



Healthcare Support Workers

The Development of the Clinical
Healthcare Support Worker Role:
A Review of the Evidence

1. Introduction

There is currently a major focus on the Healthcare Support Worker (HCSW) agenda for a number of reasons including role development, regulation issues, skill mix considerations, cost pressures, new methods of service delivery, recruitment and retention issues.

Against this background of interest in the Clinical HCSW role a narrative literature review was undertaken with the aims of:

- placing the role in context
- identifying evidence around the role
- identifying best practice around the role
- identifying developments and intelligence around the role

2. The literature review

The literature was located by a combination of a personal electronic literature search backed up by a search carried out by the Health Management Library.

The personal literature search was conducted via the Knowledge Network using the following databases: Medline; All Evidence Based Medicine Reviews; British Nursing Index, ERIC, CINAHL (Computerised Index of Allied Health Literature). No time limit was placed on the search but the most informative and relevant papers appeared from the year 2000 onwards. The review was devoted to Clinical Healthcare Support Workers.

This is not a systematic review but analysis of the literature leads to confidence that it is a comprehensive overview of evidence around the HCSW agenda due to:

- the same themes emerging throughout the literature
- a cross check of the original personal search by the search from the Health Management Library

An overview of the literature reveals that:

- The majority of evidence and published papers are from the UK (Centre for Allied Health Evidence (CAHE) 2006)
- In terms of sector and professions:
 - The majority of the literature is from the acute hospital sector (Bosley and Dale 2008, CAHE 2006)
 - Within the hospital sector the literature is drawn from across a number of professions and emanates originally from the Healthcare Assistant (HCA) role but is now recognising and reflecting the respective different levels within the HCSW structure

As this is a narrative review the literature has not been subjected to the rigorous selection procedures associated with the methodology of a systematic review. Therefore the quality of the literature cannot be guaranteed to the same degree as that which appears in a systematic review. However the majority of the evidence presented here has been published in peer reviewed journals which provides a degree of assurance as to its validity.

3. Presentation of the literature

The literature is drawn from the year 2000 onwards with the earlier papers addressing the healthcare assistant (HCA) agenda.

The research into the HCA role is largely transferable to the grades of HCSWs that have evolved from this original role. The literature has been grouped into the main themes identified below and within each theme the evidence is presented in chronological order with the earliest first to reflect progression over time as the HCA role has evolved into that now commonly recognised under the generic HCSW heading.

The topics and themes identified from the literature are:

- Definitions of HCSWs
- Evolution of the HCSW Role
- Number of HCSWs
- Characteristics of HCSWs
- Education and training provided for HCSW development
- Supervision of HCSWs
- Mentorship of HCSWs in training
- Relationships with other healthcare workers
- Boundary disputes and professional identity
- Roles and scopes of practice
- Tasks conducted by HCSWs
- Job descriptions
- Regulation
- The impact of HCSWs
- Views of HCSWs on education and the role
- Views of managers on the role
- Views of registered practitioners on the role
- Service users' views on the role
- Development into registered roles
- Future developments
- The Assistant Practitioner Role

4. Definitions of HCSWs

There are a number of approaches to defining what a HCSW is.

A systematic review (CAHE 2006) into the role of rehabilitation support workers, which looked at support workers in all settings, concluded that there was little agreement in the literature to what constitutes the definition of a support worker.

This is partly explained by reference to Nancarrow et al. (2005) who stated that “... *the titles and roles of support workers vary according to the service and the setting in which the provider is employed*”. This is illustrated by a range of job titles including rehabilitation assistants, support workers, healthcare assistants, community rehabilitation team therapists, healthcare support workers, rehabilitation support workers, care practitioners, care assistants, therapy assistants (for physiotherapy, occupational therapy, podiatry), technical instructors.

The number of job titles associated with HCSW roles was illustrated by a scoping exercise in Wales (Health Professions Wales (HPW) 2004) which identified over 260 individual job titles associated with this type of role.

Notwithstanding the diversity in job titles a common factor relating to all HCSWs is their professional status in being unregistered. This has implications for the accountability of their actions and the requirement that they are supervised by registered healthcare professionals.

The emergence of a career framework in health (Skills for Health 2005) and Scottish Credit and Qualification's Framework (SCQF) (www.sqa.org.uk) provide a means of mapping and defining the hierarchical levels which sit under the umbrella term of HCSW.

Table 1 - Mapping of HCSW roles to Career Level Framework and SCQF Level Framework

Career Framework		Qualification's Framework	
Level	Description	SCQF Level	Description
2	<p>Support Worker</p> <p>Frequently have the job title of healthcare assistant/technician. They are probably studying for, or have attained, a national vocational qualification (NVQ) at level 2.</p>	6	<p>Healthcare Support Worker</p> <p>The HCSW has the awareness and ability to address the basic care needs of individual patients/clients under the direction and supervision of healthcare professionals. They support the multidisciplinary team in the delivery of high quality care. The HCSW will possess, or have the opportunity to attain within an agreed timeframe, education at SCQF level 6.</p>
3	<p>Senior Healthcare Assistants/ Technicians</p> <p>Have a higher level of responsibility than support workers. They are probably studying for, or have attained through an assessment of prior experiential learning, a level 3 NVQ.</p>	7	<p>Senior Healthcare Support Worker</p> <p>The Senior HCSW can evidence previous experience and/or consolidation of practice as a HCSW or can evidence an appropriate level of knowledge. They will have the understanding and ability to deliver delegated care under the direction and supervision of healthcare professionals and support the multidisciplinary team in the delivery of high quality care. The Senior HCSW will possess, or have the opportunity to attain within an agreed timeframe, education at SCQF level 7.</p>
4	<p>Assistant practitioners/ associate practitioners</p> <p>Probably studying for a foundation degree/BTEC higher or higher national diploma. Their responsibilities will include delivering protocol-based clinical care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner.</p>	8	<p>Assistant Practitioner</p> <p>The Assistant Practitioner can evidence previous experience and consolidation of practice as a Senior HCSW and/or has the appropriate skills and knowledge and demonstrates the depth of understanding and ability required to participate in the planning and carrying out of holistic, protocol based care under the direction and supervision of healthcare professionals. They will assist and support the multidisciplinary team in the delivery of high quality care. The Assistant Practitioner will possess or have the opportunity to attain within an agreed timeframe, education at SCQF level 8.</p>
Source	Skills for Health (2005)		NHS Education for Scotland (2010)

The reference to Agenda for Change (AfC) bands (DH 1999) is another way of categorising the respective HCSW levels. Typically a healthcare support worker will be a band 2, a senior HCSW (sometimes referred to as an Associate Practitioner) a band 3 and an Assistant Practitioner a band 4.

Most recently the Scottish Government (2010) has clearly defined a Healthcare Support Worker in relation to induction standards and codes. The comprehensive definition can be found at <http://www.hcswtoolkit.nes.scot.nhs.uk/resources/standards-and-codes>

Individual professional organisations also describe and define HCSWs in relation to the particular context which they operate in. Examples are provided in Appendix 1.

5. Evolution of the HCSW role

In terms of chronology, the role of a HCSW has evolved from that of a healthcare assistant (HCA).

The term HCA is still used interchangeably and synonymously with that of a HCSW and some support staff are still referred to as HCAs. In this respect it is helpful to recognise the characteristics of a HCA.

Bosley and Dale (2008) note that “a healthcare assistant is the title officially applied to staff working at National Vocational Qualification (NVQ) level 2 or 3 in healthcare, which equates to GCSE and A level respectively. HCAs may be recruited from among existing unqualified support staff, and in hospitals they commonly engage in nursing duties and direct patient care, such as bathing, monitoring, and observing patients, and talking to and reassuring patients and their relatives”.

To place the HCA role in historical context Thornley (2000) outlined the range of titles which the equivalent of healthcare assistants were referred to: generic support worker; clinical support worker; healthcare support worker; care team assistant; nursing assistant; ward assistant; theatre assistant; community care worker; home carer; scientific helper; doctors’ assistant; and even ‘bed maker’.

i) Origins of Support Workers

The history of support workers and healthcare assistants in nursing is outlined by Kessler et al. (2010). Nursing assistants can be traced back to the Crimean War and in modern times the main impetus was the recognition of the nursing auxiliary role in 1955. The support worker role progressively developed until the formal introduction of the HCA role alongside the NHS and Community Care Act 1990. The Act introduced the HCA role as a local grade for newly created Trusts to complement the existing nursing auxiliary role. Similarly the history of the introduction of support workers in midwifery and the AHP professions are outlined in the all Wales scoping report (HPW 2004).

The midwifery support worker has been slower to emerge in comparison to the nursing equivalent because of differences in midwifery education and the way midwives practice. In terms of education it was not possible to introduce the maternity care assistant role as a part replacement for a student contribution as happened in nursing in the early 1990s. At this point diploma level nurse education was introduced meaning student nurses became supernumerary and the role of support worker accordingly assumed a greater significance at this level of care. Also the midwife enjoys an autonomous role demonstrating their expertise in care delivery which also limits the potential contribution of students and support workers. However reported shortages in registered midwives and associated difficulties in delivering maternity services has seen a rise in the number of maternity care assistants in a number of NHS trusts in Wales (HPW 2004).

There have also been variations in the adoption of support workers across the AHP professions. Physiotherapy (formerly remedial gymnastics) and occupational therapy (OT) support workers can be traced back to 1948 when they were known as “aides” and took on more of a housekeeping role than be engaged in direct contact with patients. In physiotherapy there

was a shortage in qualified staff in the 1960s with an increase in the delivery of services for the elderly meaning that support workers were employed to fill this gap. Subsequently there has also been an increase in the “technical instructor” grade to coincide with the expansion of services and shortfalls in qualified staff. Ellis and Connell (2001) estimated that physiotherapy assistants constituted around 20% of the physiotherapy workforce.

In OT the “technician” grade has been well established with skilled tradesmen such as joiners and carpenters employed in workshops producing aids to help daily living activities.

Radiography has a history of employing support staff known as “dark room technicians”. This role has been subsequently developed into a wider “helper’s” role which also incorporates associated nursing, clerical and portering duties. Increasing demand for radiography services and predicted shortages of qualified radiographers has led to the emergence of the assistant practitioner role in the last ten years throughout the UK.

In other professions such as Speech and Language Therapy (SLT) and health visiting the introduction of support workers are more recent in comparison. However traditionally these professional groups have had close relationships with other support staff such as nursery nurses and education support staff. The scoping report also notes the development of more comprehensive pre-school screening programmes has prompted the introduction of support staff in audiology and orthoptics.

Podiatry (Farndon and Nancarrow 2003) and dietetics (Le Cornu and Halliday 2008) are identified as the latest adopters of support workers. The number of podiatry workers in Wales is described as small (HPW 2004) and dietetic support workers were first introduced in the late 1990s to counter increasing levels of malnutrition in hospitals (Le Cornu and Halliday 2008).

ii) The emergence of support workers in other areas

As well as HCSWs operating in nursing, midwifery and the allied health professions the literature confirms the breadth of other areas and clinical specialties which employ support workers. These include nursing homes (Baldwin et al. 2003, Fitzpatrick and Roberts 2004), intermediate care (spanning health and social care, Nancarrow 2005), older people (Field and Smith 2003), rehabilitation (Galloway and Smith 2005) and mental health (Torjesen 2009). In addition there is the emergence of a generic support worker identified in a systematic review of the support worker literature (CAHE 2006). This type of support worker is characterised as one who can work across different professional boundaries.

6. Rationale for the introduction of HCSWs

A review of the literature identifies a combination of international, national and local drivers behind the introduction of HCSWs.

i) International drivers

Bosley and Dale (2008) observe a number of common themes/factors across developed countries causing pressure on both primary and secondary healthcare systems. Briefly these include: an ageing population; more sophisticated medical treatments resulting from technological and pharmaceutical advances; increasing costs of delivering healthcare; increasing patient expectations; shortages of skilled, qualified healthcare staff.

One solution to these pressures is role development which changes traditional boundaries between staff groups by extending, delegating, substituting existing roles or introducing new ones. Thus nurses may take on tasks that were the exclusive territory of doctors and similarly support workers will be utilised for some tasks that were the responsibility of nurses.

Other factors identified in an international context include increases in chronic disease, growth of day surgery and the subsequent expansion of primary and community care and the continued reduction in the length of hospital stay. The combination of these challenges drives the need for the creation of a flexible healthcare workforce (CAHE 2006).

ii) National drivers

The particular circumstances of the British healthcare system are noted as being a factor in the development of HCSWs. An international systematic review conducted across all types of support workers revealed that more than half of the papers located originated from the UK signifying the interest in this type of healthcare worker (CAHE 2006). This predominance of British based papers is attributed to staffing pressures in the NHS and the particular developing needs of the population.

The British context is also addressed by Wakefield et al. (2009) who identify a range of workforce changes related to the emergence of assistant practitioners (table 2). Although the majority of these changes are identified as being peculiar to the British healthcare system it is recognised that some have their origins in European legislation, for example the European Working Time Directive (EWTD) which limits the working hours of medical staff.

Table 2 - Major Factors Driving Workforce Changes within the UK

1. Employment policies	European working time directive 2009
	Improving working lives document
	Age diversity legislation 2006
2. Restructuring the workforce	Gershon report
	Requirement for improvements in productive time
3. Regulatory frameworks	Professional regulation
	Support staff regulation
4. Workforce preparation	Modernising medical careers framework
	Knowledge and skills framework
	Life long learning
5. HR management, workforce pay and rewards	Agenda for Change
	Introduction of the electronic staff record system in the NHS
	Workforce changes (for example ageing workforce and retirement trends)
	Workforce shortages in diagnostic services
6. Commissioning of services	Commissioning a patient-led NHS
	Payment by results framework
	Practice-based commissioning frameworks
	Reduced financial growth for the NHS from 2008 onwards
	Growth of the independent sector as a provider of NHS services
	Current financial pressures within healthcare
7. Patient populations	Demographic changes
	Chronic disease management
	National service frameworks
	Clinical effectiveness and clinical governance

Source: Wakefield et al. (2009), p287

At a high level the practical reasons for the introduction of HCSWs are identified by NHS Education for Scotland (2010).

- 1 relief/substitute: releasing professionals from non-core activities and taking on work previously the remit of registered practitioners
- 2 co-producer: providing complementary and distinctive capabilities
- 3 apprentice: providing a stepping stone into qualified work.

iii) Local drivers

While the literature provides an overview of national and international drivers for the introduction of HCSWs a good example of local needs is provided by McGowan and Campbell (2010a). They report on the running of a pilot course to develop nursing assistant practitioners (APs) for a chemotherapy unit. Local drivers which were cited included: an increase in chemotherapy workload placing increased demands on chemotherapy nurses; significant amounts of workload in the chemotherapy unit resulting from supportive care; recruitment and retention difficulties with qualified chemotherapy nurses. These local drivers contributed to a regional review of chemotherapy services which identified new and improved ways of working. The new ways of working included introducing the supporting role of AP to address difficulties with recruiting and retaining registered nursing staff for chemotherapy administration and supportive care (e.g. care of central lines, venepuncture, cannulation, managing blood transfusions).

Likewise Ellis and Connell (2001) report a combination of national and local catalysts prompting the introduction of physiotherapy support workers. National drivers were a shortage in qualified staff and increasing service demands from the growing elderly population. Local drivers, perceived to have more effect, were identified as changes in rehabilitation services, recruitment of new supervisory staff, alterations in funding of posts and the existence of national or specific locally initiated assistants' training schemes.

7. Scottish Policy Context

The emphasis on the development of healthcare support workers in Scotland in recent times is documented throughout the literature.

Dunlop (2004) identifies government and NHS policies as being a particular stimulus driving HCSW career development. The Scottish Executive Health Department (SEHD) published Learning Together in 1999 which outlined a training and education strategy for all NHS staff in Scotland, both registered and unregistered. The clear message from the strategy was that all staff regardless of status should have the opportunity to develop themselves as part of the modernisation of the NHS in Scotland. Learning Together required all health boards to ensure that all staff had an annual personal development plan meeting with their manager, and that access to learning and development opportunities were improved.

At the same time the Department of Health (1999) issued UK-wide proposals for Agenda for Change. This was the new pay grading structure in the NHS which covered all staff except for doctors, dentists and senior managers. Agenda for Change, which was implemented in October 2004, equates pay to the knowledge and skills required to undertake a particular NHS post. The Agenda for Change agreement has three components which made up a package of new terms and conditions of service, these were

- Terms and conditions
- Job evaluation (to establish pay band for post)
- NHS Knowledge and Skills Framework (NHS KSF)

The consequence of the introduction of NHS KSF strand of Agenda for Change was the requirement for all NHS employees to have an annual joint development review with their manager. The output is an agreed personal development plan to develop the skills and knowledge for their particular job as well as for future career development.

The impetus toward HCSW development was continued by the Scottish Executive with the publication of Caring for Scotland (SEHD 2001), a strategy for nursing and midwifery (Cowie 2002). The strategy gave directors of nursing a number of responsibilities toward HCSWs including ensuring that all support workers in their organisations undertook training by 2005 to maintain standards of practice.

HCSWs came under further scrutiny with a consultation exercise around their regulation. The Consultation on the Regulation of Health Care Support Staff and Social Care Support Staff in Scotland (SEHD 2004) was undertaken from May to August 2004. The outcomes of the consultation are summarised by Birch and Martin (2009). Briefly the responses indicated backing for the regulation of support workers. Respondents on the whole felt that support workers should be responsible for their own practice and this would be dictated by their level of training and scope of practice. The regulation of HCSWs is further discussed in section 19.

More recent Scottish NHS policy directives Delivering Care, Enabling Health (SEHD 2006) and Better Health, Better Care (Scottish Government Health Directorates (SGHD) 2007) have affirmed the drive to develop the NHSScotland workforce. Factors such as role development and changing demographics, for example an ageing workforce, have led to an increased focus on non-registered staff playing a more prominent role in the delivery of healthcare.

The development of the workforce emerged as a key part of a stakeholder consultation exercise subsequently held to identify the drivers required to implement Better Health, Better Care. The actions resulting from the consultation were accordingly outlined in a Force for Improvement (Scottish Government 2009). Three particular core challenges were identified in relation to developing the workforce: ensuring a quality workforce; delivering best value across the workforce; working toward an integrated workforce. The role of health care support workers was recognised as having contributed to a more widely skilled workforce which has resulted in increased service capacity. Moving forward, multi-disciplinary education and training will be required for all staff to demonstrate core competencies related to the patient safety and quality improvement agendas. The KSF, NHS Careers Framework and Scottish Credit and Qualifications Framework (SCQF 2009) provide the context for the development and delivery of education and training for the existing and future HCSW workforce (NES 2010).

Aside from government policy a range of NHS workforce development initiatives has given HCSWs the opportunity to develop professionally. The NHS Knowledge and Skills Framework (NHS KSF), the long-term strand of Agenda for Change which facilitates the individual personal development process, was agreed in 2004 (SEHD 2004). The NHS KSF, through mechanisms such as a joint development review (JDR) and personal development plan (PDP), allows HCSWs to identify areas for personal development which will aid their career progression. Similarly the career level framework (Skills for Health 2005), as previously discussed, has put in place a structure which identifies three distinct levels for HCSWs to operate at. As such it provides a framework for HCSWs to progress their careers.



8. Number of HCSWs

The number of HCSWs are considerable. Different definitions of what a HCSW is and does result in a variety of estimates as to their numbers.

Bosley and Dale (2008) report on a 2005 study which estimated the number of HCAs employed across different NHS settings in England at 39,522 along with a further 128,325 nursing auxiliaries or assistants.

More recently Kessler et al. (2010) discuss various approaches to defining the support worker role which results in different estimates as to their number. For example in defining support workers as those who support clinical staff, classified as those who provide support to doctors and nurses, scientific, therapeutic and technical staff, ambulance staff in England in 2008 there were 284,000 full time equivalent (FTE) a significant rise from the equivalent figure of 220,000 (FTE) in 1998.

These examples illustrate, as with the attempt to capture a universal definition of HCSWs, that there is no definitive answer but it is apparent they constitute a significant proportion of the NHS workforce and are growing in number.

In terms of coverage of nursing assistant practitioners in England, Spilsbury et al. (2009) estimated their distribution from a 2007 survey of Nurse Directors. Of those trusts which responded (143/168), forty-six per cent (n=66) of Trusts had introduced assistant practitioners and 22% (n=31) were planning to implement them before 2009. The authors identified a wide variation in the numbers of APs between Strategic Health Authorities, Trusts and clinical areas. The remaining responding trusts (n=46) were resistant to introducing the role. Reasons given for this reluctance included no perceived need for the role, lack of evidence of effectiveness, financial constraints and professional and patient safety concerns.

In Scotland it is possible to identify the numbers of staff in A4C bands 2, 3 and 4 as constituting the HCSW workforce. At September 2009, for those working in primary and secondary care, this amounts to 24,341 staff.

Table 3 - Information Services Division (ISD) Workforce Statistics (headcount, September 2009)

	A4C Bands			
	2	3	4	Total
Nursing	12878	5254	470	18602
Midwifery	302	42	69	413
AHPs	267	1233	504	2004
<i>Other Therapeutic</i>				
Clinical Psychology and Counselling	9	42		51
Optometry			3	3
Pharmacy	314	40	360	714
Play specialists		3	58	61
Personal and Social Care				
Health promotion			11	11
Healthcare Science	692	887	178	1757
Total	14462	7501	1653	23616
Primary Care ¹				725 ²
				24341

Note: Excludes social services, tertiary sector

¹ Figure for primary care is drawn from NHS Scotland, National Primary Care, Workforce Planning Survey (December 2009) and relates to an estimated figure for HCAs and phlebotomists

² In comparison Bosley and Dale (2008) report an estimate of 6,700 HCAs in 8,451 general practices in England.

9. Characteristics of HCSWs

Demographic, personal and work based characteristics

The literature provides a consistent profile of HCSWs across a number of occupations.

Thornley (2000) carried out a survey of HCAs and nursing auxiliaries and states the "outstanding characteristics of these workers is their maturity and experience". Similarly Kessler et al. (2010) summarised the HCSW workforce in their study as tending to be "mature women with partners and children". These characteristics and qualities are reflected across a number of studies.

i) Age

Thornley (2000) discovered that the great majority of HCAs are aged over 30, with nearly half aged over 40. Similarly, the great majority of Nursing Auxiliaries (NAs) are aged over 30, with 60 per cent of this workforce aged over 40 and fully a third aged 50 or over. Similarly Ellis and Connell (2001) established in a study of physiotherapy assistants that most were over 35 (13/16). More recently Benson and Smith (2006) in an evaluation of trainee APs (n=50) in Greater Manchester found an average age of 40 years ranging from 23 to 56 years. The majority (60%) of radiography trainee APs in a Scottish study (Colthart et al. 2010b) were aged over 40. Leach and Wilton (2009) in an evaluation of trainee APs in five clinical areas note that all but one had undertaken their study and training as mature students. The average age of support workers in Kessler et al's 2010 study was 42.6.

Outside the secondary sector a Scottish survey of HCAs and Phlebotomists in primary care found that 49% (309/630) were aged 45 and over. (NHS Scotland, National Primary Care, Workforce Planning Survey 2009).

ii) Sex

The HCSW workforce are predominately female in line with the NHS workforce as a whole. Eighty two percent of trainee APs in the Greater Manchester evaluation were female (Benson and Smith 2006). Equally the majority (26/31) of radiography trainee APs in a Scottish educational programme were female (Colthart et al. 2010b). In a study of physiotherapy assistants all 18 were women (Ellis and Connell 2001). Kessler et al. (2010) found that across four English acute trusts females accounted for between 84% to 95% of all nursing support workers.

iii) Ethnicity

There is limited data on the ethnicity of the HCSW workforce. Ninety percent of trainee APs in NHS North West gave their ethnicity as White British (Benson and Smith 2006). More recently Kessler et al. (2010) have provided valuable data. In a survey of four acute trusts they found a significant variation in the proportion declaring themselves as Black and Minority Ethnic (BME) depending on the respective geographic location of the trust: South 24%; Midlands 17%; North 10%; London 43%.

iv) Dependants

The age and sex profile of the HCSW workforce is reflected in those that they care for. Benson and Smith (2006) reported that over half (54%) of the trainee AP respondents to their evaluation of their educational programmes had dependants ranging from pre-school children and school children to elderly or sick relatives. Responsibility for dependants is also referred to in the context of providing transferable caring skills (see experience below). Kessler et al. (2010) report that typically around 75% of HCSWs in their study have a partner and children.

v) Experience

Studies identify both formal job experience and informal caring experience as being key characteristics of the HCSW workforce.

In terms of formal job experience Thornley (2000) identified that around half of HCAs have over five years experience and nearly a third had between 10 and 28 years experience. Similarly the average length of employment as a NA was 12 years with over a quarter having worked between 19 and 31 or more years in the job. Ellis and Connell's (2001) study of physiotherapy assistants revealed they had 5.6 years average service in this role. Trainee radiography assistant practitioners had on average 12.9 years service in the NHS (range 3 to 30 years) (Colthart et al. 2010b). In a study of four acute trusts Kessler et al. (2010) found that the average length of service of support workers was 9 years. At the lower end around a quarter had less than 2 years experience in the role and at the other end around a third had more than 10 years experience.

In relation to less formal caring experience Thornley (2000) points to the fact that as a mature workforce "many recognize their 'informal' caring experience at home (e.g. care of children, the elderly and/or disabled) as an important part of their ability to cope with the role of HCA".

vi) Career history

Kessler et al. (2010) looked at nursing HCSWs' broader career histories encompassing both areas of previous employment and most recent area of employment prior to becoming a support worker. In relation to all previous employment experience not surprisingly common areas were social care and healthcare with between a third and a half having worked there. Other areas of significant previous employment were retail (just less than 50% in most trusts) and manufacturing and leisure at around 25% each respectively. Interestingly a significant proportion of around a third had been full-time unpaid domestic carers at some point.

Similarly in terms of most recent employment prior to embarking on a support worker role the most common areas were social care and healthcare in that order with between 43% and 62% of support workers across the trusts coming from these two areas. This leads Kessler et al. (2010) to conclude that few other occupations offer a "springboard" directly into the support worker role. They also found that a small proportion (maximum of 5% in any trust) became a support worker directly from a full-time domestic caring role.

vii) Working patterns

There was some variation in the proportions of HCSWs working part-time. Ellis and Connell (2001) found that all but one of the physiotherapy assistants (17/18) in their study worked part-time. Kessler et al. (2010) revealed that around a quarter of support workers across four trusts worked part-time (defined as less than 29 hours per week). Studies of trainee assistant practitioners reflect the fact that most work full-time, for example 94% (Benson and Smith 2006) and 75% (Colthart et al. 2010b) respectively.

viii) Comparison with nurses

Kessler et al. (2010), as part of their study, compared a number of characteristics of the healthcare support workforce with that of nurses. A number of interesting findings emerged from this comparison.

- Age: nurses (38.4) were on average younger than HCSWs (42.6)
- Years of service: both groups had on average 9 years service
- Support workers are much less likely to have BME backgrounds than nurses
- A majority of support workers, typically around three quarters, have a partner and children. Nurses are as likely to have a partner but less likely to have children.
- Support workers were significantly more likely to work part-time than nurses, a finding which might be related to their greater childcare responsibilities
- A noteworthy minority of support workers, around one third, is the sole or main income earner. Nurses are more likely to assume primary earner status than support workers.
- Support workers were more likely than nurses to have a connection to the local community. For example a considerable and much higher proportion of support workers than nurses had attended a local primary school. This suggests that support workers are more firmly embedded in the local community than their nursing colleagues.



10. Education to prepare for and develop the HCSW role

The literature identifies both formal and informal mechanisms for educating the HCSW workforce. Formal education takes the form of external accredited qualifications. Informal education is characterised as in-house training such as shadowing, on-the-job learning and short courses.

i) Types of education provided - formal and informal

a) Formal education

Formal education will follow a set structure and cover identified skills and competencies which will be assessed on completion of the programme. Successful completion of the programme will result in attainment of a recognised, accredited qualification. A number of different types of formal qualifications have been undertaken across the HCSW workforce.

Typically the primary type of qualification introduced has been a National Vocational Qualification (NVQ). Keeney, Hasson and McKenna (2005a) describe NVQs as “statements of competence in employment, and their purpose is to provide access to work-based training and facilitate the attainment of national occupational standards”. NVQs provided both a formal recognition of HCAs’ experiential learning and also the means for their potential progress into registered nurse training. In Scotland the equivalent to NVQs are Scottish Vocational Qualifications (see www.sqa.org.uk for the range of SVQs available).

Similarly foundation degrees (Selfe at al. 2008), which were launched in 2001 around the same time as the introduction of the assistant practitioner, have become a recognised qualification, particularly for that grade of HCSW.

The introduction of foundation degrees in Greater Manchester for NHS North West is charted in a case study (Kilgannon 2007). Foundation degrees were seen as a good solution to the need to provide education for APs as their delivery would allow support workers to be retained in the workforce during their training. It was also recognised that previous methods of training had had either a competency or knowledge-based approach. The foundation degree offered an opportunity to develop these together in an integrated way within the work context.

In Scotland a suite of Higher National Certificates (HNCs) have been developed for the AHP HCSW workforce. HNCs are currently offered in Radiography, Speech and Language Therapy, Physiotherapy and Occupational Therapy (see www.sqa.org.uk). The qualifications are designed to support all levels from support worker to preparing individuals to become assistant practitioners.

The different levels of formal education required for the respective grades of HCSWs in terms of the Scottish Credit and Qualifications Framework (SCQF) are outlined in table 1 (see p3). Briefly a HCSW requires to be educated to SCQF level 6, a senior HCSW to level 7 and an Assistant Practitioner to level 8 (see also NES 2010, p14-15).

In relation to developing support workers and assistants into assistant practitioner roles the provision of education in radiography demonstrates the range of different qualifications utilised. Education provision to develop Assistant Practitioners began as early as 2001 with a two year pilot course at the University of Leeds (Whyke 2003). Radiography support workers undertook an access course for a year and then joined undergraduate radiography students in their first year of studies. Ten support workers started and successfully completed the course. On completion of their studies they were awarded a Certificate of Education in Radiography Studies (Cert. HE). Subsequently seven trainees took up posts as Assistant Practitioners and three resigned to become student radiographers by joining the second year of the radiography undergraduate course. Similarly a distance learning course for Assistant Practitioners has been run by Anglia Ruskin University since 2002 (Winnard, Kittle 2008). A NES scoping exercise (NES 2004) identified courses at five other HEIs including Robert Gordon University as well as NVQ Level 3 Diagnostic and Therapeutic support delivered by further education institutions.

The accounts of the development of individual educational solutions for the introduction of Assistant Practitioners are described by a number of authors. These involved work-placed learning in combination with a NVQ (Betts et al. 2003), a Higher Certificate in Education (Forsyth et al. 2003) and a Diploma in Higher Education (Hodgson et al. 2005). Alternatively a foundation degree programme may be undertaken (Shaw 2005).

b) Informal education

Keeney, Hasson and McKenna (2005b) discuss informal training alongside the formal component. They characterise the content, delivery and duration of informal training programmes as being based on the requirements of individual healthcare settings. Trainees receive no formal academic credit for completing such courses and many healthcare settings provide training at their own cost.

The provision of informal training is not quantified in the literature but a survey of 387 Allied Health Profession HCSWs and Assistant Practitioners in Scotland, carried out as part of the market research for the validation of the HNC in Speech and Language Therapy (2008), demonstrated that the predominant mode of education was in-service (80%, 310/387) followed by SVQ (18%, 70/387) and HNC (9%, 35/387). Other education was cited by 30% (115/387).

ii) Education and training needs

A review of core training requirements for support workers is presented in detail in a systematic review (CAHE 2006). This review specifically addressed the question of what training was required by support workers in community rehabilitation but the generic evidence is drawn from across the entire HCSW literature. The 15 core training requirements identified are drawn from 18 studies (Table 14, page 67) and reproduced in table 4 below. In discussing the documented core requirements the authors note that a number of them relate to aspects such as occupational health and safety, care skills, communication skills, professional issues, etc. These reflect the desire to provide safe, effective, efficient, patient centred and equitable healthcare.

The systematic review (CAHE 2006) concluded that while a variety of training programmes exist for support workers, the core training requirements include aspects of occupational health and safety, care skills, communications skills and professional issues. The wide variety of training models reflected the variability of the roles these support workers undertook in diverse and changeable working environments.

Table 4 – Core Training Requirements for Support Workers

Organisational structure	Communication	First aid	Anatomy/physiology	Infection control
OHS/manual handling	Professional issues	Care principles	Recording/reporting	Admin/Clerical
House keeping/maintenance	Care skills	Study skills	Team work	Community/culture

Source: CAHE (2006), Table 14, page 67

In a British context there is a paper which addressed the training needs of HCSWs. Moseley et al. (2007) ran a scoping study which aimed to estimate how many support workers need further training and which competencies the training should target. Their Welsh study surveyed all the support workers and their managers at work on a given day in four NHS Trusts, two independent sector healthcare organizations and in social care. The study was designed as a self-report questionnaire survey using as its basis 32 descriptors from the NHS Knowledge and Skills Framework levels 1 and 2. An overall response rate of 77% was achieved covering 117 respondents (82 support workers and 35 managers).

Thirty-five per cent of respondents thought that HCSWs were 'unable' to perform six or more of the 32 descriptors used, whilst on the criterion of being 'less than able', the figure was 64%. Support workers and their managers agreed closely on where the difficulties lay in achieving KSF competencies. Those difficulties lay in two particular areas - biomedical/ physiological knowledge and data-handling.

The main relevance of the study to clinical practice is that there should be a greater concentration on the more scientific areas of expertise and a similar emphasis is needed for those who train mentors or supervisors. These implications will become more important over time as scientific knowledge about medicine and healthcare increases.

iii) Format of training carried out

The training programmes identified (n=28) were analysed in terms of their format and method of delivery (CAHE 2006). Programmes were delivered by a combination of theoretical teaching and practical experience. The particular methods, duration and setting for each respective programme are summarised (table 15, Training Models for Support Workers, p69).

iv) Evaluation of the training and education provided

A recurring theme in the literature relates to historic deficits in education and training provided for HCSWs.

Keeney et al. (2005b) in reviewing the relevant literature identified three problems with vocational training programmes for HCAs. Firstly no consistency in their duration, secondly questions over who is responsible for and pays for the training and finally a lack of consensus on the content of the training. Taking all these into account they agreed with White (2002) who stated that there was no consensus on the best way of providing minimum standards of training to HCAs.

This echoes the findings of Ramprogus and O'Brien (2002) (cited in Keeney, Hasson, McKenna, 2005a) who surveyed 200 HCAs in NHS trusts and found that there were some short courses on anatomy and physiology, communication skills and personal care but in general there was a lack of organized and systematic education and training.

In terms of allied health professions a lack of access to appropriate training for support workers has been identified in occupational therapy (Nancarrow and Mackey 2005) and similarly a lack of provision of training for dietetic support workers (Le Cornu and Halliday 2008). Similarly Leach and Wilton (2008), reporting on an evaluation of assistant practitioner training across a variety of professions, noted difficulties relating to workplace learning in terms of logistical problems in providing radiography placements.

Where vocational qualifications have been put in place there has been some criticism of their operation. Agnew (2001) (cited in Keeney, Hasson and McKenna (2005a)) criticised the NVQ system for a lack of time for support and assessment in the workplace and because of an open-ended structure which allowed the lack of fixed deadlines to lead to non-completion. Nancarrow and Mackey (2005), in an evaluation of training for OT APs, reported concerns about the consistency of the quality of NVQ training and assessment.

Understanding of vocational qualifications may also be an issue. Nancarrow and Mackey (2005) observed that the qualified supervising OTs had little understanding of the content of NVQs and did not confer the same value to vocational qualifications as university qualifications. In effect the OTs perceived university qualifications to equate to a level of clinical skills and competence which was not implied by the vocational qualifications achieved by the assistant practitioners.

The difficulties noted above by a variety of authors are neatly summed up in the conclusion of a scoping exercise in Wales (HPW 2004, p253) which examined training and development opportunities. The findings, covering 14,445 HCSWs, concluded that:

“the existing provision of training and development opportunities for support staff in the NHS in Wales, varies considerably in quality, quantity and level of provision, with diversity across the different healthcare professions within individual Trusts and Local Health Boards. There is a lack of accredited training directly linked to role competencies and measurable against national standards, for example the Knowledge and Skills Framework or National Occupational Standards. Transferable credit is, therefore, very limited”.

v) Case studies – local training courses

There are a number of individual accounts in the literature which describe training courses developed to provide a local solution to an identified training need for HCSWs. These case studies are valuable in learning from the experience of those who have devised and implemented training and education programmes to prepare HCSWs for practice.

McCready and Macdonald (2002) describe the setting up of a course which was designed to meet perceived knowledge and skills gaps for HCAs working with cancer patients. The course was accredited by a local university and attracted 12 credits at level one. The course was delivered over ten weeks and consisted of 90 hours taught time and private study with an additional 50 hours for assignments. There were no formal entry requirements other than basic literacy skills and a desire to undertake the course. In terms of content the course consisted of ten stand alone units ranging from biology

and life history of cancer to general causes, cancer prevention and screening. The course was underpinned by the need to improve communication skills and related the content to psychosocial factors and holistic caring. In terms of outcomes a small scale evaluation reported positive feedback from the HCAs on improvements in the care they were delivering and their knowledge of cancer care.

Field and Smith (2003) report on a short course aimed at educating and supporting HCAs involved in the care of older people. The authors identified a need to provide a basic care course for HCAs after characterising existing training as “fragmented”. The course focused on elements of essential care and interestingly the content was in part influenced by user involvement. Focus groups of recent patients were conducted and they prioritised *privacy, dignity and communication* as being their most valued components in the delivery of basic care. The course consisted of 30 hours of taught theory and private study. The course leaders were in the process of seeking accreditation for the course at the time of publication of the paper.

The course was routinely evaluated by questionnaires but the authors recognised the need to go further than this and were planning to evaluate the impact of the course on clinical practice. This was to be done by a combination of methods, primarily observation by the course leaders of the HCAs in their clinical areas against the key aims and learning outcomes of the course. This would be supplemented by feedback from the HCAs’ themselves by questionnaires and focus groups as well as the observations of nursing and interprofessional colleagues.

Arblaster et al. (2004) illustrate the benefits of a three staged education programme in developing HCSWs and outline several factors which have contributed to its success. The first phase is the “Essence of Care” programme which is a mandatory induction course for all new HCSWs. The programme is of seven day’s duration and covers areas such as principles of self-care and food and nutrition. The first phase is assessed by means of a competency based workbook which must be successfully completed within six months of finishing this first phase.

Having successfully completed the first phase all HCSWs are required to undertake the second stage which is a NVQ in Care level 2. The third and final phase is the NVQ in Care Level 3 which is open to those who have passed the level 2 qualification and meet a variety of criteria including that they are in or intend to apply for a senior HCSW role. Attainment of the level 3 qualification allows the support worker to apply for senior HCSW roles, nurse training or NVQ assessor training.

A number of factors are identified which have ensured the programme has achieved its aim of developing support workers into senior HCSWs. These factors relate to both support for the individual and support for the educational programme system.

In terms of supporting the individual, study skills training is provided at two points on the programme. This is firstly after the initial "Essence of Care" course and prior to undertaking the NVQ. In preparation for NVQ study it covers areas such as learning styles and reflective practice. Having completed the level 3 qualification additional study skills training was introduced for those going on to university based nurse training following feedback from participants that there was a large academic gap between NVQs and university study. The second study skills course lasts for two days and covers topics such as critical appraisal, presentation skills, referencing and writing and formatting essays.

The educational system has been supported by a dedicated team of four registered nurses and senior HCSWs as peripatetic NVQ assessors. Initially the amount of NVQ participants was limited by the number of work based assessors available. Traditionally this function had been carried out by registered nurses but pressure of work had constrained their ability to carry out this role. A solution of training senior HCSWs as assessors who had completed the programme themselves was identified as a means of getting round this obstacle. The success of this solution can be gauged by the fact that prior to the introduction of HCSWs as assessors 12 support workers a year were completing the course and this number rose to 45 per year after the change. A personal account of a HCSW becoming a NVQ assessor for this programme is given by Muddiman (2010).

McGloin and Knowles (2005) report on an evaluation of a progressive, tiered course to train critical care (CCA) assistants. The 18 month course consisted of: a two week orientation programme, a ten week foundation programme which covered the trust's own support worker competencies; a one year NVQ level 3 care course and the trust's advanced support worker competencies; finally a twelve week course adapted from the operating department's NVQ level 3 units and the trust's CCA competencies completed by a final assessment case study and MCQ.

The CCA role was initiated in a what was described as a "hurried" manner following the successful attainment of funding to support the training. The training was implemented immediately on receipt of funding and this had implications for the introduction of the CCA role in the department. The evaluation reports that the implementation of the CCA role was met with "trepidation" among the intensive care nurses that would be working alongside these assistants. There was a feeling that the role had been introduced too quickly without sufficient consultation with relevant nursing staff. The authors surmise that if the nurses had been more involved in determining the role this would have led to less worry and concern. The evaluation also revealed concerns from registered nursing staff relating to their own code of professional conduct and the CCAs' quality of patient care, accountability and responsibilities.

The findings lead McGloin and Knowles to recommend a number of prerequisites for the successful introduction of the CCA's role: a clear definition of the role from the outset; the deployment of dedicated practice development staff to develop the role; the use of appropriate change management techniques to ensure that all appropriate staff contributing to the training are fully consulted and involved.

Rehabilitation support workers were the recipients of a short two day course detailed by Galloway and Smith (2005). The course was aimed at the particular needs of those working in the rehabilitation environment which crosses the health, social services, voluntary and independent sectors. As such the course was run under the auspices of a Primary Care Trust (PCT). In common with Field and Smith (cited above) a focus group

was employed to identify the education and training requirements for the course. The focus group identified the need to provide a portfolio of interdisciplinary educational provision to meet the needs of a diverse workforce with opportunities for academic credit and award. The education should provide career development and access to other CPD opportunities.

The course was attended by healthcare assistants, rehabilitation support workers and occupational therapy and physiotherapy technical instructors. Learning outcomes focused on both generic and rehabilitation specific issues: principles of rehabilitation; principles of client centred care; current issues in rehabilitation practice; review current practice through reflection and identify areas for development.

An evaluation highlighted the strength of the training as the value placed on all support worker roles in the PCT. Similarly participants were able to learn from colleagues. The course demonstrated partnership working between the PCT and university which has enabled the integration of theory, research and clinical practice. Future plans to develop the course included the introduction of work based learning and experiential learning.

The literature also reports on the development of pilot courses which add to the body of evidence surrounding education and training for HCSWs. One such example of this was a national training course for HCAs commissioned by the Department of Health and Children in Ireland (Keeney S, Hasson F, McKenna HP, 2005a).

The training culminated in the award of a Healthcare Support Certificate and was composed of eight modules (three mandatory modules, two elective modules related to a specialist working area, a communication module, a general studies module and a work experience module). The course lasted six months and was initiated by one week's intensive training followed by one day a week for the remainder of the time. In addition there was a clinical placement which required an additional 20 days over the six month period. The training was delivered by classroom teaching of both theory and practical skills which were then assessed in a clinical setting.

An evaluation identified a number of recurring themes which led the authors to make six observations on the future running of the course. The evaluation concluded that on the positive side the course increased knowledge and confidence, improved understanding, provided greater awareness of patient-focused care. However all participants thought the course duration was too short for the amount of work involved.

Most recently McGowan and Campbell (2010b) describe the rationale and operation of a pilot course to enable support workers to become assistant practitioners in a chemotherapy unit in Edinburgh. The course was delivered by a variety of modules from a combination of a further education college and a higher education institution.

An independent evaluation identified four particular challenges that emerged over the course of the pilot: more support required in the clinical area to achieve clinical competencies and complete a practice workbook; lack of understanding of the assistant practitioner role; the need for the education to be pitched at the right SCQF level; the academic difficulties encountered when moving from level 7 based education to level 8. In all these instances solutions were identified to meet these challenges.

vi) Challenges in undertaking education

Benson and Smith (2006) report on the main challenges faced by TAPs (n = 50) as they completed their two years on a Foundation Degree programme. The most commonly identified problems were a lack of time to complete their studies against a backdrop of work and domestic commitments (42/50) and their difficulty in gaining understanding of their role in their working environment (37/50). Less frequently cited concerns included lack of resources (13/50) and problems with placements (13/50).

The financial challenge was highlighted by Leach and Wilton (2008) who identified the need to earn while learning was seen as paramount by assistant practitioners undertaking foundation degrees to prepare them for this role.

McGowan and Campbell (2010) identified a number of aspects for development following the initial running of a pilot course to train APs to work in a chemotherapy unit. Firstly the recruitment of future participants should become more formal and that potential candidates should be able to demonstrate capabilities in a band 3 post. In terms of the course content, a number of areas were identified which would enhance its value for example covering aspects of psychology to enable APs to be able to support patients and have a greater understanding of the impact of bad news and issues surrounding death. Academic and clinical support for trainee APs (TAPs) emerged as an important issue in the evaluation of the course and it was recommended that a policy should be drawn up to identify mentors' commitment when supporting and training APs, ensure equity of support and monitor mentors' additional workload burdens. Finally the course was recognised as being potentially transferable to other clinical areas and this could be achieved in partnership with an HEI in developing a core generic content for the AP role and adding specialised units for individual areas of nursing such as intensive care and mental health nursing.

vii) Conclusion on HCSW education and training evidence in the literature

A review of education and training over time for HCAs and HCSWs is characterised by Bosley and Dale (2008) as "neither statutory nor standardised". This has led to calls in the literature for the introduction of more organised training formerly for HCAs and latterly for HCSWs (Keeney, Hasson, McKenna 2005a). This has included a recent call for the introduction of mandatory training for all HCSWs by the RCN (Sprinks 2009).

Whilst acknowledging the difficulties associated with training and education for the support workforce, on the positive side Keeney, Hasson, McKenna (2005a) concluded that educational courses are feasible for HCAs and where they have been implemented they have helped achieve an increase in knowledge, confidence and skills. This positive impact of training was echoed in a systematic review (CAHE 2006) which noted evidence of support workers knowledge and care skills having improved on completion of training programmes. Indirect benefits of participation in training programmes were positive staff recruitment and clearer definition of roles.

In order to optimise the effectiveness of education provided evidence in the literature highlights that training programmes need to identify and address local barriers to uptake (such as finance constraints, cultural issues, career ladders) for them to succeed (CAHE 2006). In this respect experience and knowledge gained from accounts of designing and running local training courses is valuable.

11. Competencies and core standards

Closely related to identifying training and education needs have been exercises and projects setting out the competencies required for HCSWs.

The identified competencies are comprehensively summarised by the CAHE review (2006, p56). The summary conveniently divides the competencies into generic (table 11), allied health professions (table 12) and healthcare/nursing assistants (table 13).

The authors note that the common core competencies reflected in the literature are related to occupational health and safety, communication, administration, commitment to life long learning and professional issues (such as ethical conduct, dignity and patient confidentiality).

Competencies for support workers who work within specific disciplines reflect the unique requirements of those disciplines. The generic and discipline specific competencies required by the local setting in which support workers are employed are likely to differ according to service type, staff levels, etc.

An illustration of core competencies are provided by Keeney, Hasson and McKenna (2005b) who identified these for a pilot training programme in Ireland for healthcare assistants across care settings and client populations:

More recently Skills for Health (2009) launched core standards for Assistant Practitioners. These are not mandatory standards but considered best practice and cover the deployment and management of APs as well as their recruitment, education and training, competencies and development (Sprinks 2009).

The need to identify the competencies HCSWs require to practice and how best to ensure they gain these is identified as a research gap by Lizarondo et al. (2010). Related to this is the need to devise an educational programme which incorporates a skills escalation framework which will allow HCSWs to develop their careers.

Taking the initiative	Listening effectively
Problem solving	Communicating orally and in writing
Being numerate and literate	Working effectively in group situations
Taking responsibility for one's learning and progress	Having information and communication technology skills
Sourcing and organising information effectively	Understanding health and safety issues
Applying theoretical knowledge in practical contexts	Reflecting on and evaluating the quality of own learning and achievement

12. Supervision of HCSWs

The non-registered status of HCSWs has implications for their clinical supervision.

The onus on registered staff to supervise support workers is illustrated by the College of Radiographer's Scopes of Practice for Assistant Practitioners (CoR 2007a, b):

"An Assistant Practitioner performs protocol-limited clinical tasks under the direction and supervision of a state registered practitioner."

Nancarrow and Mackey (2005) identified supervision as one of the key themes to emerge from their evaluation of OT assistant practitioner training. All participants in the evaluation, including service users, recognised the importance of supervision for assistant practitioners. Supervision was categorised as both formal and informal in nature. Formal supervision related to ensuring the competence of the assistant practitioner, supporting their clinical role and providing pastoral support. Such formal supervision should be on a regular basis with an identified member of staff. Informal supervision was characterised as being more ad-hoc in response to immediate needs such as a day-to-day problem arising. This type of supervision may be carried out on an interprofessional basis by different levels of staff.

An important observation in relation to supervision was a lack of experience of this role by the OTs being asked to carry this out. In practice this led some to over supervise (being over controlling) and others to under supervise (not wanting to supervise). Closely associated with supervision were issues of professional responsibility (the question of the accountability of non-registered staff in comparison to HPC registered staff) and the competence of non-registered staff who have undertaken vocational qualifications. In this respect only OTs who had been involved in actual NVQ training recognised and valued the qualifications as an indicator of the competence of that particular assistant practitioner.

Nancarrow et al. (2005) investigated the operation of support workers in intermediate care in England. Intermediate care encompasses community based care delivered through a combination of primary care trusts and social services. As such this type of care is very diverse given the type of environment it operates

in. Typical roles identified for support workers were multidisciplinary working, meeting rehabilitation needs, providing personal care and enablement.

The study covered 794 support workers and identified three models of supervision. Firstly by means of a mentor who may be a registered practitioner. Little detail was given however on who the mentor was and how the mentoring process worked in practice. The second mechanism was by team supervision from members of the multi-disciplinary team. Typically this type of supervision was carried out by attendance at regular (mostly monthly) meetings or contacting an appropriate member of staff. Finally direct formal or informal supervision through the line manager or team leader was reported.

The authors concluded that the variations in supervision may necessitate the need for a good practice model for support workers. This might involve gaining a consensus as to what constitutes 'appropriate' supervision for support workers in different types of settings.

A systematic review (CAHE 2006) investigated supervision in the context of methods of service delivery. A review of the way services were delivered by support workers in 47 studies revealed that most are underpinned by supervision and explicit task delegation as opposed to independent working where the support workers practice individually.

The systematic review concluded that "while there was consensus for supervision of the support staff, there was little consensus on how much supervision was required and the most effective methods of supervision". Similarly an important finding from the literature were concerns expressed by qualified practitioners for training in supervision and delegation to enable them to carry out these tasks effectively.

13. Mentorship of HCSWs

The need to support HCSWs, typically in the form of mentorship, is acknowledged in the literature.

Leach and Wilton (2009), in an evaluation of AP roles, reported that the assistant practitioners discussed the importance of having a champion for their role. This champion would support their development and encourage the growth of new skills and competencies.

McGowan and Campbell (2010b) describe the development of a pilot course to train assistant practitioners for a chemotherapy unit. One of the issues to emerge from the evaluation was difficulties encountered in providing adequate mentorship support. Initially each trainee AP was assigned their own named clinical mentor, who as a registered nurse (RN), took on this role in addition to their normal clinical workload. However this arrangement did not function well in practice and as a result an appropriately trained RN was employed to carry out the mentoring function for the four trainee APs in their respective clinical areas. This experience led the authors to recommend that a policy should be developed to identify mentors' commitment when supporting and training APs, ensure equity of support and monitor mentors' additional workload burdens

Colthart et al. (2010a) investigated the experience of radiographers acting as mentors on an educational programme to prepare support workers to become APs. The programmes employed a combination of academic and workplace learning (two days per week) and as such mentors were integral to the successful operation of the programmes. The mentors identified personal and professional development benefits for themselves in undertaking this role. However there was some tensions identified in providing mentoring time for both TAPs and radiography undergraduates. The mentors identified the provision of protected time and better knowledge of the theoretical teaching the TAPs were receiving at college as a means of improving their ability to carry out this role.

14. Relationships with other healthcare workers

The participation of HCSWs in multi-disciplinary teams raises the question of their relationships with those they work in these team based environments.

Spilsbury and Meyer (2004) undertook a case study which examined the relationship of HCAs and registered nursing staff in an English acute hospital. The interactions between the HCAs and nursing staff are characterised under the headings of the *use*, *misuse* and *non-use* of HCAs.

Firstly in terms of use, the HCA job descriptions noted three main areas of work: direct care, housekeeping and clerical duties. In practice the majority of HCA work activity came under the heading of direct care with in contrast RNs tending to move away from direct bedside care to activities such as paperwork and discharge planning. These types of typical work activity were perceived by both HCAs and RNs as having implications for patient care, safety and nursing teamwork.

The *misuse* of HCAs is described as situations where HCAs were used in ways that were beyond the expectations of formal policies and was described by the authors of being an "exploitation of the HCA role". This may have occurred because of increased workload or under-staffing. An example of this was asking HCAs to undertake blood glucose monitoring without providing training for this particular task, as required by local policy.

Non-use of HCAs was exemplified by RNs preventing HCAs from putting their skills and experience into practice. The authors identified four particular ways RNs restricted HCAs;

- 1 the use of credentials such as the title nurse to differentiate between the role of nurse and HCA
- 2 the work which RNs permitted HCAs did not take account of their skills, experience and qualifications e.g. a trained dietician working as an HCA not being allowed to give dietary advice, HCAs who had previously worked as phlebotomists with healthcare agency services but were told that they could not take blood as part of their current role.
- 3 RNs outwardly restricting HCA's involvement in certain perceived higher level tasks which were reported as being the nurse's job e.g. wound dressings
- 4 RNs ignoring the HCAs' knowledge of the organization and local community that they had gained through experience. Whilst RNs may have recognized this experience they chose not to use it practice. For example RNs not involving HCAs in discussions about patient care and discharges.

The case study illustrates the need for HCAs to be employed in the most effective manner if their contribution to patient care is to be maximised.

Keeney, Hasson, McKenna (2005b) in reviewing the literature on HCAs (in their study of managers' perceptions of HCAs) observe that integration within and acceptance by the healthcare team was a major issue which has prompted much controversy and discussion. Evidence suggests that the introduction of HCAs has been met with scepticism by a number of qualified staff who regard them as a cheaper alternative which have encroached on their role and territory.

More recently there has been a debate on the ratio of registered staff to non-registered staff. Sprinks (2009) reports that the RCN suggests that the benchmark ratio in an acute setting should be around 65 per cent registered staff to 35 per cent non-registered. Ideal ratios depend on a number of factors, including geographical location, the number of elective admissions and the type of ward. It is clear that the ratio of non-registered staff to registered staff has risen over recent times. For example in the NHS in England in 1998 there were the equivalent of 10.5 band five or six equivalent nurses for every one HCA. By 2008 the respective figure was 6.6 nurses to each HCA, a rise of over 40% in the proportions of HCAs (Gainsbury 2009).

The ratio of registered to non-registered staff is part of a wider deliberation on ideal skill mixes. The interest in skill mix is usually linked to the dual outcomes of patient care and cost to determine which is the optimal combination of staff for both of these factors.

The evidence on using different grades of nursing staff (skill mix) has been systematically reviewed by the National Nursing Research Unit at King's College London (NNRU 2009). The volume of evidence is small and mostly originates from the USA. Given the dearth of literature in this area it was concluded that the limited evidence available does not support the UK introducing a nurse in a direct care-giving role below that of the Band 5 registered nurse. Further the success of initiatives to formalise the training of Band 4 assistant practitioners is likely to depend on clear role boundaries and strong leadership.

15. Boundary disputes and professional identity

The relationships between registered and non-registered staff has resulted in debates in the literature about boundaries and professional identity. A number of papers have addressed this subject area.

Nancarrow and Mackey (2005) identified a lack of a clear career direction for qualified occupational therapists, creating uncertainty about which aspects of their job they should be 'giving away' to assistants. This resulted in a need to clarify career structures and accountability relationships between existing and new staff members and ensure that appropriate training is available to support staff in their new roles.

Bosley and Dale (2008) provide a detailed overview of the literature in this area in relation to nursing. They observe that nurses may experience uncertainty as they themselves are asked to take on tasks previously undertaken by medical staff and in turn see their traditional domain "encroached" upon by HCAs. Nurses differentiate themselves from HCAs in a number of ways: by professional qualifications and their accountability as registered healthcare professionals; their level of knowledge; their emphasis on patient-centred, holistic care in comparison to their perceptions of HCAs undertaking a task oriented approach. There is evidence of nurses sensing a loss of relationships with patients and attempting to protect their identity by restricting the roles of HCAs. Equally HCAs may choose to withhold patient and other information from nurses in an attempt to increase their influence. This leads to the conclusion that neither of these situations are conducive to effective teamwork or patient care.

Leach and Wilton (2009) carried out an evaluation of sixteen APs in a number of occupations in an English Strategic Health Authority (SHA). The APs reported initially encountering fear from registered staff that their professional roles were being eroded. This prompted the authors to observe that this echoes "the reluctance of some registered staff to either let go skills that they had thought belonged solely to them or the fear of letting unregistered staff practice these skills without direct supervision".

16. Roles and scopes of practice

i) Classification of and types of roles

The CAHE systematic review (2006) neatly summarises the range of activities carried out by HCSWs in terms of direct and indirect roles. Charting these roles over time as HCAs have evolved into HCSWs, the review notes that typical activities of housekeeping, hotel, clerical and general care duties have changed somewhat to support workers concentrating more on basic care duties and non-nursing duties.

A number of factors are identified by the review in explaining the variety and diversity of roles undertaken by HCSWs. These factors include the attitudes and beliefs of the qualified health professional with whom the support worker will work, lack of clarity of their own role by the qualified health professional, the perceived training of the support worker and the local needs of the health service where the support worker is employed. In addition personal and contextual factors such as experience, responsibility and staffing will play a part in defining the HCSW role.

A full tabular description and analysis of the direct and indirect roles of HCSWs is presented in the review. Direct roles (table 6, p33) are summarised as combination of general hygiene, portering and assistance in the administration of clinical services. Indirect roles (table 7, p37) are typically a combination of administrative duties, housekeeping and maintenance of workplace and equipment.

More recently a systematic review of allied health assistants charted their roles and responsibilities (Lizarondo et al. 2010). The review classifies these under the headings of clinical and non-clinical duties. Typical clinical duties include preparing patients for treatment, providing patients with physical and social support, patient education. Non-clinical duties encompass areas such as administration, stock ordering, recording statistics, housekeeping and cleaning. The review observes that many of the clinical duties mirror those of registered AHPs.

The reference to boundary disputes in the literature point to the need for a clear definition of HCSWs' roles. However the evidence drawn from the literature suggests that this is not the case in practice. The Welsh scoping study (HPW 2004, p12) referred to previously noted that "while the use of support staff in some professions may have a long history and in others may constitute a large proportion of the workforce, this does not necessarily mean the roles are well defined. On the contrary".

ii) Critique of HCSW roles

The literature reflects the variation in HCSWs' roles across professions and also reveals a number of recurring themes.

Thornley (2000) examined the roles of nursing auxiliaries (equated to a lower grade HCSW) and HCAs. This study concluded that "that the boundaries between so-called 'ancillary' work and 'nursing' work continue to be highly blurred and fluid, with both the traditional grade of NA and the 'new' grade of HCA engaging widely in 'nursing' duties, and with job titles used almost interchangeably in most Trusts".

Ellis and Connell (2001) looked at the roles of physiotherapy assistants and concluded that there was variation in the scope of activities of the 18 assistants across one English NHS region. Supervisors in the study were of the opinion that the assistant's role equated more to that of a junior physiotherapist in elderly care and rehabilitation. The supervisors viewed the assistants as undertaking new roles in the community in that they were extending the availability of physiotherapy care. Finally there was evidence in outpatient departments of assistants undertaking new, extended roles and tasks, for example electrotherapy.

Baldwin et al. (2003) considered the evidence across all sectors in the process of examining the roles of support workers in nursing homes. The authors concluded that the majority of the support worker role focussed on direct patient care activities but that a lack of role clarification was apparent. This was evident in differences of opinion between support workers and RNs over the role of support workers in the care process. Support workers regarded their role as similar to RNs whereas nurses saw them as providing “basic nursing care”.

Keeney et al. (2005b) in reviewing the literature around this theme identified a number of interesting findings from research that had been carried out in relation to HCA roles. These include a UK study (Anderson 1996) which reported difficulty among qualified staff in accepting their need to alter roles as a result of the introduction of HCAs. This study identified the lack of a clear distinction between the activities that lie within and outside the domain of qualified staff. Previous to this Harper (1986) had concluded that with the increased number of HCAs in the UK, nurses would drift away from direct patient care to indirect supervisory roles. He warned that caution was needed as more nursing time could be spent on the supervision of HCAs, leaving little time for other professional interventions. Keeney et al. also cited a number of other similar reports which they feel demonstrated concerns that HCAs were undertaking nursing activities which should only be performed by nurses (Dolt 1998, NHS Executive 1998, Snell 1998).

Hancock et al. (2005) also present a comprehensive overview of the literature in this area in setting the context for their research into role development of HCAs (see also Hancock and Campbell 2006). The study was small in scale but a noteworthy aspect of this research was the inclusion of patient’s views. In practical terms the study revealed that HCAs were taking on roles normally associated with nursing such as taking blood and dressing wounds. However organizational and local culture appeared important in dictating the boundaries of the HCA’s role.

The authors address the particular question of delineation in relation to HCA and nursing roles. The study found that after the HCAs had completed a development course their role was not well defined and variations existed. Although changes were detected in the HCA roles the majority of registered staff were reluctant to delegate core ‘nursing’ activities for a variety of reasons: role transition, uncertainty about role boundaries, fear of losing part(s) of their role and concerns about responsibility.

In analysing the reasons for this reluctance the authors identified *cultural competence* and *trust* as being key as to why certain HCAs were able to develop their role more than others. *Cultural competence* relates to the beliefs, values, norms and practices of a group which guide its thinking, decision making and action. It is encapsulated in the phrase “the way we do things around here”. In reality this meant that “HCAs practised according to local agreement, with significant variation between wards/departments about what constituted acceptable practice”. This is put forward as an explanation for the change or absence of change in HCAs roles.

Similarly *trust* was identified as being pivotal to the HCA role and was affected by their relationship with their colleagues. Although the HCA may have demonstrated *cultural competence* in terms of awareness of their own role and how it fitted into the team there was also the issue of trust to be considered. The authors refer to Rogers (1983) who suggested that the need for power over others is based on a lack of trust, and that until trust is established, those in power will always feel it is their obligation to control. This may explain the reluctance of some RNs and Midwives to allow HCAs to develop their roles.

These findings have implications for the content of educational programmes in that they must take account of context. It is not enough to assume knowledge acquired via an educational programme is independent of the personal, interpersonal and organizational context that it will operate in. With this in mind the authors put forward recommendations to improve the environment that HCAs develop their roles in on completion of their educational programme. These recommendations include provisos that: explicit policies in relation to roles of the HCA should be formalized in discussion with HCAs and their colleagues; and that a consistent, formalized, open approach to role transition is required at both local and organizational levels in order that role changes are successful.

A number of recent studies have specifically looked at the introduction of assistant practitioners into the workforce and their role. Spilsbury et al. (2009) mapped the roles of assistant practitioners across acute trusts in England by canvassing the opinions of directors of nursing. They found that APs were mostly being employed in medical and surgical wards. A recurring theme in their research however was uncertainty on a number of levels as to the role of assistant practitioners and this extended to other HCSWs. In particular there was a need for role clarification between bands 2, 3 and 4 support workers. This was apparent in hospitals where APs have been introduced as there was uncertainty between the roles of bands 3 and 4. Equally in hospitals where there was no APs the directors of nursing were of the opinion that the existing bands 2 and 3 were already operating in extended roles and so there was no need to introduce band 4 APs. This also prompts the question of whether such bands 3 and 4 are being undervalued and underpaid.

Continuing the investigation of APs, Wakefield et al. (2010) examined the job descriptions of 27 AP roles in three acute trusts in England. They examined the job descriptions against a framework that categorised their clinical roles in terms of their emphasis on how independent or dependent the role was. This is in the context that AP roles should deliver protocol based care which would have previously been the responsibility of registered practitioners and that such care should be under the direct supervision of a registered practitioner.

The study found that there were instances where APs were expected to go beyond delivering protocol based care and act independently. This contradiction leads to uncertainty as to where the AP role fits into the nursing workforce. This uncertainty is exacerbated by the Skills for Health (2008) career framework descriptors which recommend that level 4 practitioners (i.e. assistant practitioners) should “develop self-directed working practices” and “make judgements requiring comparison of options”.

The study concludes that “it still not clear what managers and workforce planners want from the AP role as it does not have a clearly defined position in the clinical hierarchy despite being located at level 4 on the SfH (2008) Framework.”

Confusion over the role of APs is echoed in McGowan and Campbell's (2010b) account of the introduction of a pilot scheme to introduce APs in a chemotherapy unit. One of the main findings from the evaluation was that nursing staff were confused about the AP role and their level of responsibilities. The pilot scheme's solution was for the trainee AP's mentor to give nursing staff verbal and written updates on their progress including the clinical competencies they had achieved. Looking at the wider picture the authors believe that there is a need for the roles of newly qualified staff nurse, APs and nursing assistants to be clearly differentiated.

iii) Guidance on HCSW roles

The need to remove ambiguity from HCSW roles and has led to the emergence of guidance documents. The aim of these documents is to specify the types of roles that HCSWs can undertake and in so doing introduce a degree of uniformity. Examples of these include setting out role parameters for the three levels of HCSWs (NES 2010) and scopes of practice produced by professional organisations (see for example College of Radiographers 2007a, b) which outline acceptable and equally importantly unacceptable roles for radiography APs.

17. Tasks conducted by HCSWs

At a micro level Bosley and Dale (2008) summarise the constituent tasks which HCAs incorporate into their roles in both the secondary and primary care sectors.

In a hospital setting these include practical nursing care such as bathing and emotional support. In some cases the literature reflects the feeling that HCAs are able to build up closer relationships with patients than nurses and perceive their role to be similar with the exception of drug administration, paperwork and professional accountability. There is also evidence in the literature of HCAs going beyond what would be generally deemed to be the boundaries of their levels of responsibility. Tasks identified in this context include: undertaking systematic observations and electrocardiogram tracings; monitoring blood glucose levels without supervision; taking blood and dressing wounds; administering drugs while unsupervised; running clinics without a nurse. Further the HCA role has been found to encompass teaching nursing students and newly qualified nurses and communicating with doctors about patients. In general practice HCAs have been trained to undertake clinical procedures such as blood pressure and new patient checks, health promotion, urinalysis, weight and height recording, ordering supplies, equipment sterilisation and phlebotomy.

18. HCSW job descriptions

A number of studies have specifically examined HCSW job descriptions.

The Welsh scoping study (HPW 2004) identified 103 job descriptions, most commonly in nursing, occupational therapy, physiotherapy and speech and language therapy. The job descriptions were analysed to identify common tasks, roles and skills across the professions.

The analysis revealed a number of generic and specific skills. Generic skills were summarised under the headings of: team working; care delivery (direct/indirect, clinical skills); supporting trained staff; assisting with care delivery; health and safety/patient safety; equipment/stock maintenance; record keeping; administration and communication.

Specific skills were associated with the HCSW displaying more autonomy and assuming greater levels of responsibility. These types of skills included: carrying a caseload under supervision; patient/client assessment; teaching new staff and/or patients; client group skills; supervision of new and other staff.

Benson and Smith (2006) investigated the drawing up of job descriptions in the “Delivering the Workforce” project to develop the assistant practitioner role in Greater Manchester. Their research revealed varying progress across respective pilot sites in the project in drawing up job descriptions. This meant that as some trainee assistant practitioners neared completion of their training there was the possibility of no job description being in place for them as they took up their duties. In reality job descriptions should definitely be in place at this stage. This has implications in ensuring that there is a clearly defined role for the AP which has been identified elsewhere in the literature as being important for the efficient functioning of the post (CAHE 2006). A clearly documented definition of roles is essential to avoid confusion among other healthcare professionals as to the boundaries of respective team members’ duties.

Wakefield et al. specifically examined the job descriptions of assistant practitioners in two related studies. The first study (2009) analysed the job descriptions of 16 AP posts in an acute hospital trust in England. The aim of the

study was to compare the content of the job descriptions against the policy vision of the posts as being *assistive* in nature. *Assistive* essentially means that “APs are expected to undertake those tasks specifically designed to assist and support the work of the registered practitioner under whose direct supervision they are managed”. As such the AP is not expected to act autonomously or independently. Analysis of the job descriptions revealed that only one post was truly *assistive* with the remainder being classified across a framework encompassing various elements of *supportive*, *substitutive* and *autonomous* practice. This situation leads the authors to conclude that this has the potential to lead to role confusion, role conflict and exploitation around the AP role. In reality this could lead to role substitution, reassignment and delegation which is not what the AP role was intended for.

The second paper (Wakefield et al. 2010) widened the study by adding another 11 AP job descriptions from a further two acute trusts to the original 16 job descriptions. The extended study confirmed similar findings to the first in terms of classifying the additional job descriptions as *assistive*, *supportive*, *substitutive* and *autonomous*. The authors highlight the contradiction from Skills for Health level 4 career framework descriptors (Skills for Health 2008) which call for APs to “develop self-directed work practices” and “make judgements requiring comparison of options”. In effect these desired actions go beyond *assisting* or helping and being *self-directed* and *making judgements* are associated with registered practitioner roles.

The crossover of practices from registered practitioners to non-registered staff such as APs has the potential to lead to blurring of role boundaries. One way of countering role blurring is to draw up “robust, clear and publicly-defined job descriptors” (cited by Rolfe et al. 1999). However in this study Wakefield et al. (2010) conclude that “job descriptions did not clearly define APs’ scope of practice. This led to confusion about what they could, should and/or did undertake as part of their role”.

19. Regulation

Regulation of HCAs and HCSWs is a subject which has recurred over time in the literature.

Hopkin (2008) identifies a number of aspects which characterise regulation. Essentially regulation entails being on a professional register which brings with it professional accountability. In effect any member of the healthcare workforce has a duty of care to their patients but it is only those who are professionally regulated who are held professionally accountable. Regulation also has many facets other than being on a professional register. These facets include having standards for practice and education which include standards of entry to the register, a code of ethical conduct, titles that are clearly understood by all and an agreed definition of roles and functions. Most importantly entry to a professional register requires evidence of fitness to practice in relation to health, character and training.

There has been an ongoing debate in the literature regarding the regulation of HCAs and now HCSWs and it has gained increased attention over recent times (O'Dowd 2009, Blakemore 2009). The purposes for professionally led regulation are outlined clearly by the RCN (2007) as: public protection; education; safety of the individual; competence; performance management; quality assurance; setting standards. Arguments in setting the case for and against regulation have been well rehearsed in the literature. Briefly the arguments for are that HCSWs are in direct contact with patients and regulation will provide patient safety and public protection (Hopkin 2008). Equally regulation will protect individual HCSWs by providing standards, education, professional development, defining their scope of practice and giving value and recognition to their role.

Conversely regulation is undesirable (Youg 2008) because it in itself will not provide protection for patients as evidenced by a number of high profile medical scandals (e.g. Shipman, Allit) where patients were harmed by regulated healthcare professionals who had already proved their knowledge and competence to practice. Patient safety depends on any number of other factors such as trustworthiness of the individual involved which will not necessarily be picked up in the regulation process. Also in a nursing context the regulation of

HCSWs may lead to the mistaken belief that they are sufficiently qualified to replace nurses. Essentially the question is posed - "is it safer for the public to be cared for by a number of HCAs who are led, monitored and supervised by nurses, or by HCAs, who, following regulation, are perceived by many to have the ability and authority to decide what nursing care is needed by patients?" The author believes that in fiscally challenging times the opportunity to replace nurses with regulated HCAs would be too tempting with an overall increase in the number of the latter at the expense of the former based on the justification of regulation.

i) Government policy

The background to policy developments in the regulation of HCSWs are outlined in depth by Birch and Martin (2009). The debate on regulation has also been conducted by government. Two parallel consultations were held in 2004 seeking views on the regulation of support workers by the Department of Health in England (which also covered Wales) and the Scottish Executive. Both consultations resulted in a consensus for regulation. In Scotland there was a strong majority (90%) and in England a subsequent white paper resulting from the consultation intimated that those who responded to the consultation were in favour of regulation for some types of support workers but not necessarily all of this occupational group.

As a consequence of the consultations and consideration by the Review of Non-medical Regulation (Foster Review 2005), Scotland was chosen to pilot a project for the four home nations which addressed minimum standards for HCSWs. The standards contained three elements: induction standards for healthcare support workers; a code of conduct for healthcare support workers; a code of practice for NHS Scotland employers. The pilot was conducted on a voluntary basis over two years in three health boards and an independent sector hospital. The findings are detailed by QIS (2008) and Birch and Martin (2009). As a result of the pilot induction standards for HCSWs are to become mandatory in Scotland from December 2010.

ii) Professional and regulatory bodies

The Royal College of Nursing (RCN) is clear in its support for regulation (RCN 2007). Prior to this the RCN had allowed HCAs with a level 3 NVQ to join the RCN register (Hancock et al. 2006). The RCN's commitment to regulation was recently reiterated by its general secretary Peter Carter who thinks that it would rectify the "fragmented approach" to training across the NHS (Sprinks 2009). The RCN would initially like to see APs regulated first in a staged process for all HCSWs (RCN 2007) but others caution against this single level approach.

Adams (2010), in arguing the case for regulation as head of nursing at UNISON, notes that there too many variations in the roles and responsibilities of HCAs to base regulation on a job title (or equally a pay band) alone. As such all HCAs should be regulated. UNISON currently favours HPC to be the body responsible for regulation (Santry 2010).

The issue of regulation has prompted recent comment from the Nursing and Midwifery Council (NMC) that they are in favour of such a process and accordingly they commissioned research from the National Nursing Research Unit (NNRU) to explore the matter further (Santry 2010). The NNRU subsequently published a scoping report (Griffiths and Robinson 2010) which summarised the evidence surrounding a number of aspects of regulating HCSWs. Interestingly the authors conclude that there is a "strong" case for regulation despite being unable to find unequivocal evidence that a lack of regulation for HCSWs poses a risk to patient safety. The rationale for regulation is that the current situation allows individuals who have been previously dismissed from healthcare posts for misconduct to be re-employed as support workers. Also it is evident that HCSWs are currently undertaking clinical tasks that they are not trained for which poses a potential risk to patients. The report goes on to note that regulation will have implications for the standardisation of training.

The current unregulated status of HCSWs has attracted recent comment in the literature. Bosley and Dale (2008) recognise the positive aspect of regulation in that it would standardise training but on the downside the formality and increased responsibility associated with it may deter some from going down the route of developing HCAs. Spilsbury et al. (2009), in a survey of acute trusts in England, found that some had not introduced the assistant practitioner role due to concerns over patient safety related to the unregulated status of this group. Wakefield et al. (2010) point out the pitfalls of the current situation for APs in that they are caught between two stools. One stool is the unregulated one and the other is regulated by registration and legislation. Having analysed their job descriptions and noted that in some cases the APs are involved in substitutive and autonomous nursing tasks, this could leave them in an exposed situation if something were to go wrong. In this case there would be no clear directives to guide their actions and give them subsequent protection.



20. The impact of HCSWs

One of the reasons cited for the non-introduction of assistant practitioner roles across some trusts in England was a lack of evidence for their effectiveness (Spilsbury et al. 2009).

Bosley and Dale (2008) concur with this view and report that “despite very limited evidence of the impact or effectiveness of HCAs, the role is being advanced in general practice”. Recognition of the need to evaluate the impact of HCSW roles has led to the initiation of a programme of research, which is currently underway, funded by the Department of Health (Spilsbury and Atkin 2009).

A review of the literature suggests there is some limited evidence of impact and that which does exist is of questionable quality and value. The systematic review of rehabilitation support workers (CAHE 2006), which was broadened to look at all support workers, sought to identify firstly outcome measures by which effectiveness could be measured and secondly what evidence exists by virtue of these outcome measures.

Outcome measures identified in the review were categorised as relating to (a) patients, (b) individual(s) providing healthcare and (c) other stakeholders with an interest but not directly involved in patient care e.g. funders, managers and the community. Typical outcome measures for patients were satisfaction, communication and quality of living measures. For those providing the healthcare, measures included efficiency, knowledge and skills and job satisfaction. Measures for the other stakeholders related to costs, quality of care, safety and recruitment and retention.

In summary the outcome measures reported in studies related to either evaluation of services provided by the support worker or evaluation of training programmes for them.

Having identified the outcome measure the review summarises the effects identified by them in the literature. However there is a health warning given as to the quality of the research. Most of the evidence emanates from qualitative research which is limited by methodological deficiencies. Further the nature of qualitative research restricts the generalisability of its findings. In addition empirical evidence based on sound outcome measures is described as “scant”. Notwithstanding these deficiencies the review summarises the evidence as mostly positive across all outcome measures and stakeholder groups (table 10, p52).

An example of study contained in the CAHE review is research by Hancock et al. (2005). This was a small scale qualitative study which aimed to evaluate the impact of a HCA Development Programme on care delivery. With this in mind participants in the study included patients themselves. In undertaking the study the authors concurred with the general feeling that “there is a lack of comprehensive evidence regarding their role in terms of their contribution to, and impact on, patients and other members of the healthcare team”. The study findings in relation to patient care concluded that completion of the programme had resulted in a more holistic approach to care.

Similarly Betts et al. (2003) describe how the introduction of Radiography Assistant Practitioners enabled them to staff a chest room which they had previously had difficulty in operating due to a difficulty in recruiting radiographers. The Assistant Practitioners helped spread the workload in their department and in doing so reduced stress and pressure for other staff and improved the overall service for patients.

A small scale study of the impact of associate and assistant practitioner roles is reported by Leach and Wilton (2009). This study was conducted in an English strategic health authority across a number of occupations in both acute and primary care. The views of APs and managers were sought by questionnaire and interview. The study reports the perceptions of participants and as such anecdotal evidence is presented. Identified impacts cited were benefits to patient care, service improvement, cost effectiveness and personal benefits for the APs. The anecdotal nature of the findings is acknowledged by the authors who highlight the need to substantiate these with hard evidence.

The perceptions of the impact of the Assistant Practitioner role on practice is presented by radiography mentors and APs themselves in an evaluation of an educational programme. The APs mainly saw their role as an enabling one in freeing up radiographers to undertake more specialised examinations (Colthart et al. 2010b). This recognizes their role in the radiography four tier model (DH 2003) and their contribution to the radiography team. The four tier model was a new model of service delivery within radiography initiated in 1999. The model has four levels that represent escalating competencies and responsibilities within a multidisciplinary team. The first level is the assistant practitioner which progresses into the levels of practitioner, advanced practitioner and consultant practitioner.

Assistant Practitioners in diagnostic imaging undertake the non-complex radiography procedures as laid down by their scope of practice (CoR 2007a). This should enable radiographers to expand their own role within radiology services, providing a more efficient clinical diagnostic pathway for the patient, including reduced waiting times. In radiotherapy, more generic impacts were identified, like maintaining capacity by providing cover for sickness absences.

Similarly mentors (Colthart et al. 2010a) offered their perceptions of the impact of the APs in aspects of their radiography department's operations. The largest positive effect was observed in teamworking with 15 out of 22 mentors noting a beneficial outcome from the presence of trainee APs. Similarly half of the mentors (n=11) felt the programme had been beneficial for the patient's experience in their department. On the downside some mentors reported a negative impact on the speed of service delivery but not on the quality of practice.

i) Benefits of HCSWs

The literature identifies a range of benefits for employing HCSWs but most of these are anecdotal given the lack of robust evidence of the impact of the roles at the present time. For example Leach and Wilton (2008) evaluated the introduction of associate and assistant practitioner roles in a strategic health authority in England. The evaluation included the views of both the APs (n=16) and managers (n=6). Perceived benefits identified from the establishment of these HCSW posts are categorised under a number of headings: patient care; service improvement and team benefits; cost benefits; personal benefits.

In terms of patient care the APs felt that they contributed positively to the patient experience and delivery of care in a number of areas: by providing continuity of care; by being able to spend more time with patients which allowed them to communicate, explain procedures and answer their questions; by observing if changes in care were needed by being the member of staff who was most in regular contact with patients. Other indirect benefits of the AP role for patient care included freeing up registered staff to take on more complex clinical procedures and in helping to shorten or prevent hospital admissions.

Service improvements cited included observing the processes and procedures used and identifying changes to transform the care provided to patients. Examples include:

- in a Radiography department APs have reorganised the use of rooms to ensure that all paperwork is completed and patients are fully prepped to allow them to go straight in to the X-ray room once it is free, ensuring there are no gaps in service delivery.
- an incontinence assessment tool has been developed by an AP, which, since its introduction has cut the number of catheterisations and has been noted in an infection control audit.

Team benefits relate to the role of the AP and how they interact with other members of staff. APs have been noted as supporting band 2 and 3 staff. In some cases this has been formalised in job descriptions thus: "APs help to train new band three assistants and assist in the management of their workload, helping practically when required". Such supervision frees up registered from performing this type of task. In practical terms examples were cited of APs signing off competencies for radiography students and catheterisation for junior doctors. Looking forward, all the APs would like to become mentors for trainee APs and some would like to progress to become NVQ assessors.

Other associated benefits for members of their teams related to freeing up time for registered staff. This allowed such staff to take on more complex clinical cases as previously mentioned and also enabled them to spend more time on assessing, planning and evaluating their clinical work. More free time also allowed some registered staff to be able to attend courses. APs were also seen as a resource in covering for sick leave and in so doing helping to keep waiting lists down.

Reference was also made to cost savings by respondents to the evaluation (both APs and managers) but these financial benefits are not backed up by any hard evidence and are purely based on subjective personal opinions. For example the manager of a breast screening unit observed that "I can have two APs for the price of one mammographer" without any economic appraisal of the relative merits or costs in changing the skill mix in this way. In this respect Lizarondo et al. (2010) note that the cost effectiveness of alternate workforce models which incorporate HCSWs have not been widely investigated to date. Therefore research is required with cost effectiveness as a central outcome measure to evaluate the impact of HCSWs in the workforce.

Personal benefits for the APs are summarised as being greater job satisfaction and enhanced self-esteem. The APs were glad to have had a second chance at education and were proud to have changed the attitudes of registered staff towards them. In some cases the positive experience of becoming an AP had translated into their personal life.

McGowan and Campbell (2010a), in their evaluation of introducing the AP role into a chemotherapy unit, summarise the benefits of the AP role outlined in the literature. These benefits described validate some of those identified by Leach and Wilton (2008 above). In particular in enabling registered nurses to perform more complex procedures and assessments and to use their skills and knowledge more appropriately and effectively; facilitating continuity of care. In addition offering AP development opportunities may offer career progression to non-registered staff and in so doing facilitate staff retention. Career advancement may also encourage APs to consider studying to become a registered professional (cited from Macleod and Clark 2007).

21. Stakeholders' insights into HCSW education and the role

i) Views of HCSWs

A number of studies have reported on HCSWs' own experiences and perceptions. These studies tend to concentrate on the views of HCSWs in evaluations of education programmes to prepare them for the role rather than investigations into the role itself.

An example of this is Keeney, Hasson and McKenna (2005a) who report the views of 22 HCAs in Ireland who were undertaking a national training course. Semi-structured interviews with the trainees revealed positive changes as a result of attendance on the course. Benefits cited by the trainees included more confidence in their ability to undertake delegated duties and improvement in their knowledge and care skills.

Similarly Hancock et al (2006) sought the views of HCAs on two particular aspects of their development. Firstly the impact (outcomes) of their attendance on an education programme to develop their role and secondly the preparedness of HCAs to undertake the programme and the new developed HCA role they would be undertaking. The outcomes indicated positive changes to the HCAs' role, which included skill and knowledge development, increased confidence and initiative and a more holistic approach to care. Secondly there was a range of opinion from the HCAs on their role development with both favourable and unfavourable views expressed. Similarly not all HCAs interviewed (2/12) were willing to enter an educational programme to assist their role development.

Another account of student experiences is reported in a case study describing the piloting of a training course for assistant practitioners in a chemotherapy unit (McGowan and Campbell, 2010). Initially students felt apprehensive on beginning the course but developed confidence in their clinical practice ability as it progressed. Other issues highlighted by the TAPs included the workload associated with the course. There was also anxiety expressed in moving from a further education college to a higher education college for one of the units. Associated with this was the difference in moving from SCQF level 7 to level 8 education in terms of a perceived "step up". Finally the TAPs stressed the need for formalised clinical and educational support and that this must be clearly outlined at the outset for both students and those supporting them.

In terms of views on the particular HCSW role, Dransfield (2006) gives an anecdotal, personal account of his four years as a radiography Assistant Practitioner. Initially he reports there was reservation from some staff and a degree of uncertainty as to his responsibilities and boundaries due to a lack of clear guidelines. However with time the role became more accepted and his responsibilities were clarified and extended, particularly in the last year of his account.

Most recently Kessler et al. (2010) present an informative summary of HCAs attitudes to their role. This was a comprehensive two year study commissioned by the National Institute for Health Research (NIHR) which used a mixed methods approach to explore a variety of aspects of the HCA role in England. The HCAs included in the study demonstrated disaffection with their banding (band 2) and their associated pay, qualifications and tasks. In effect they felt they were undervalued for their qualifications and were able to carry out more advanced tasks than they were being paid for. In some cases this led to entrenchment into Band 2 roles and a reluctance to take on more advanced tasks and duties. Other difficulties were encountered in HCAs' relations with nurses and other healthcare professional groupings. On the positive side the HCAs enjoyed their jobs and in particular the patient centred aspect of it which gave them intrinsic rewards in caring for others. The enjoyment of their jobs manifested itself in the HCAs expressing job satisfaction and low intentions to leave the role. The study also identified an emotional dimension to the HCA role. Firstly in the HCAs managing their own emotions (e.g. dealing with death) and also dealing with others' emotions (e.g. patients and their relatives).

ii) Views of managers on the role

Mackey and Nancarrow (2004) evaluated the introduction of assistant practitioners in occupational therapy among a range of stakeholders including managers. These new roles were viewed as a challenge in that a degree of innovation and flexibility was required to introduce them but these elements were restricted by the need to adhere to clinical governance. The managers identified a range of factors which were seen as helpful in implementing the AP role: having a 'champion' for the role at the management level, an innovative and flexible environment for service delivery, willingness of managers and clinicians to try new ideas and learn from their mistakes, and a team attitude that embraces 'modern' ways of working.

Keeney, Hasson, McKenna (2005b) surveyed healthcare managers in Ireland on their attitudes to a national training course and their willingness to employ HCAs who had completed the course. The training course contained core units and elective units relating to their particular area of practice. Most of the respondents (n=70) indicated a willingness to employ HCAs and identified additional content they would like added to the training. This related to mental health, health promotion, care of the elderly, challenging behaviour skills and training in the management and prevention of violence. Managers thought it important to have explicit standard entry criteria for the course. In terms of the role of the HCA, most managers saw it as supporting nurses and midwives but a small number felt that it could encroach on these professional groups. The authors note that perceptions of encroachment has the potential for role confusion, role strain and role conflict.

Leach and Wilton (2008), in an evaluation of associate and assistant practitioner roles, sought the views of managers as to developing these roles. The principal advice was the need for good communication with all members of the department and the importance of prior planning. This involves examining carefully what the department's service needs are and drawing up a clear job description. Managers also identified the need for them to support the APs in a number of ways. Primarily in the role as champion as many of the APs indicated that they would not have undertaken the foundation

degree without the prompting and support of their managers. The manager also had an important role to play in allaying the fears of other members of staff who felt threatened by this new role.

iii) Views of registered practitioners on the role

This literature frequently makes reference to the attitudes of registered staff to HCSWs (CAHE 2006). The following references are illustrative of the views of healthcare professionals to the HCSW role.

Mackey (2004) examined the views of occupational therapists to extending the role of support workers. A series of focus groups were held across a community trust in England with 36 participants taking part. The main factors identified as being of importance in extending the support role were the need to: increase role clarity; lessen role threat; review organizational effectiveness; ensure clear delegation and design and implement responsive training programmes. In addition the author noted that many of the OT support workers had completed or were in the process of attaining a NVQ. However not all qualified occupational therapists were aware of the content, assessment and knowledge base of this type of qualification.

Alcorn and Topping (2009) specifically addressed the question of registered nurses' attitudes toward healthcare assistants. They employed a survey method which received responses from 148 RNs working in the surgical directorate of an English NHS trust. The study revealed that most RNs indicated they delegated tasks to HCAs and recognised that they themselves remained accountable for the action of those HCAs. The majority of RNs did not perceive their role and the role of the HCA as the same. More than half of the respondents felt that HCAs should be held accountable for their actions if adequately trained and prepared and were in favour of registration for HCAs. Expansion of the HCA workforce was perceived by a minority as a strategy to replace RNs and a cost-cutting exercise. Most respondents agreed that patient care was enhanced via investment in the development of HCAs. The authors

conclude that the role of RNs in developing HCAs has implications for their own training needs in ensuring that they are adequately equipped to supervise and delegate work to HCAs.

Kessler et al. (2010) investigated the views of registered nurses toward support workers. The study concluded that in general nurses valued the support workers but there was some ambiguity around certain role boundaries reflecting this recurring theme in the wider literature.

iv) Views of service users on the role

A small number of studies have sought the views of service users on their interactions with HCSWs. Mackey and Nancarrow (2004), in their evaluation of OT assistant practitioners, included the views of a limited number of patients. The study revealed that patients could not differentiate between qualified and unqualified members of staff. Further to this patients had no concerns about staff members having formal qualifications as long as that member of staff was properly trained to do their job. There was a lack of understanding of the OT AP role among patients who did however value the ability of such workers to spend more time with them on a regular basis. One area noted as important by all stakeholders to the evaluation, including service users, was the supervision of APs, both formal and informal. Interestingly the APs themselves and their managers put forward the theory that APs are able to identify more easily with patients than registered staff as they tend to come from a similar background and do not use technical or complicated language.

More recently Kessler et al. (2010), in their study of HCAs in English acute hospitals (in medical and surgical wards), investigated the views of former patients by focus groups (n=94) and questionnaires (n=1651) in two separate phases of their study. The project identified three particular research questions in relation to the impact of HCAs from the patient perspective, namely whether patients could tell the difference between HCAs and nurses; whether patients developed a different type of relationship with HCAs and nurses; and if so, whether this difference mattered to patients.

The study revealed that in general, patients could not easily identify HCAs and in so doing differentiate them from registered nursing staff. Notwithstanding this difficulty however it appeared that patients in general were able to relate better to HCAs than nurses. Further it emerged that HCAs appeared better equipped than nurses in dealing with patients in certain circumstances, for example when patients were upset or confused. However patients in other types of situations still preferred to interact with a nurse rather than an HCA. The research revealed that when patients were able to distinguish between HCAs and registered nurses they reported a more positive care experience. This leads to the conclusion that it is important to help patients recognise HCAs and educate them as to their role so they are better informed about what member of a ward team to approach in a given situation. In this respect different types and colours of uniforms will not in themselves educate patients and the onus is on staff to introduce themselves and their particular role and responsibilities to patients.

22. Development into registered roles

There is an appetite for a section of HCSWs to develop themselves further into registered healthcare professionals.

Thornley (2000) in a survey of HCAs reported that 52% were interested in undertaking registered nursing training. McGloin and Knowles (2005) report on a training programme for critical care assistants of which, on completion of, all six went on to pre-registration nurse training. A survey of AHP HCSWs in Scotland revealed that 58% (207/357) would like to train as a qualified AHP (NES 2008). Similarly a quarter (8/31) of radiography APs in Scotland would like to train in time to become radiographers (NES 2009). Kessler et al. (2010) surveyed HCAs and found that across four acute trusts between 26% to 40% of them expressed ambitions to become registered nurses.

There a number of challenges identified in the literature associated with HCSWs training to become registered professionals. Thornley (2000) sought the opinions of HCAs and the main factor which would impact on them undertaking such training was related to financial considerations. On the positive side the ability to undertake training "on the job" while maintaining employment would mean that their salaries would be protected. This is particularly important for HCAs who receive low incomes and would not be able to sacrifice these to train full-time.

Gould et al. (2004), in the absence of hard evidence derived from the experience of HCAs undertaking pre-registration nursing programmes, identified a range of indicators associated with successful completion of pre-registration courses by nursing students. These indicators were predicted as being potentially transferable to HCAs for them to be successful in completing equivalent courses. A number of studies were reviewed to provide an insight into the type of individual most likely to attain registration and the support they may require to do so. Age and education were identified as being predictive factors in a study of four pre-registration diploma nursing cohorts at the same university (evidence cited from Kevern et al. 1999). Those most likely to be successful were mature women with previous care experience and particularly those in this

category who had recent academic study experience. In contrast younger students with little academic experience were significantly less likely to successfully complete the course. This has implications as the typical profile of a HCSW is a mature female who lacks formal qualifications and academic experience. This suggests that putting systems in place to support the learning of HCSWs is important particularly for those with no recent academic experience. In terms of the content of pre-registration nursing courses biological science was found to be most problematical for students to grasp ahead of any other theoretical teaching. Finally research into pre-registration nursing courses has highlighted the support required by older learners. This is particularly in relation to their domestic commitments as for example they would appreciate clinical placements nearer home. This is directly relevant to HCSWs who are likely to fall into this category of type of learner.

Hibbert (2006) undertook a qualitative study to investigate the factors that affect HCAs progressing to nurse training. Semi-structured interviews were held with all 28 strategic health authorities (SHAs) in England. The main factors identified as hindering HCAs progressing were: a lack of definition of the HCA role and the level they should be operating at; lack of financial support; low numbers of HCAs being able to access secondments into nurse training which are regarded as being the only viable affordable training option especially for mature HCAs; a lack of recognition of HCAs existing knowledge (e.g. NVQs) which is then duplicated during nurse training thus lengthening it unnecessarily; a perception from the SHAs that HCAs lacked confidence in pursuing academic studies, for example academic writing, completing assessments and in some particular subjects e.g. physiology (related to this was a perception that HCAs were concerned about studying in groups of young learners).

These barriers led Hibbert to make a series of recommendations to counter them: firstly to create a clear definition of the HCA role; secondly to evaluate financial support for HCAs undertaking nurse training; thirdly to establish transparent systems to improve access to opportunities (e.g. secondments) to undertake nurse training; fourthly HEIs should offer APEL for all HCAs.

Kessler et al. (2010) found an association between length of service as an HCA and desire to become a registered nurse. Those who were newer to the role (e.g. 2 years or less) were more likely to want to become a nurse than those with lengthy periods of service (e.g. 10 years or more). Similarly for those HCAs who held the desire to pursue a nursing career this ambition progressively diminished over time with a significant drop after 10 years service. Reasons identified for not wanting to become a nurse included: enjoyment of current HCA role; exposure to the downsides of nursing from working alongside registered staff; a perception of being too old to begin studying; lack of confidence in being able to undertake a nursing role with the responsibilities it entails; domestic pressures.

23. The role of the Assistant Practitioner

Interest in the Assistant Practitioner role has intensified in recent times as the futures shape of NHS workforce is examined and debated particularly in relation to the nursing component (RCN 2009).

The emergence of the assistant practitioner role has attracted a number of papers dedicated to its particular development (Nancarrow and Mackey 2005; Spilsbury et al. 2009; Benson and Smith 2006; Leach and Wilton 2008, 2009; McGowan and Campbell 2010a, b).

A useful summary of the experience of introducing the AP role over six years in NHS North West has been recently published (Mullen 2010). There are now over 2000 APs embedded and operating in this SHA and evaluations highlight four key characteristics that need to be present in an organization to help ensure the smooth introduction of the role. These are: a supportive team with strong role awareness; consistent support from management; clarity of role; regular clear communication within the organization.

The interest in APs is illustrated by a scoping exercise commissioned by Skills for Health which examined the role in depth across England (Mackinnon and Kearney 2009). The scoping exercise was a result of concerns from Skills for Health regarding variations in the role which led to it setting up a task group to develop core standards for APs in England. The report investigated the education and training of APs, assessed their job descriptions and identified the services and professions they support. The scoping was carried out by a combination of interviews with workforce leads in all England's 10 SHAs, assessment of AP job descriptions and a review of regional reports recounting the particular development of APs in that area.

Briefly the scoping exercise found that there was no common definition of APs and summarised the impact of the role that was evident this far. A total of over 60 AP roles were identified across England working in different service areas and associated with different professional roles. There were variations in entry qualifications required to enter the role. The authors identified two particular problems in relation to the operation of the AP role in practice. Firstly in some regions it was reported that senior staff were not completely comfortable with APs and are not sure how they should be used and what value to attach to their qualifications. Secondly there was feedback from some registered practitioners that they felt APs "diluted" their own professional qualifications. The scoping report notes that the role has been formalised faster in some parts of England than others with different emphasis on foundation degrees as an entry requirement. In practice the role itself differs in terms of its breadth. Given all this, the authors conclude that APs are still work in progress with lack of evidence as to the best approach for developing the role.

In order to develop the AP role, Skills for Health (2009) published a nationally transferable roles template which includes both common core competencies and role specific competencies.

24. Future developments

As well as considering the past experience of HCSWs, the literature also looks forward in considering what the future will hold for this fast developing group of NHS staff. The following gives an indication of issues that are emerging around the HCSW agenda.

Bosley and Dale (2008) report that more support staff will be required to relieve nurses of routine healthcare tasks. They suggest that up to an additional 74,000 HCAs will be required over the next 20 years.

In terms of regulation Sprinks (2009) reports that the Department of Health has no plans to introduce standards for HCSW training, but is developing education and training for NHS staff in five key job roles, including acute nursing support workers and maternity support workers.

Unison has been consulting key stakeholders to develop a national support worker induction programme and proposals for mandatory training (Adams 2010). Unison represents around 100,000 HCAs and is particularly active in advancing their agenda.

Similarly Unison is drafting its own set of HCA core competencies and specialist extras for areas including acute and mental health which it will present at its HCA conference in September 2010 (Clover 2010).

On the career front Spilsbury et al. (2009) identify a plateau effect for some kinds of HCSWs, in this case assistant practitioners, as there may be a lack of further opportunities for such individuals to continue their development unless they undertake training as a registered professional.

25. Limitations of the literature

In considering the evidence presented one should be aware of the limitations of the literature.

Kessler et al. (2010) summarised these thus:

“The literature on support roles in health provides insights into these issues: on the personal characteristics of support workers; on the malleability of roles; on their degraded nature; and on the ambiguity of nurses’ attitudes towards them. This literature has, however, been fractured, focusing on discrete issues and lacking an integrated analytical framework; it has also been uneven in terms of the issues covered and in the forms of investigation”.

Similarly the scale and type of studies from which the evidence is drawn has attracted criticism from Lizarondo et al. (2010). These are typically small-scale, quality improvement (case study) projects rather than larger multi-centre projects from which more transferable evidence can be drawn. The authors call for a mix of both approaches as each can provide valuable evidence.

26. Conclusion

A review of the HCA and HCSW literature presents a number of clear messages relevant to supporting education and training for these groups of healthcare staff. The main messages to emerge are as follows:

Definitions

- There is no universal definition of a HCSW and various approaches have been used to categorise this workforce. This lack of consensus has implications as summarised thus:

“the lack of suitable and uniform definition prohibits clear identification of the role played by support workers, their boundaries for tasks undertaken and prevents rigorous measurement of their service performance” (CAHE 2006).

Workforce numbers

- The different definitions of the HCSW workforce makes it difficult in establishing their precise numbers but it is clear they are a substantial and growing element of the NHS workforce.

Characteristics of the HCSW workforce

- The literature paints a fairly consistent picture of HCSWs’ demographics, work backgrounds and employment patterns. The demographics and caring commitment demonstrated by a large proportion of the HCSW workforce has implications for arranging and supporting their training and education.

Education and training for HCSWs

- The literature points to reliance on informal training for HCAs in earlier time periods with the introduction of formal qualifications for HCSWs in more recent times. Historically the education and training has been criticised for its lack of uniformity and consistency.
- A number of individual cases studies are presented which point to a number of lessons when considering the design of HCSW training. These lessons include: the value of consulting stakeholders and service users in their design; the need to equip participants with study skills; the importance of establishing and having support systems in place e.g. dedicated mentors.

Roles of HCSWs

- A recurring theme in the literature is the exploration of the roles of HCSWs. The investigation has included studies of job descriptions in an attempt to clarify what tasks and duties HCSWs undertake. The exploration of HCSWs roles reveals a number of related issues which impact on how these staff and their registered colleagues interact and work. These issues include blurring of roles between professional groups, boundary disputes and concerns over professional identity.
- The literature reflects variation and confusion over HCSW roles which has consequences for the registered staff they work with. The clear implication from this is that HCSW roles should be clearly defined and just as importantly clearly understood.

Regulation of HCSWs

- The literature embraces the long standing debate over the regulation of HCSWs outlining the rationale and benefits of moving in this direction. A consensus seems to have emerged from professional bodies in favour of such regulation. The move towards regulation has implications for standardising HCSW training and education.

Impact of HCSWs

- There is limited evidence regarding the impact of HCSWs on a variety of outcomes including clinical practice. However this has been recognised and is currently the focus of a Department of Health funded project in England for the assistant practitioner role. The evidence which does exist tends to be of debatable quality and anecdotal in nature. That said however a number of benefits resulting from the employment of HCSWs are put forward. The establishment of robust evidence as to the value of HCSWs will be important in consolidating these roles and maximising their potential.

Stakeholders' views on HCSW roles

- The operation of HCSWs roles in multi-disciplinary teams is reflected in the range of insights to the role provided in the literature. The views of HCSWs themselves, their managers, mentors, supervisors, registered staff colleagues and service users are all presented. In terms of HCSWs themselves, their views have been largely gathered in relation to their experience of training and education rather than on the role per se. However collectively all these stakeholder insights are helpful in defining the role and in the context of education and training in identifying means of supporting those undertaking such development.

Development into registered roles

- The literature suggests that a proportion of HCSWs have aspirations to develop their careers and also identifies barriers and enablers to them successfully attaining registered status.

Differentiation of HCSW roles in the literature

- The development of HCSWs on three career levels is beginning to be reflected in the literature. This is evidenced by the number of more recent papers dedicated to examining the assistant practitioner role. This complements the existing body of evidence on HCAs and support workers and gives a fuller picture of these respective HCSW roles and the relationship between them.

i) Recommendations for development of HCSWs

The systematic review (CAHE 2006), referred to throughout, conveniently summarises in the form of ten recommendations a number of the findings and themes echoed in this current literature review:

- 1 There is little doubt regarding the value of support workers in healthcare. There is historical and growing positive evidence for utilising support workers in healthcare.
- 2 Utilisation of support workers should be underpinned by clear definition of their roles and allocation of duties. Delegation of specific tasks to support workers should be documented to avoid confusion among other healthcare professionals.
- 3 Support workers can be utilised in a mixture of both direct and indirect roles. The process underpinning the composites of direct and indirect roles of the support worker will be influenced by local factors.
- 4 Service delivery models involving support workers should be underpinned by supervision and specific task delegation. Such a framework provides flexibility for local health services.
- 5 Support workers need to be supervised, especially during direct roles. As the literature does not shed any light on the framework for supervision, this provides the opportunity for local health services to develop geographic specific supervision models for support workers.
- 6 It needs to be recognised health professionals who are required to supervise also require training in supervision and ongoing support. Expectation that health professionals are aware of supervisory roles and are competent in the provision of effective supervision may lead to potential angst among stakeholders.
- 7 Clarifications on accountability for support workers interventions need to be established and documented. As the literature is unclear on the accountability of support workers and health professionals are fearful of litigations it is imperative such clarifications are provided to all stakeholders prior to health service provision.

- 8 Due to the nature of service delivery provided by support workers, evaluation of outcomes specific to the intervention provided by support workers will be difficult. However, global measures of outcomes from the perspective of all stakeholders are required. This can be undertaken via multiple approaches measuring both processes and outcome indicators at regular intervals e.g. audit, surveys, interviews, focus groups.
- 9 Increasingly the historical perception of support workers being “untrained” and “unqualified” is becoming less prevalent. There is an expectation that support workers are equipped with some core competencies and depending upon the specialties they work with, they should be equipped with additional skills, knowledge and attitudes. The training to secure these skills should be acquired in the form of formal and informal training. Presence of either of them in isolation is seen to be insufficient. While there are numerous avenues for training, there are several barriers in accessing these training opportunities. These barriers (such as cost of training, lack of adequate resources to relieve support workers to undertake training) need to be identified, recognised and subsequently addressed for support workers to access these training opportunities. Additionally, an environment which supports ongoing life long learning should also be created.
- 10 Support workers need to be supported. Support workers can be marginalised, mistreated and not recognised as being integral to the team. Such practices will lead to poor working environments and potentially poor quality care. Support workers need to be supported within and across the organisation at all levels, provided with clear career pathways and opportunities for promotions and be consulted in decision making processes, if they are equipped to do so.

ii) Areas for further research

The need to establish best practice in the introduction of HCSWs roles is reflected in the call for targeted research in a number of specific areas (CAHE 2006, adapted for all HCSWs from a review of rehabilitation support workers).

- Exploration of the growing place of HCSWs in healthcare and especially in the community, due to the gradual shifting of care from acute hospital setting into community rehabilitation settings
- Identification of a uniform definition of support workers in healthcare
- Provision of evidence of the roles and boundaries for support workers in healthcare
- Tests of the short and long term effectiveness of models of service delivery and outcomes of care provided by support workers in healthcare
- A focus on uniform core competencies for HCSWs in healthcare and the provision of a framework for competencies for support workers who specialise in working within specific disciplines
- Provision of evidence for innovative and effective training models for support workers
- Specific focus on the barriers to uptake of training of HCSWs
- Exploration of other healthcare staff’s perspective of HCSWs, their role as supervisors and their perception of delegating tasks to HCSWs
- Establish all stakeholders’ perspectives of support worker involvement in healthcare and achieve a consensus

Similarly Lizarondo et al. (2010) identify a range of information gaps in relation to AHP support workers that are worthy of investigation.

- How HCSWs are used to supplement, complement or replace registered staff
- The optimal mix of HCSWs to registered staff
- The impact on outcomes of changing roles in patient care

Finally the need to explore how registered nurses currently delegate and supervise HCAs was highlighted by Alcorn and Topping (2009).

Appendix 1

Examples of professional organisations' descriptions of HCSWs

British Dietetic Association

Dietetic Assistants work with registered dietitians in either a community or hospital setting. A dietetic assistant working in a hospital may, for example, be involved in assisting patients requiring special diets to choose from the hospital menu, collecting information regarding patients' intake and weight as and liaising with the dietitian regarding patients' progress. Within a community setting, dietetic assistants may work with the dietitian to assess the food and health needs of local residents and assist in enabling people to eat a healthier diet to prevent disease.

Chartered Society of Physiotherapy

The CSP refers to a support worker as one who is "delivering or supporting the delivery of physiotherapy under a registered physiotherapist or registered Allied Health Professional (AHP). This includes rehabilitation assistants, technical instructors, assistant practitioners, generic assistants, and any of 300 different role titles".

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