undertake clinical work in domains… previously… the remit of registered professionals… transcended many… boundaries that have hitherto been strictly demarcated between different professions”.

This definition clearly advocates that role encroachment and role transgression was expected and, to some extent, actively encouraged so that boundaries between registered practitioners and what could be considered traditional assistant roles were expected to be redefined.

For this reason, the AP role was located firmly within band 4 on the Agenda for Change framework (Department of Health, 2004a) and subsequently situated at level 4 on the Skills for Health (2007) careers framework. As Fig 1 shows, band 4 equates to a higher level support worker, yet this role is clearly situated beneath registered practitioners, reinforcing the notion that APs should be considered as having lower occupational status than nurses so should not be expected to take on nurses’ roles (DH, 2004a).

However, the policy vision clearly indicates that APs would be able to “do more” than “traditional” healthcare assistants by taking on some of nurses’ duties, freeing up the latter to achieve better patient outcomes (Wakefield et al, 2009; Sargent, 2006).

Consequently, the AP role was introduced to deliver protocol based care tailored to the needs of a particular ward or clinical area, and thus expected to be supervised by a registered practitioner (Skills for Health, 2007; Sargent, 2006).

The rationale for expanding the supportive workforce has to some extent been underpinned by Buchan and Dal Poz’s (2002) findings; they suggested that changes to the supportive healthcare workforce have often led to increased organisational effectiveness.

Yet, if AP roles are to be effective, these workers need clear and unambiguous job descriptions that reflect the supportive nature of their work (Wakefield et al, 2009; Sandall et al, 2007).

**AIM**

This article aims to highlight some of the occupational uncertainties APs are exposed to as part of their role.

By definition, job descriptions provide a framework within which practitioners are expected to work (DH, 2004a; 2004b). When job descriptions are unclear, it becomes more difficult to establish definitive occupational boundaries, while the reverse – that is, rigid job descriptions – stifles creativity and flexibility, which undermines the reason why APs were introduced.

Furthermore, when roles are not clearly delineated, this can lead to exploitation, disquiet and dissatisfaction, which can have a negative impact on patient care (Wakefield et al, 2009).

**METHOD**

This article draws on data taken from 16 AP job descriptions representing all clinical nursing divisions in one acute trust in the UK, supplemented by 11 job descriptions from two other acute trusts (see Table 1).

The job descriptions were examined to identify similarities and differences in their content and gain a better understanding of what APs were expected to do as part of their role. For this reason we focused our attention mainly on the clinical roles and responsibilities APs were asked/expected to undertake.

In addition, we examined the extent to which APs were used in a truly assistive capacity, as envisaged by policy, to establish whether they were expected to assist nurses, act as their substitute or take on a totally independent role.

The job descriptions were developed before Agenda for Change (DH, 2004a) and national job profiles (DH, 2004b) were implemented. The study therefore highlighted any potential inconsistencies in role expectations across diverse clinical specialties to reveal possible deviations from the policy vision (DH, 2004b).

**Ethics and analysis**

Job descriptions used in this analysis were coded to protect trusts’ anonymity, in line with the requirements of the National Research Ethics Service’s approval process. Two members of the research team first examined each job description from a