-attend training and can take on a caseload of patients requiring venepuncture providing their competency has been assessed at least once in the new trust..
- There should be a planned orientation, induction and support programme for newly employed SNR workers. They will need to be introduced to both the generalities of care provision (for example the need to ensure that quality and equality is central to practice) and the specifics of the work they will be asked to do.

There are various avenues for on-going training and Continuing Practice Development (CPD) in the National Support Worker Framework at Appendix 5[9] Keeping SNR staff up to date, in terms of the activity that they undertake, is important for both them, the professional staff that delegates activity to them, and to the clients with whom they work.

8. Supervision

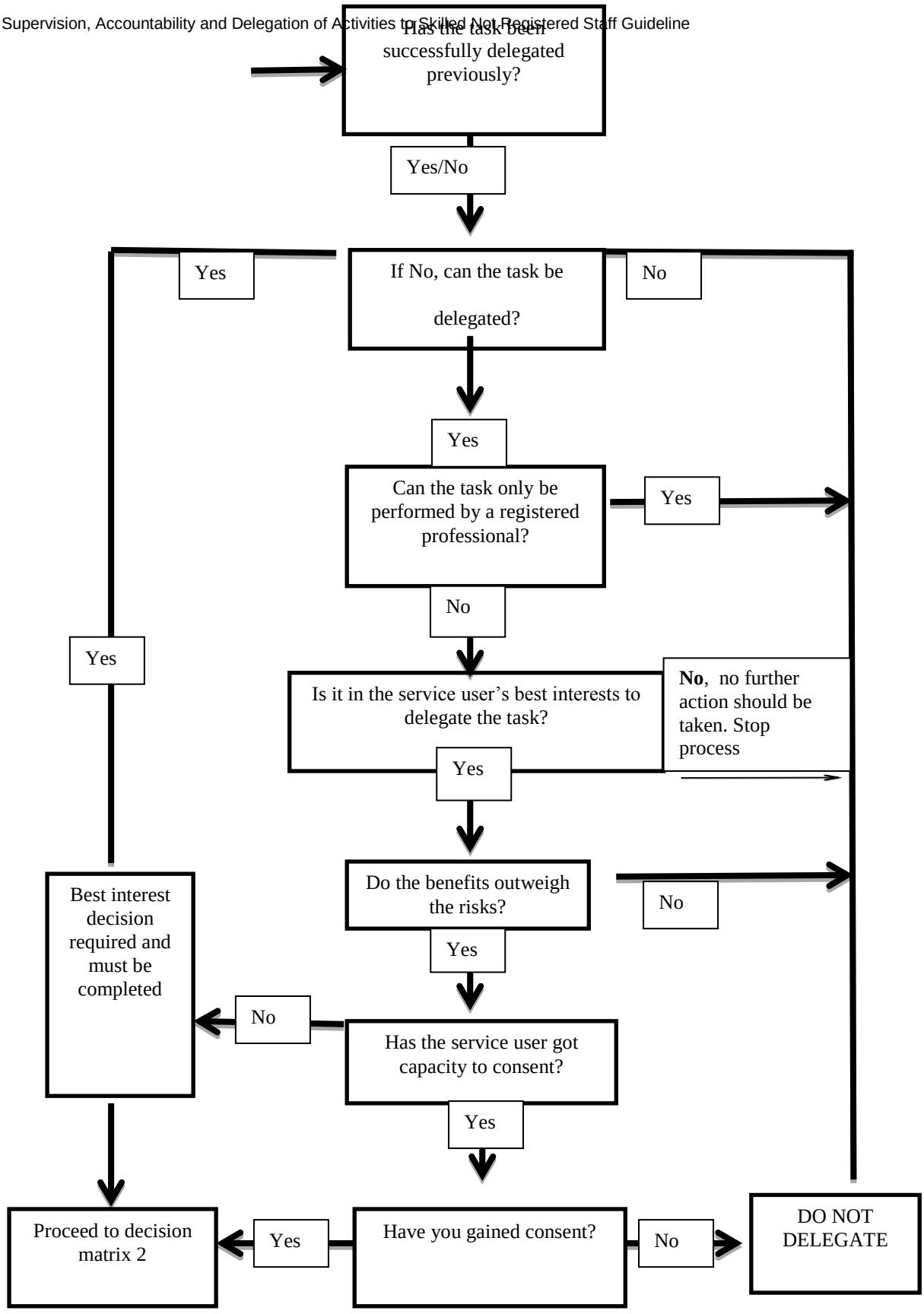
Where there is no Registered Professional as the delegator, then there must be a supervision system provided by a Registered Professional to the SNR.
Supervision can vary in terms of what it covers. It may incorporate elements of direction, guidance, observation, and joint working, and discussion, exchange of ideas and co-ordination of activities. It may be direct or indirect, according to the nature of the work being delegated. The decision concerning the amount and type of supervision required by a SNR worker is based on the registered professional's judgement and is determined by the recorded knowledge and competence of the SNR worker, the needs of the service user, the service setting, and the delegated tasks. The following should apply:

- There should be a system in place for SNR workers to access supervision and clinical advice as required
- Regular supervision time is agreed between the registered professional and the SNR worker and a record is made of each session in line with Torbay Care Trust clinical supervision and social care supervision policy
- The registered professional must have the necessary skills to support and assess the SNR worker (supervisee)
- The SNR worker shares responsibility for raising issues in supervision and may initiate discussion or request additional information/support.

- **Regular re- assessment of the SNR's competence relevant to the delegated task is at the Registered Professionals' discretion but must not exceed 6 months**
- If the SNR has previously been undertaking a skill but has had a prolonged leave of absence, sickness, pregnancy etc. They must re-attend training and be re-assessed as competent, or attend a return to work course, prior to being delegated any clinical tasks.

Appendix 1 :Decision Matrix One – Assessment of Task
(To be read in conjunction with descriptor table for assessment of task)

Start

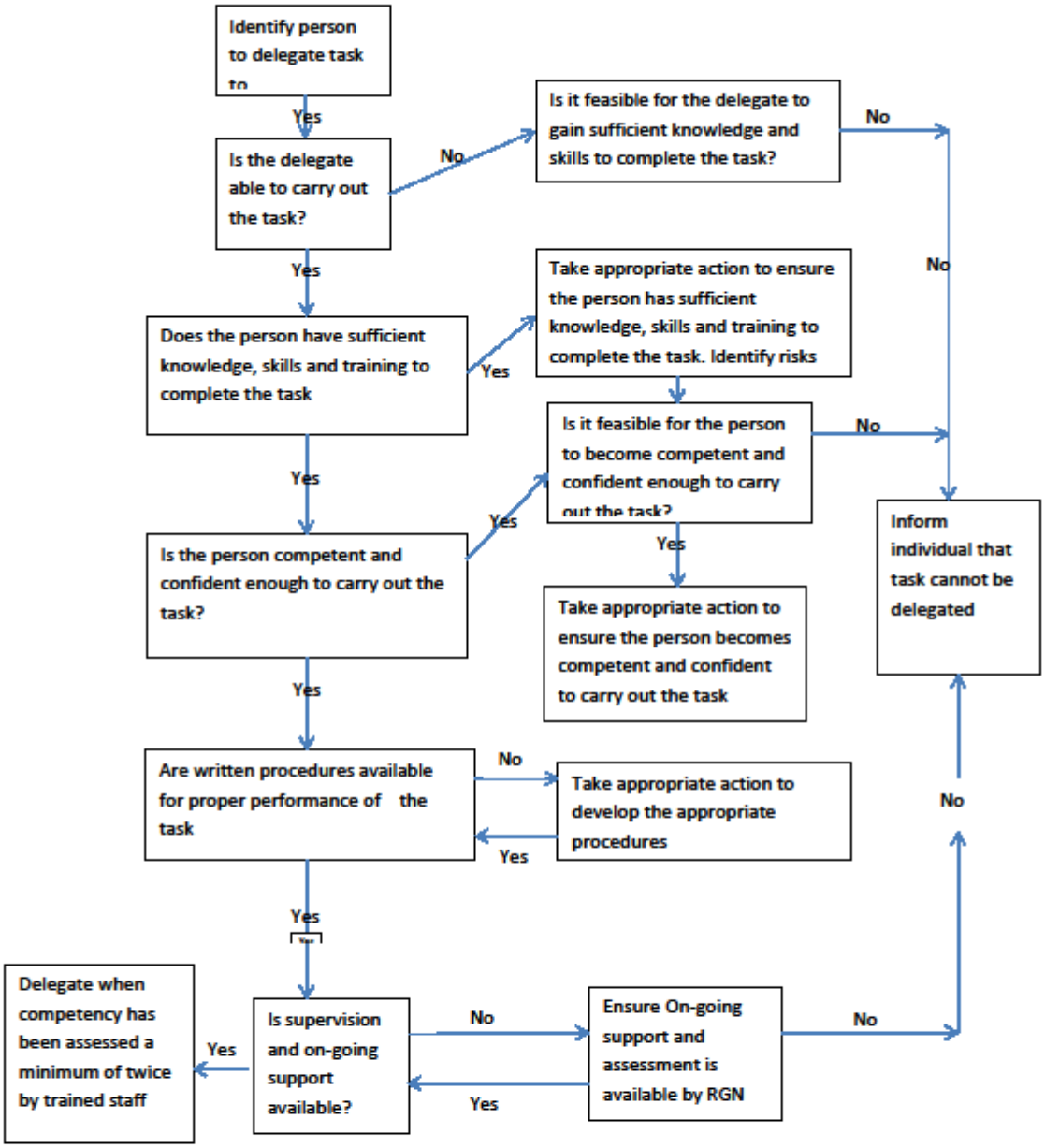

Has the task been successfully delegated previously?
Yes/No
If No, can the task be delegated?
Yes
No
Yes
Can the task only be performed by a registered professional?
Yes
No
Yes
Is it in the service user's best interests to delegate the task?
No, no further action should be taken. Stop process
Yes
Do the benefits outweigh the risks?
No
Yes
Best interest decision required and must be completed
No
Has the service user got capacity to consent?
Yes
Proceed to decision matrix 2
Yes
Have you gained consent?
No
DO NOT DELEGATE

DESCRIPTOR TABLE FOR ASSESSMENT OF TASK
This stage will assist delegators in deciding if the task can or cannot be delegated

Descriptor table for Assessment of Task

Question	Descriptor
Can the task be delegated?	When considering whether the task can be delegated take into account the level of the task, what skills the SNR would need to perform the task and if this is a task that needs to be delegated?
Can this task only be performed by a registered practitioner?	Before this task is delegated it needs to be considered whether this task must be performed by someone authorised in the profession.
Do the benefits outweigh the risks to the service user?	Having conducted a benefit and risk assessment, have the benefits of delegating the task outweigh the risks of delegating the task? What risks have been identified? Should the Risk Enablement Tool be used?
Do you need to gain service user consent?	In certain circumstances you may need to gain service user consent to carry out the task.
Have you gained service user consent?	Have you consulted with the service user and made them aware that the task that is being undertaken on them will be conducted by an identified SNR?

Appendix 2: Decision Matrix Two – Assessment of Individual
(To be read in conjunction with descriptor table for assessment of individual)



Decision Matrix Two – Assessment of Individual (possible delegate)

To be read in conjunction with descriptor table for assessment of task

DESCRIPTOR TABLE FOR ASSESSMENT OF INDIVIDUAL
This stage will enable you to identify the correct individual to delegate the task

Question	Descriptor
Identify individual	Having decided that the task is delegable it is important to identify whether there is someone available to conduct the task.
Is the individual available to conduct the task?	Having identified the individual, are they readily available to conduct the task?
Does the person have sufficient knowledge, skills and training to undertake the task?	When determining whether the individual has sufficient knowledge, skills and training to undertake the task please bear in mind the following; Has the individual been trained to carry out this task before? When was this training last given? Has the task changed since training was given? Has the SNR's training been updated since their last training session?
Is the person competent and confident to carry out the said task?	When considering whether the person is competent and confident to carry out the task please note the following; Has the person expressed concerns about the task? Do you believe the person to be competent to carry out the task? Is the person confident in themselves to carry out the task? What risks have been identified? Should the Risk Enablement Tool be used?
Are written procedures available for proper performance of the task?	Before the person is given the delegated task please check to see if there are written procedures or policy documents available to assist the person when carrying out the task.
Is supervision required?	The delegator will need to decide whether this task requires supervision.
Is supervision available?	When carrying out the delegated task will the person have access to support if required?

Appendix 3

Name:	Main ID:	Completed by:

FACE Mental Capacity Assessment

What prompted this assessment?(*i.e. summary of relevant history*)

Details:

What is the specific decision to be taken? (*if this is a review, detail previous decision about capacity*)

Details:

Key roles	Closest Person	Lasting Power of Attorney (LPA)- health and welfare	Enduring Power of Attorney (EPA)/ LPA-financial	Court of Protection Deputy (*CPD*)	Other
Name					
Tel. No.					
Role					

Determination of capacity (This is a specific, not general determination. Note any documentation referenced)

Is there an impairment of or disturbance in the functioning of the person's mind or brain?	Permanent impairment ☐	Fluctuation impairment ☐	Temporary impairment ☐	No ☐

Details:

Is the person able to understand the information related to the decision?	Yes ☐	No ☐

Details:

Are they able to retain information related to the decision?	Yes ☐	No ☐

Details:

Are they able to use or weigh the information whilst considering the decision?	Yes ☐	No ☐

Details:

Are they able to communicate their decision by any means?	Yes ☐	No ☐

Details:

A 'No' answer in any of the 4 domains above constitutes incapacity. If all 'Yes' go to Assessment Summary.

Were all reasonable steps taken to maximise the person's capacity to make the decision?	Yes ☐	No ☐

Details:

Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐

Details:

Who was consulted about the determination? (Give names and roles. If case conference held details attendees)

Details:

Face Mental Capacity Assessment Version 2

Name:	Main ID:	Completed by:

Advance decisions to refuse treatment (Note any documentation referenced)

Is there an advance decision relevant to the decision?	No ☐	Yes ☐	If yes select option and give details	Similar treatment ☐	Similar circumstances ☐

Details of similar treatment or circumstances:

Advance decision type	Written ☐	Verbal ☐	Date of advance decision	

What was the decision (*give details. If advance decision was verbal, detail to whom in what circumstances*)

In this decision still applicable	Yes ☐	No ☐	If 'No' select option below and give reasons(*check guidance*)

Withdrawn ☐	Unanticipated circumstances ☐	LPA/EPA granted regarding decision ☐	Inconsistent behaviour ☐	Detained under Mental Health Act 1983 ☐	Other ☐

Details:

Determination of best interest (Note any documentation referenced)

IMCA required	Yes ☐	No ☐	Name		Tel. No.	

What is most important to the person as regards to this decision? (*current and past views,e.g. written statement*)

Details:

Views of interested others (E.G. family, friends, carers,LPA, IMCA, CPD, etc. Give names and roles. If no-one justify)

Details:

Views of professionals involved

Details:

Describe any possible conflicts of interest with regard to this decision

Details:

Assessment summary (Remember any judgement about mental capacity is specific to this decision

Decision requires arbitration?	No ☐	Independent medication ☐	Court of a Protection ☐

Considering all the factors what final decision has been reached? (*If arbitration required detail*)

Details:

I confirm that this decision is the least restrictive option or intervention possible.Special considerations for life-sustaining treatment have been considered or are not applicable.This decision has not been biased by age,appearance ,condition,gender or race.Every effort has been made to communicate with the person concerned.

Decision -maker		Role	
Organisation		Telephone No.	
Signature		☐	Decision date

Face Mental Capacity Assessment Version 2 Page 2 of 2

Appendix 4
The National Policy Context Driving the Development of Support Workers

The changing support workforce

A new tier of the health and social care workforce has been growing over the past 2 decades. Increasingly multi-professional support workers, as opposed to the previous and traditional healthcare assistant or therapy assistant, support the work of registered professionals. In the UK there are over a million workers whose role can be broadly described as a support worker with approximately 30 different job titles. The support workforce across the whole health care sector in the UK is growing both in terms of numbers and in the development of its scope of activity. Increasingly, this group of staff is playing a crucial role in the delivery of services to patients and clients, and participates fully as part of the health and social care team.

A wide range of driver's looks set to sustain this growth and development.
The requirement for more flexibility in service delivery.

The need for flexibility has been driven from several quarters. The NHS Plan[11] (England) confirmed the drive to blur professional boundaries, a feature that was beginning to manifest itself in practice. The resulting flexibility of approach in relation to who does what, at what time and in what setting, has changed the skill mix of teams. Often it is the support worker who is the main deliverer of the patients' management programme. It is the support worker who provides the consistency for the patient/client. Financial imperatives will always govern the shape of any health care system resulting in the need to make the best use of scarce resources. The development of support workers is one of the key resulting initiatives.

An increasing emphasis on patient-centred care group service models.
This initiative again driven by the NHS Plan, has put patients/clients at the centre of decision-making and more recently has given the patient real choice in where they access health care[12 13.] Over recent years the introduction of community rehabilitation teams has led to an increase in therapy assistants who work more generically, supporting the work of different disciplines thereby facilitating a more client-centred model of care. The policy drivers relating to services for older people place high importance on inter-professional teams working across both health and social care sectors. Policy statements make significant reference to generic workers who support multi professional clinical teams. The audit commission stated that 'the deployment of generic assistants, who cover more than one discipline, helps by providing a much more flexible and efficient workforce that fits well with the multi-professional focus of rehabilitation and the complex needs of the patient and carers'. The NSF for Older People (England) has identified four principles to underpin planning and delivery:

- person centred care
- whole system working
- timely access to specialist care and
- promoting health and active life

The shift towards an NHS that is increasingly focused on the delivery of primary care

The development of Primary Care Trusts [England], Local Health Boards [Wales], Health and Social Care Groups [Northern Ireland] and Community Health Partnerships from Health Boards [Scotland], and the push for greater co-operation between health and social services has led to the increasing development of rehabilitation and care teams in primary care settings. Scarce resources have again meant that the local workforce of support workers has been increasingly utilised.
The prioritisation of rehabilitation and intermediate care

The shift towards community rather than institutional care alleviates the pressure on secondary care by freeing up more beds and reducing attendances in accident and emergency departments. This combined with the drive to establish multi-disciplinary teams has, in part, led to the growth of support workers.

Greater use of protocols and guidelines in the delivery of service

The establishment of protocols has allowed services to identify a patient pathway, and the expected interventions along that pathway for a particular speciality, e.g., hip and knee replacement surgery in orthopaedics. A protocol allows a normal expected treatment scenario to be delegated to a support worker who is trained to deliver care according to the protocol, and importantly, to recognise when the patient/client does not fit the expected and identified norm along that pathway or within that protocol.

The need for managers to provide a comprehensive 24/7 service

In teams where there is a relatively high ratio of support workers to registered staff, it makes sense that the support worker delivers a large proportion of care that can be delegated by other practitioners. In practice, this means that the support worker will spend more time with each patient/client than the registered staff. The benefits of this approach are that the patient/client can develop a more continuous relationship with a single support worker. This reduces the potential of a number of different registered staff seeing the same patient/client and aims for seamless care.

Changes in the scope of practice, and role redesign

The NHS Plan formally introduced the idea that registered staff could broaden or add to their scope of practice. Most registered staff groups have taken up the challenge and the development of the advanced practitioner grades has taken off in the last 3-4 years with the establishment of Consultant Nurses, Consultant AHP's, Clinical Specialists and Extended Scope Practitioners. As the registered staff take on more advanced tasks, support workers in particular, can be used to successfully 'back-fill' and deliver activity traditionally the remit of a registered practitioner. There is resistance to this, however, within some professions[16]
Recruitment and retention difficulties with regard to registered staff
Professions such as speech and language therapy or physiotherapy are recognised as national workforces. National workforces suffer from shortages whereas support workers are locally trained and recruited and therefore should be more plentiful in

supply. There is, however, often competition for this workforce from other sectors, such as the retail sector, who can offer competitive salaries and working conditions.

Accountability, delegation and competence

Registered professionals are regulated within statute and are accountable to their regulatory body- i.e. Nursing and Midwifery Council (NMC) for nurses, midwives and health visitors and, Health Professions Council (HPC) for physiotherapists, dietitians, speech and language therapists and so on.

Although support workers are not currently regulated by statute they are accountable for their actions in four ways:

- To the patient/client - civil law (duty of care) The support worker is accountable for their actions and omissions when they can reasonably foresee that they would be likely to injure people, or cause further discomfort or harm, e.g. If a support worker failed to report that a patient had fallen out of bed

- To the public – criminal law e.g. If a support worker were to physically assault a patient, then they would be held accountable and could be prosecuted under criminal law, as well as being in breach of their contract of employment

- To the employer - employment law Working outside of their job description would breach the employment contract

- To the Professional Code of Conduct – a code of conduct exists for some professions. Ethical, moral and legal issues form the code in conjunction with standards of practice.

Biblography

British Association of Prosthetists and Orthotists, British Dietetic Association, College of Occupational Therapists, The Chartered Society of Physiotherapy, Royal College of Speech and Language Therapists, Society and College of Radiographers, Society of Chiropodists and Podiatrists. Joint Statement on Foundation Degrees for Support Workers - a collaborative statement. London; BAPO, BDA, COT, CSP, RCSLT, SCOR and SCPOD: [2004] Accessed 31 January 2006 http://www.csp.org.uk/director/libraryandpublications/publications.cfm?item_id=1AD5087EE66055E7920E5556638D9824

Martin E, McFerran TA. Dictionary of nursing. 4th edition. Oxford: Oxford University Press; 2004.

Mackey H, Nancarrow S. Assistant practitioners: issues of accountability, delegation and competence. Int J Ther Rehabil 2005;12(8): 331-8.

Nursing and Midwifery Council. Code of Professional Conduct: Standards for conduct, performance and ethics – Protecting the public through professional standards. London: Nursing and Midwifery Council; 2004. http://www.nmc-uk.org/

Royal College of Speech and Language Therapists. Competencies Project Support Practitioner Framework. Royal College of Speech and Language Therapists; 2002

Royal College of Speech and Language Therapists. Standards for Working with Support Practitioners. Royal College of Speech and Language Therapists; 2003

Storey L. The crackerjack model of nursing and its relationship to accountability. Nurse Education in Practice; 2002 vol 2 pp 133-141

The Chartered Society of Physiotherapy. Physiotherapy assistants' code of conduct. London: The Chartered Society of Physiotherapy; 2002. http://www.csp.org.uk/uploads/documents/csp_assistants_code_conduct.pdf

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). Scope of professional practice. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting; 1992.

The Chartered Society of Physiotherapy, College of Occupational Therapists. A national framework for support worker education and development jointly developed by the Chartered Society of Physiotherapy (CSP), College of Occupational Therapists(COT). London: The Chartered Society of Physiotherapy, College of Occupational Therapists; 2005. http://www.csp.org.uk/uploads/documents/csp_assistants_framework_main3.pdf

National Occupational Standards websites:

- Skills for Health http://www.skillsforhealth.org.uk
- Skills for Care http://www.topssengland.net/
- Care Council for Wales http://www.ccwales.org.uk/
- Scottish Social Services Council http://www.sssc.uk.com/
- Northern Ireland Social Care Council http://www.niscc.info/

References

1 The Chartered Society of Physiotherapy Member, Networks and Relations. Physiotherapy assistants' role mapping project. London: CSP [1999]

2 Farndon L, Nancarrow S. Employment and career development opportunities for podiatrists and foot care assistants in the NHS. Br J Pod 2993;6(4):103-8.

3 Barter M, Furmidge ML. Unlicensed assistive personnel: issues relating to delegation and supervision. J Nurse Admin 1994;24(4):36-40.

4 The Chartered Society of Physiotherapy. Core standards of physiotherapy practice. Standard 14 Record keeping. 2nd edition. London: CSP [2005]. http://www.csp.org.uk/uploads/documents/csp_corestandards_2005.pdf

5 Department of Health. Regulation of health care staff in England and Wales: a consultation document. London: DOH; 2004. http://www.dh.gov.uk/assetRoot/04/08/51/72/04085172.pdf

6 Scottish Executive Health Department and Social Work Services Inspectorate. Regulation of health care support staff and social care support staff in Scotland. A consultation document. Edinburgh: Scottish Executive Health Department and Social Work Services Inspectorate; 2004. http://www.scotland.gov.uk/consultations/health/rohc-00.asp

7 Mackey H, Nancarrow S. Assistant practitioners: issues of accountability, delegation and competence. Int J Ther Rehabil. 2005;12(8): 331-8.

8 The Chartered Society of Physiotherapy. Physiotherapy Competence and Capability resource pack. London. CSP [2005].

http://www.csp.org.uk

9. The Chartered Society of Physiotherapy, College of Occupational Therapists. A national framework for support worker education and development jointly developed by the Chartered Society of Physiotherapy (CSP), College of Occupational Therapists (COT). London: CSP, COT. [2005].

http://www.csp.org.uk

10. Department of Health. The NHS knowledge and skills framework (NHS KSF) and the development review process. London: DOH; 2004.

http://www.dh.gov.uk/assetRoot/04/09/08/6104090861.pdf

11. Department of Health. The NHS Plan: a plan for investment, a plan for reform. London: DOH [2000]. http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

12 Department of Health. Choice, responsiveness and equity in the NHS and social care: a national consultation. London: DOH [2003]. http://www.dh.gov.uk/assetRoot/04/07/53/08/04075308.pdf

13 Department of Health. Building on the best: choice, responsiveness and equity in the NHS and social care: a national consultation. London: DOH [2003]. http://www.dh.gov.uk/assetRoot/04/06/84/00/04068400.pdf

14 Department of Health. National service framework for older people. London: DOH [2001]. http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf

15 Changing Workforce Programme. Developing support worker roles in rehabilitation and intermediate care services. London: NHS Modernisation Agency; 2003.

16 Mackey H, Nancarrow S. Report on the introduction and evaluation of a Technical Instructor II Occupational Therapy Assistant. Stoke-on-Trent: North Staffordshire Combined Healthcare Trust; 2004.

17 Buchan J. O'May F. International recruitment of Physiotherapists: a report for the Chartered Society of Physiotherapy London CSP [2000]