

# National Nursing RESEARCH UNIT



**KING'S**  
*College*  
**LONDON**

Moving forward with healthcare  
support workforce regulation

A scoping review: evidence,  
questions, risks and options

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## Summary

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This scoping review was commissioned by the Nursing and Midwifery Council of the United Kingdom in view of growing concerns that healthcare support workers are increasingly extending their role to undertake tasks previously undertaken by registered professionals but remain an unregulated workforce. Lack of regulation has meant that there is little control over entry to employment and little standardization of roles, competencies and education. A wide range of proposals currently exists for taking regulation of this workforce forwards, but with diverse approaches to choice of regulator and level of regulation required.

### *Objectives and methods*

The review had three objectives:

- Assess the evidence of risks presented to public protection from an unregulated healthcare support workforce and the evidence of benefits of regulation.
- Identify and consider key questions to be addressed in developing models of regulation.
- Make recommendations for further work required in taking healthcare support worker regulation forwards.

Methods entailed a review and appraisal of published sources including: government reports on extending regulation; position papers published by professional and statutory organizations; research on the healthcare support workforce; and examples of existing models of regulating healthcare care support workers. Discussions were held with an expert group.

### *Assessing risks and benefits*

It proved not possible to demonstrate unequivocally that an unregulated healthcare support workforce presents a risk to public safety and that this risk would be prevented by regulation. However, evidence indicates that there are instances in which lack of regulation has meant that employment as a healthcare support worker has been obtained by people who have been dismissed from a previous healthcare post for misconduct. Evidence also exists that healthcare support workers undertake tasks for which they are not trained; tasks which should be carried out under the direction of a registered practitioner are performed unsupervised; and deployment may depend on staffing levels, trust policies, and perceptions of registered staff rather than on qualifications and competence of healthcare support workers.

There is thus a strong case for regulation in that it would control access to employment, be accompanied by defined and nationally agreed competencies and mandatory, standardized training, and clarify the scope of individual support workers' practice.

### *Key questions in developing models of regulation*

The review identified six broad areas of questions to be addressed in developing models of regulation.

- Taking forward the assistant practitioner role in nursing

While the policy vision for the role of assistant practitioner is one of assisting and supporting registered practitioners and carrying out protocol-based tasks under the supervision of registered practitioners, there is evidence that in practice it is perceived as a substitutive and autonomous role. There is an urgent need for regulation of this group of staff but a decision needs to be made as to whether this should be as a senior support worker or as a second level qualified nurse.

- Developing roles and competencies

A key starting point in the process of regulation has to be a decision as to what roles the healthcare service requires its support workers to fulfil. These roles can then be developed as a hierarchy of posts, each with attached levels of responsibilities and competencies. Attention will need to be given to generic and specific competencies and the extent to which support workers are able to work across settings and between health and social care. Reviewing and drawing together all existing competencies, including those recently developed in the course of a Scottish pilot study of employer-led regulation, will provide the basis for developing a new framework; facilitate transition of staff between sectors; and help clarify issues of responsibility, delegation and accountability between registered staff and support workers.

- Choice of regulator and regulatory procedures

Views differ as to whether all healthcare support workers should be regulated as a single group under one regulator, most likely the Health Professions Council, or whether those working closely with a regulated professional group should be regulated by the same body. Thus in the case of support workers assisting registered nurses and midwives, professional organizations argue in favour of the Nursing and Midwifery Council as the appropriate regulator. The review considered the various arguments for and against each proposal.

Options have been advanced for a 'light touch' regulation for support workers on the grounds that full regulation is not proportionate to the level of risk that they might present. A licensing regime has been proposed as a possibility in this respect, probably under the aegis of an

existing regulator. The review suggested that risks to patient safety could be posed by: employer-based regulation on the grounds that only a national regulator could keep track of a mobile workforce; and by voluntary as opposed to compulsory regulation since the former might be avoided by people about whom there is most concern.

- Providing and accrediting education

Currently diverse organizations are involved in providing and accrediting education and training for healthcare support workers. To some extent, decisions about how to streamline and co-ordinate provision and accreditation will depend on choice of regulator. In the meantime, work can be undertaken on mapping existing educational provision onto the development of the new competency framework and thus gaps in current provision can be identified. Work could also begin on determining what provision should be made for continuing professional development and in developing on-site and off-site formats for training, since it will not be possible to take all members of the workforce requiring training off-site for this purpose. Evidence exists that resources of staff time and course funding are not always forthcoming and, once education is mandatory, clarity will be needed as to how and by whom these resources will be provided.

- Professional and workforce implications of regulation

Regulation of healthcare support workers is likely to be accompanied by the development of clear pathways between levels and a route into registered nursing. This, in turn, may have implications for recruitment and retention; information to this effect will be useful for workforce planning. Consideration will need to be given to meeting expectations that may be raised from regulation and associated career pathways and training.

- Risks from processes and outcomes of regulation

Risks may arise as a consequence of adopting one model of regulation rather than another. The review suggested that risks to public safety could be presented by an employer-led model of regulation as opposed to a national body model of regulation; and by voluntary as opposed to compulsory registration. Risks to the coherence of a career pathway for healthcare support workers could result from splitting the regulation of healthcare support workers between different regulators.

Risks may also arise from significant but unintended consequences of regulation. Regulation will define the scope of practice for each group of healthcare support workers and clarify the situations in which they can be employed. However, regulation could also lead to decisions to employ greater proportions of healthcare support workers in preference to registered practitioners, particularly at a time of economic constraint; research has indicated that this, in turn, may result in poorer patient outcomes.

### *Areas for further work.*

Recommendations for further work took the form of: decisions that are required to progress regulation; reviews and research to inform the process; actions that can be taken now; and questions that require further analysis.

Decisions include: making a commitment in principle to regulation; deciding how current work on protecting the title of nurse should articulate with developing a competency framework; and deciding whether assistant practitioners should be regulated as senior healthcare support workers or second level qualified nurses.

Reviews/research include: reviewing adverse incidents involving healthcare support workers to increase understanding of the risks that may be presented by continued lack of regulation; reviewing and drawing together all existing information on roles, competencies and education as the basis of a new framework; and research on the potential effects of regulation on recruitment and retention in the healthcare support workforce.

Actions include: all the organizations likely to be involved in regulation comprising a group under an independent chair to take forward initial work on mapping roles and competencies.

Analysis of specific questions includes: consideration of how to synchronize registration with a safeguarding authority and a regulatory body into a single process; and costs analysis of, for example, providing work-based and off-site training and apportioning costs of regulation between support workers, employers and central government.

### *Conclusions and implications*

Moving forwards with healthcare support worker regulation entails a large programme of work involving different groups of stakeholders. The review demonstrated the inter linked nature of much of the further work required and thus an holistic as opposed to a piecemeal approach should be adopted in taking this forwards.

Many of the decisions as to how the regulation of healthcare support workers will be progressed and associated actions will be the prerogative of organizations other than the NMC, especially the four devolved administrations. As the regulatory body for nursing and midwifery, however, the NMC has a central role in providing advice and initiating action. In the first instance it is suggested that the NMC:

- make the case with other stakeholders for healthcare support worker regulation
- initiate debates on the decisions to be taken
- take a lead in moving actions forwards
- commission further reviews/research and further analytical work either as a sole organization or in collaboration with other organizations.

- has a key role in initiating discussions to achieve a consensus among the various stakeholders involved on the way forwards.

## 1. Introduction

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Recent years have seen a growing emphasis on regulation and inspection with a focus on public protection. Regulation contributes to public protection by:

- Setting standards that an individual must meet to be admitted to the regulatory body.
- Setting standards of conduct and minimum standards of Continuing Professional Development (CPD) that practitioners must achieve in order to remain on the register.
- Providing a mechanism to take action against unacceptable standards of conduct by registered practitioners.
- Quality assuring the provision of education and training to ensure that it meets the minimum standards set by the regulatory body.

Regulation may serve other functions: it can provide a professional body to guide, support and recognize a group of workers; and it may also assist the process of workforce planning in making clear the legalised scope of practice for a given group of workers. A growing emphasis on regulation has been accompanied by efforts to identify the principles of effective regulation and concerns that extending a regulatory framework to include a new group of workers incurs administrative and cost burdens for employees, employers and the taxpayer.

The principles and processes of regulation are currently the subject of much debate in the context of healthcare support workers (HCSWs), a currently unregulated workforce. In the UK, many HCSWs provide direct services related to patient care and treatment, and support the work of registered nurses and midwives. Additionally many work with other professions and in social care settings. During the last decade their roles have been changing and some staff are now extending their role to include tasks previously undertaken exclusively by registered professionals. Moreover, future developments in nursing and midwifery roles may mean that more and more activities previously undertaken by professional staff may be devolved to HCSWs. The lack of statutory provision for the regulation of this workforce means however, that there is little control over entry to employment and little standardization of roles and responsibilities, of education and competence, and of title and pay.

There is also significant uncertainty about the number of people occupying such roles although it is clear that it is large. The NHS currently employs over 303,000 support staff for doctors and nurses and a further 60,000 support staff for scientific therapeutic and technical staff. A significant proportion of these will be in HCSW roles. The numbers outside the NHS are unknown but across health and social care sectors there are likely to be an even greater

number employed in a variety of settings including care homes and by providers of home care.

The changing nature of HCSWs' roles in healthcare has led to growing public and professional concern about the risks posed to public safety by their lack of regulation. These concerns have recently increased following the introduction into nursing of higher-level support workers in the form of assistant practitioners. In response to these concerns, the Nursing and Midwifery Council of the United Kingdom (NMC) commissioned the National Nursing Research Unit (NNRU) of King's College London to undertake a scoping review of the subject. As the organization responsible for the regulation of nursing and midwifery, the Council has a major concern with a group of workers increasingly involved in nursing and midwifery tasks. The regulation of healthcare support workers is however, a subject over which there are strongly held views and one in which many organizations have vested interests, including trade unions, regulatory bodies and employers. Recognition of this strength and diversity of view, contributed to the NMC deciding to commission an independent organization to review the evidence and consider the questions, risks and options that the subject presents.

The aim of this project is to assist the NMC in its deliberative processes concerning potential regulation of the healthcare support workforce and to this end has three objectives.

- Assess the evidence of risks presented to public protection from an unregulated healthcare support workforce and evidence of the benefits of regulation.
- Identify and consider key questions to be addressed in developing models of regulation.
- Make recommendations for further work required in taking healthcare support worker regulation forwards.

The term "healthcare support worker" is used to encompass a wide range of roles. Our concern here is with those HCSWs who work alongside nurses and midwives providing direct clinical care in institutional and community settings in the NHS and independent sectors. Throughout the report, the term healthcare support worker includes those who support the work of registered nurses and those who support the work of registered midwives. In discussing the evidence, when reference is made to nursing and nurses this does not include midwifery and midwives unless explicitly stated.

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## 2. Methods

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The work was undertaken through a review and appraisal of published sources. These were assessed for evidence that an unregulated healthcare workforce might present a risk to public safety and for evidence of benefits of regulation, and assessed in terms of implications for developing key questions in taking regulation forwards. Published sources included:

- Government reports on the question of extending regulation.
- Position papers on regulation generally and regulation of HCSWs in particular.
- Research studies of HCSWs' profile, role, content of work, training and views about regulation.
- Examples of models of regulation of healthcare support workers.

The key sources used are briefly described below.

### *Government reports*

The project draws on existing government work on regulation: in particular, a pilot project for employer-led regulation of HCSWs (NHS Quality Improvement Scotland 2008); a consideration of regulation of the social care workforce (DH 2009a); and an investigation into extending professional and occupational regulation generally (DH 2009b).

### *Position papers by organizations*

Proposals for the regulation of healthcare support workers have been put forward by the Royal College of Nursing (RCN 2007, 2009) and by Unison, the trade union to which many HCSWs belong. The NMC has held a number of seminars on the subject, most recently in 2008 involving 143 stakeholders from across the UK and the views of the Health Professions Council (HPC) are available in a report of consultations undertaken as part of a Department of Health review of regulation (DH 2006b).

### *Research studies of UK healthcare support workers*

Recent years have witnessed a growing volume of studies on the healthcare support workforce encompassing a wide range of methods and undertaken primarily in NHS settings. Studies reviewed for this project included those that focused on: the profile of HCSWs; the content of their work; the extent to which they were supervised; the nature of education and training; perceptions of risks that they might present to public safety; career opportunities as an unregulated workforce and views about regulation. The aims and methods of a number of core significant studies are briefly summarised here. We have retained the original

terminology used for HCSWs including Nursing Auxilliaries (NAs) and Health Care Assistants (HCAs).

Thornley (2000) reports on two national surveys undertaken in 1997 and 1998 respectively. The 1997 study included a national survey of trust human resource or personnel managers (response rate 80%) together with a national sample survey of HCAs (26-33% response rate). The survey work was complemented by in-depth case studies in 10 trusts and interviews with HCAs and managers or Unison lead negotiators in 32 trusts. The 1998 study also entailed a national survey of HCAs (22-29% response rates). Thornley (2000) observed that HCA response rates are difficult to judge as figures on base numbers of staff are not reliable.

In 1997, the Department of Health commissioned a survey of the roles, functions and responsibilities of support workers employed in healthcare settings with the aim of considering the extent of regulation that might be appropriate for this workforce; findings were not reported until some years later (Saks & Allsop 2007). The study focused primarily on the perceptions of Chief Executives; questionnaires were sent to all these staff in key organizations providing health in the public, private and independent sectors (15% response rate) and supplemented by focus groups, regional workshops and interviews with other key stakeholders.

Spilsbury and Meyer (2004) undertook a mixed methods design to generate in-depth accounts of HCAs' work in one NHS hospital. Semi-structured interviews were held with 33 HCAs, participant observation was undertaken with a purposive sample of 10 HCAs and four focus groups were held with various grades of registered nurses. The study explored: the skills and experience of HCAs; content of their work; how their work is negotiated in practice; the extent to which it is supervised; and the nature of relationships between HCAs and registered nurses.

Knibbs et al (2006) also explored the work of NAs with a study in two NHS acute trusts of staff with NVQ level 3, NVQ level 2, and those without formal certified training. Questionnaires were sent to all the NAs in all the clinical wards that employed four or more NAs (n=570, response rate 34%) and 51 ward managers (response rate 69%). The study focused on: NAs' profile; tasks undertaken; working environment and satisfaction; issues surrounding delegated duties; and aspirations to become a registered nurse. Ward managers were questioned about: ideal and actual proportions of NAs to RNs on their wards; values of NAs; training capacity; and tasks undertaken. These topics were also explored through focus groups of NAs and semi-structured interviews with managers.

The work of maternity support workers were the subject of a national study by Sandall et al (2007) in which telephone interviews were held with key personnel in a representative sample of NHS trusts providing maternity care in England; the sample included 98 acute

trusts and 10 primary care trusts. The study aimed to provide a systematic overview of the numbers, scope and range of practice, level of training, skill mix and service arrangements.

For several years, Unison has undertaken annual surveys of its HCA members; this report includes findings from the 2008 survey (Unison 2008). A sample of 10,000 was drawn from the 100,000 HCA members of the union (response rate 13.5%). Most respondents worked in the NHS; information was obtained on: HCAs' profile and views on several aspects of their work, including views about regulation.

A three-year project by Kessler et al, due to report in July 2010, has explored the profile, role, experiences and aspirations of support workers and considered their impact on a range of stakeholders. The first phase of the study involved interviews with key national stakeholders on strategic intent and policy development while the second phase took the form of interviews in 29 wards across four hospital sites with nurses, support workers (mainly at bands 2 and 3) and patients. Findings were combined with those from ward observations. Preliminary findings have been made available at a conference presentation in March 2010 (Kessler et al 2010).

The relatively new role of assistant practitioner has been the subject of a two-year study with a draft final report submitted to the funding body in May 2010 (Spilsbury 2010). Findings made available to date include: a mapping study of current and planned introduction of the role in all acute NHS hospital trusts in England (Spilsbury et al 2009); an analysis of assistant practitioner job descriptions in all clinical divisions in one of these trusts with a focus on the extent to which the job is described as assistive and whether descriptions have been expanded to encompass more substitutive or autonomous characteristics (Wakefield et al 2009); and an in-depth study of the impact of ward-based AP roles on service delivery and the workforce (Spilsbury 2010).

Taken together, the above studies provide a considerable amount of information about healthcare support workers that is germane to the objectives of this project. However most relate primarily to NHS staff and much less information is available about HCSWs working in the independent and voluntary sectors.

### *Models of regulation for healthcare support workers*

Two models of regulation for healthcare support workers were reviewed in terms of their implications for taking HCSW regulation forwards on an UK-wide basis: first the Scottish-led pilot project of employer-led regulation; and second, licensing schemes for nursing aides in the US.

The Scottish pilot project of employer-led regulation was a two-year project (January 2007 to December 2008) that sought to test four key elements of a potential regulatory system: a set of induction standards focusing on public protection: a code of conduct for HCSWs; a code

of practice for employers; and a centrally held list of names of those HCSWs who met the standards (NHSQIS 2008). The project was undertaken in three NHS Boards; participants (470) included several groups of support staff; those working with allied health professionals, those working with nurses and midwives, pharmacy staff, ancillary and catering staff. The focus was on employer-led initiatives to improve skills and take up of a voluntary occupational register. An evaluation of the project was undertaken concurrently by the Scottish Centre for Social Research (Birch and Martin 2009). The aim of the evaluation was to assess the implementation, operation and potential of the pilot project. A mixed methods approach was adopted that included: stakeholder interviews; individual case studies; surveys of participants, non-participants, and supervisors; and desk research. The evaluation comprised both formative and summative aspects (Birch and Martin 2009).

In the US, a national licensing model of regulation has been employed for support workers who work in nursing facilities and known as certified nurse assistants (CNA). The licensed certified nurse assistant is of relevance to deliberations about HCSW regulation in the UK, since licensing is one of the options proposed for regulation of currently unregulated groups (DH 2009b).

### *Discussing preliminary work with experts*

At the beginning of March, preliminary work was presented at a meeting held under the auspices of the Chair of the NMC (Professor Tony Hazell). The audience represented many of the organizations for whom the question of healthcare support worker regulation is of considerable importance and included the four health departments, the defence services, the Royal College of Nursing, Unison, the Council of Deans, patients' organizations, and the NMC. Findings from the draft report were presented to the same expert group at the end of the project and to a meeting of the NMC Council. Discussing the work with a group of experts and with council members proved extremely valuable in informing our thinking and is reflected in this report. However, the views expressed and conclusions drawn are those of the authors and not necessarily those of the participants at the three meetings.

### *Use of source material and report structure*

The source material has been drawn on as follows: the context in which healthcare support worker regulation is being considered is discussed in Section 3 and the research evidence reviewed in Section 4. The implications of the research evidence relating to objective 1 (assessing risks and benefits) are discussed in Section 5. All the source material is drawn on for the project's second objective - developing the questions to be addressed in taking regulation forwards (Section 6). Areas for further work, the project's third objective, are identified in Section 7 and conclusions and implications are drawn together in Section 8.

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### **3. The context: the healthcare support workforce and current perspectives on regulation**

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This section reviews the context for healthcare support workforce regulation by providing a brief profile of this workforce and reviewing organizational perspectives on regulation generally and healthcare support regulation in particular.

#### **3.1 The healthcare support workforce**

Most studies indicate that the large majority of HCSWs are women; recent figures include 80% (Thornley 2000); 89% (Unison 2008); and 90% (Kessler et al 2010). Within the NHS, 83% of those with the job title HCSW or Healthcare assistant are women<sup>1</sup>. They tend to fall into older age-groups: Thornley (2000) reports that the majority are over 30 and nearly half over 40; Unison (2008) that 7% were aged between 18 and 34, 21% between 35 and 44, and 72% between 45 and 65; and Kessler et al (2010) with more than half aged 40 or over. Reported proportions from black and ethnic minority groups vary: from 4% (Unison 2008) to 22% (Kessler et al 2010).

Substantial proportions (up to two fifths) work on a part-time basis (Thornley 2000, Kessler et al 2010). Most have family commitments: Kessler et al (2010) report that 79% had a partner, 74% had children and 51% had children at a local primary school. Thornley (2000) reports that most have worked as healthcare support workers for a considerable period (around half for over five years and a third had between 10 and 28 years experience) and that most had had informal and/or formal caring experience prior to work as a HCSW.

Although there have always been unregulated staff working in hospital wards, the traditional grade of nursing auxiliary or nursing assistant achieved formal recognition in 1955 and expanded rapidly thereafter, particularly at times of shortages of qualified staff and students (Thornley 2000, McKenna et al 2004). The 1990 NHS and Community Care Act introduced a new grade of healthcare assistant into which nursing auxiliaries were gradually incorporated. The move of nursing education into higher education (Project 2000) provided the impetus for this new grade of support worker whose role was envisaged as maintaining the environment in which direct care was given by undertaking a range of ancillary duties (UKCC 1986); increasingly however, they became involved in nursing tasks as well. The then Conservative government pushed ahead with proposals for a National Council for vocational qualification certificates for this grade and intensified initiatives on increasing their proportions in the nursing workforce skill mix (Thornley 2000).

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<sup>1</sup> Data from NHS information centre iView May 2010. Includes all staff classified as HCSW and Health Care Assistants.

The 2002 Wanless report advocated expanding the numbers of HCSWs in the NHS in order to meet health service demand (RCN 2007) and this was re-iterated by the Department of Health report on Modernising Nursing Careers (DH 2006a). Today, healthcare support workers are employed in general, mental health and maternity services and work in a diversity of clinical areas in institutional and community settings. In addition to the NHS, HCSWs are employed in a variety of small organizations in the independent and voluntary sectors.

In the NHS, HCSWs are allocated to bands on the Agenda for Change framework; band 1 as the initial level entry post, followed by band 2 and band 3 often referred to as senior healthcare assistant/support worker. More recently a new higher level of support worker has been introduced with the band 4 assistant practitioner (AP); a post sometimes referred to as an associate nurse when based in the nursing workforce. The majority of HCSWs hold band 2 (54%) or 3 (41%) posts with just 4% at band 4<sup>2</sup>. Grading of staff in the independent and voluntary sectors does not correspond with the NHS banding.

The AP role was introduced as part of the NHS modernization programme to complement the work of registered professionals in hospital and community based care. As Spilsbury et al (2009) observe, the initial policy vision was that APs have a remit to deliver protocol-based care that includes work previously undertaken by registered practitioners, such as catheterization and venepuncture, and that this be undertaken under the direction and supervision of a registered practitioner. The aim of this new post is to be supportive and assistive of registered professionals enabling them to focus on achieving better patient outcomes through for example, care planning and supervisory activities (Wakefield et al 2009). The post of assistant practitioner is not however, universal across the UK: for example Wales has band 4 assistant practitioners in the therapies and radiography but not in nursing. The extent to which band 4 assistants can substitute for midwives is limited as the title of midwife is protected and midwifery tasks cannot be delegated to an autonomous practitioner below the level of a registered midwife.

Although not subject to statutory regulation, the healthcare support workforce does already enjoy a measure of regulation in the form of safeguarding checks and opportunities for education and training. Minimum requirements to obtain employment as a HCSW have been employer-led, such as CRB checks, but have been variable; now however they will be encompassed by the new vetting and barring schemes: the Independent Safeguarding Authority covering England, Northern Ireland and Wales and the Scottish Protection of Vulnerable Groups Act (DH 2009b).

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<sup>2</sup> Data from NHS information centre iView May 2010. Includes all staff classified as HCSW and Health care Assistants.

Educational opportunities primarily take the form of National Vocational Qualifications (NVQs) which were introduced in an attempt to standardize HCSW training (McKenna et al 2004). NVQs are primarily designed to give recognition and accreditation for existing competencies and skills, acquired either by experiential learning or specific on or off the job training, and are verified by internal and external assessors from the nursing, midwifery and educational professions. Available at levels 1 to 5, NVQ qualifications have no entry requirements and can be taken over a period of years. Acquisition of an NVQ is not a permit to practice but identifies the holder as competent to undertake a range of duties in a care environment (Thornley 2000, McKenna et al 2004). Assistant practitioners do require formal training although this is not standardized in that some qualify through a one-year NVQ and others through a two-year foundation degree (Spilsbury et al 2009). A further corollary of lack of regulation is indicated by the fact that pay is largely unlinked to NVQ attainment (Thornley 2000) and there is no direct correspondence between band level and NVQ level (Kessler et al 2010).

### **3.2 Current perspectives on regulation relevant to healthcare support worker regulation**

There is a longstanding view amongst government health departments, professional organizations and trades unions that the healthcare support workforce should be regulated in some way, albeit with varying agendas and differences over preferred options for the way forwards. Furthermore, a move to regulation has been recommended by work commissioned by the DH NHS Next Stage Review (Maben and Griffiths 2008) and advocated in the recent Prime Minister's Commission on Nursing (Department of Health 2010).

#### **Government perspectives on regulation of support workers**

There have been calls for consideration of regulation of support workers since 1999 and this found expression in the NHS Plan of 2000 with a commitment to consider proposals to this effect (DH 2006b). In 2004, the Department of Health carried out a public consultation on the subject involving a wide range of stakeholders on behalf of England, Wales and Northern Ireland with a parallel consultation by the Scottish Executive Health Department (DH 2006b). The outcomes of the consultation were reported in the Department of Health 2006 review of the regulation of the non-medical professions (DH 2006b). The majority of respondents favoured regulation with varying views as how this should be achieved. There was a roughly 70%/30% split in favour of the Health Professions Council regulating support workers but with many nurses and professional bodies preferring to regulate those support workers who worked with their own professions. Some representatives favoured employer-led regulation as opposed to regulation by a national statutory regulator. There was no clear consensus on who should be involved in setting standards and who should own them but a desire for a collaborative approach in this respect. The report noted that any decision on healthcare support worker regulation should await the outcome of the Scottish pilot scheme of

employer-led regulation in the NHS. This reported in 2008 and details are included in the review of models section (4.5).

2007 saw the publication of the Department of Health's White Paper on the regulation of the health professionals in the 21st century (DH 2007) and this called for further work to be undertaken on extending professional and occupational regulation to groups that were not regulated at that time. The resulting publication set out the Department of Health's views on the principles of regulating such groups (DH 2009b) and these had also been explicated to some extent in a previous report on extending regulation to the members of the adult social care workforce (DH 2009a).

As set out in the DH (2009a) document, regulation must be based on the following principles:

- There must be evidence that regulation would improve public safety and add benefits that are not achievable by non- statutory means;
- The risk associated with practice should be proportionate to the costs and impact of regulation;
- There must be clarity about how regulation fits with other standards and mechanisms, including system governance approaches; and
- Alternative models of regulation that could bring the same benefits must also be examined to inform decision-making about the most appropriate way to proceed.

These principles were reiterated in the report on extending regulation to non-regulated groups (DH 2009b). It concluded that a menu of regulatory options should be considered in deciding on whether and how a particular group should be regulated; these included:

- no regulation needed
- voluntary self-regulation
- employer-led regulation (drawing on the Scottish pilot)
- a licensing regime
- a workforce passport (for all NHS staff).

The criteria for deciding on which option might be appropriate for a given group of workers was summarised in an algorithm which focused on assessing the extent to which they presented a risk, considered in terms of whether they undertake prescribed tasks and whether or not they are supervised when doing so (DH 2009b).

## Views of professional organizations

The RCN has long advocated that all healthcare support workers should be regulated (RCN 2007). In their view, there is greatest urgency in regulating assistant practitioners (most are at band 4 and some at band 3) on the grounds that they are the group most likely to be undertaking clinically invasive nursing procedures that may pose a risk to public safety if undertaken by unregulated practitioners (RCN 2007). The RCN has proposed that bands 3 and 4 should be regulated by the NMC with consideration given to employer-led regulation for bands 1 and 2.

The RCM has advocated regulation for maternity support workers on the grounds of improving the quality of maternity care (Sandall et al 2007). A national framework is advocated for entry requirement, training and competencies; and pay and appropriate arrangements for governance. These in turn need to be determined by job profiles for roles in different settings (Sandall et al 2007). The importance of a common framework of regulation for nursing and maternity support workers is underlined by the fact that staff on lower bands may work in either nursing or maternity services.

Unison, the trade union to which many HCSWs belong, has argued that all HCSWs should be regulated; that they should be seen as a coherent occupational group and that the Health Professions Council would be the most appropriate regulator in this respect; a view which is shared by the Health Professions Council. If a group is to be identified as a higher priority than others, then Unison consider that staff working in the community and in nursing homes with few registered staff pose the greatest risk to public safety.

## Developments in other professions

Other professional groups have opted for regulating their support workforce on a uni-professional basis. Thus the General Dental Council regulates dental nurses and dental hygienists along with dentists and the General Optical Council regulates a range of staff employed in optical care (RCN 2007). Discussions about whether to regulate the social care support workforce, the group most closely allied to the healthcare support workforce, have also been couched in terms of uni-professional regulation; in this case by the General Council for Social Care (GCSC), the body responsible for regulating qualified social workers (DH 2009a). With professions that fall under the regulatory aegis of the Health Professions Councils, for example physiotherapists, there have been suggestions that their associated support workforces would also be regulated by The Health Professions Council and be included on a part of the register for physiotherapists (RCN 2007).

Discussions about regulation of the social care workforce, as with the healthcare support workforce, have considered which groups present the greatest risk to public safety and

should therefore be a priority for regulation. In this respect, home workers were deemed to be the highest priority since they usually work unsupervised in people's homes. Their need for regulation was contrasted with that of residential workers; this group work in managed environments with other staff and while it was recognized that they can compromise care, it was thought that the presence of other staff might lessen the risk to public safety. Initial consideration of the risks, costs and benefits of the case for registering home care workers suggests that conventional models of statutory regulation may be disproportionate. However, it was anticipated that the GCSC would open a register of home care workers in 2010, initially on a voluntary basis, and options for registration of additional groups of social care workers are to be kept under review.

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## 4. Research evidence

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The research evidence reviewed is presented here, categorised as follows:

- Regulating access to HCSW employment.
- Nature of HCSWs' work: content; training and supervision; and deployment.
- Experiences of introducing the assistant practitioner post.
- HCSWs: experiences of accessing education, career plans and views about regulation.
- Models of regulation and their benefits.

### 4.1 Regulating access to HCSW employment

Lack of regulation for HCSWs means that there is no system in place whereby checks can be made on an applicant's background or level of competence and thus an assessment made of whether they are suitable to undertake specific work with vulnerable patients. A survey of Chief Executives of health service organisations in the public and independent sectors ( Saks and Allsop 2007) showed that employers did use pre-service checks but that difficulties had been experienced in identifying unsuitable individuals and excluding them. The Chief Executives also reported a range of measures to maintain standards of care by HCSWs including: line management, regular supervision, staff development opportunities, and code of ethics/practice. However respondents had concerns as to whether these checks and measures were consistently applied and robust enough to protect the public. Although serious cases of abuse were rare, 36% thought that unregulated HCSWs presented a small but significant risk to the public, 26% thought the risk was moderate and 26% that it was considerable ( Saks and Allsop 2007).

While no studies were found that have tried to quantify the total number of incidents in a given period of time in which care by HCSWs has had an adverse effect on a patient, there have been some well publicized individual cases where patients have been subject to abuse by HCAs in nursing and residential homes (McKenna et al 2004, Saks and Allsop 2007). There have also been well documented instances of a lack of central regulatory control mechanisms enabling an HCSW who has been dismissed from one employer following negligent practice or misconduct to commence employment in another setting shortly afterwards and of nurses who had been removed from the nursing register to begin working as an HCA, particularly in the private nursing home sector (McKenna et al 2004).

## 4.2 Nature of HCSWs' work: content, supervision and deployment

A considerable amount of evidence now exists on the work of HCSWs; the extent to which they are trained and/or supervised and factors affecting the way in which they are deployed in clinical settings. Some studies provide information on HCSWs as a whole, others differentiate between the work of staff at different bands. Assistant practitioners are considered separately in Section 4.3.

### Content of work

Most studies show that HCSWs are still undertaking their traditional tasks of direct patient care in the form of bathing and feeding patients and undertaking a range of other work such as cleaning, clerical work and acting as messengers (Thornley 2000, Bridges et al 2003, Knibbs et al 2006, Spilsbury and Meyer 2004). HCSWs reported that involvement in direct bedside care meant that they spent more time with patients than registered nurses and that this provided more opportunities to talk and develop informal and empathic relationships with them (Spilsbury and Meyer 2004, Kessler et al 2010). Spilsbury and Meyer (2004) report that HCSWs were thus able to gather information about patients and pass this onto registered nurses but that there were no systems for formal transfer of this knowledge.

These studies showed that HCSWs were also involved in a range of tasks traditionally undertaken by registered nurses, who were now spending more time in activities such as care planning, liaison and discharge planning. Details varied but tasks reported most frequently included: catheter care, venepuncture, wound and dressing care, monitoring diagnostic machines, setting up infusion feeds, giving injections, preparation of medication and administration to patients, systemic observations, ECG tracings, taking blood samples, removal of equipment during invasive procedures, liaising with medical staff, relating medical information to relatives, and developing and updating care plans (Thornley 2000, McKenna et al 2004, Spilsbury and Meyer 2004, Knibbs et al 2006, Kessler et al 2010). Tasks undertaken by maternity support workers included monitoring of women using cardiotocograph machines and providing advice on parenting skills and breast feeding (Sandall et al 2007).

Another area of additional duties was helping to train student nurses and providing newly qualified nurses with advice and support (Thornley 2000, McKenna et al 2004, Spilsbury and Meyer 2004). In interviews held with HCSWs, many mentioned that the tasks they perform in practice were done so unofficially or informally and for that reason did not report them (Thornley 2000); suggesting that surveys are more likely to under report than over report the extent of HCSW involvement in nursing and midwifery tasks. Other studies have shown the potential for roles to drift from purely supportive functions where direct supervision might seem unnecessary into roles such as discharge planning and care coordination which clearly impinge upon professional roles (Bridges et al 2003).

## Training and supervision

It could of course be argued that HCSWs undertaking the above tasks had been shown or formally trained to do so and, depending on the nature of the task, were supervised by qualified practitioners when carrying them out. The studies reviewed did not provide detailed analyses of whether individual HCSWs had been trained to undertake all aspects of their current role and were supervised when necessary, but findings suggest that that in some instances at least, this was unlikely to be the case.

Turning first to training, then figures reported in the Unison 2008 survey indicate that this is not universal; the 2003 survey had shown that 71% had or were taking NVQ or SVQ qualifications and that by 2008 this had only risen to 72% (level 2 for 35%, level 3 for 62% and level 4 for 1%). Kessler et al (2010) report considerable variation in the trusts in their study: for example in one of the four trusts, 23% of support workers held an NVQ 2 and 17% an NVQ 3 whereas corresponding figures in another were 70% and 30%. Knibbs et al (2006) found that although there was a tendency for trained support workers (NVQ or equivalent) to be involved in the more invasive procedures, there was also evidence of HCSWs performing such tasks who were not NVQ qualified.

Over half of HCAs in the study by Thornley (2000) reported that little or none of their work is supervised with only a small minority reporting that all or most of their work is supervised. Likewise Bridges et al (2003) found HCSWs working unsupervised in hospital settings. Spilsbury and Meyer (2004), observed HCAs working predominantly alone with their work largely unsupervised. When interviewed, these HCAs said that although they were supposed to work with registered nurses, the latter did not have sufficient time to do so and so the HCAs just 'got on with it'. Registered nurses and HCAs taking part in this study regarded this situation as having implications for patient care safety. Respondents to Sandall et al's survey reported that support workers were sometimes left in charge of a shift, that little or none of their work was supervised and that they were spending increased proportions of time in non supervised direct patient care (Sandall et al 2007).

## Factors affecting deployment of HCSWs in clinical settings

The studies by (Spilsbury and Meyer 2004) and Knibbs et al (2006) indicated that tasks undertaken by HCSWs could vary according to circumstances, other than their experience and training. For example, Spilsbury and Meyer found that registered nurses asked HCSWs to undertake tasks outside their designated role when the ward was very busy or inadequately staffed, such as blood glucose monitoring or to assist in an operating theatre. However, HCSWs were not financially rewarded for taking on this extra level of responsibility and when the ward was not busy they were not required to continue provision of care at this level. Both studies reported that HCSWs were allowed to carry out certain tasks when working in one trust but then not allowed to do so when moving to another; Knibbs et al

(2006) also found that policies could even vary between departments in the same hospital. So in this sense, it was argued that HCSWs are exploited: on the one hand they may be used in ways beyond the formal expectations of their role; on the other, they were not always able to use their available skills, experience and qualifications. Unison's 2008 survey found that 81% of respondents felt that there had been a deterioration in staffing levels since 2007 and so pressures for HCSWs to extend their role beyond formal expectations may intensify.

Other criteria for deployment of HCSWs have also been revealed. Thus Knibbs et al (2006) found that ward managers felt more confident about deploying staff whom they knew and were aware that registered nurses often lacked information as to whether the support worker had adequate skills for a task. HCSWs often took responsibility for informing registered nurses and ward managers about whether they were competent to perform certain tasks; the criteria they employed included qualification levels and experience on the job, but also self imposed boundaries particularly in relation to invasive procedures e.g. catheter removal. More recently Kessler et al (2010) report that older support workers are happy to focus on patient contact through washing and dressing etc while younger staff tend to prefer involvement in more technical tasks such as observation, blood glucose monitoring and wound dressings.

### **4.3 Assistant practitioners**

Studies of the relatively new role of assistant practitioner are represented primarily by the work of Spilsbury and colleagues (Spilsbury et al 2009, Wakefield et al 2009, Spilsbury 2010). The role has also been given some consideration in the specific context of mental health nursing (Warne and McAndrew 2004).

A national census in early 2007 indicated that just under half the trusts in the 10 English Strategic Health Authorities had introduced APs and just over a fifth were planning to do so; deployment was concentrated in medical and surgical wards although some trusts were focusing on placing APs in specialist areas. Respondents in some participating trusts reported that there was uncertainty over the difference between the roles of bands 3 and 4 workers, while others reported that their band 2 and 3 post holders were already undertaking work now identified as level 4 work (Spilsbury 2009). Resistance to introducing the role, however, was found in 32% of trusts with reasons including: no perceived need for the role; lack of evidence of effectiveness; financial constraints; and concerns about professional jurisdiction and patient safety. In relation to patient safety, reluctance to introduce the role was on the grounds that APs were expected to undertake highly skilled invasive procedures but were not registered or regulated (Spilsbury et al 2009).

The tensions inherent in the national policy vision of the AP role as assistive and supportive and undertaken under supervision by a registered practitioner was further indicated in Wakefield's et al (2009) analysis of the job descriptions of AP roles in one hospital trust.

While some job descriptions only included tasks that the researchers categorised as assistive and or supportive; others includes tasks that were substitutive and/or autonomous. This confusion over AP's roles was further evidenced in the in-depth study of 3 acute trusts each with a different organisational interpretation of the role as: a generic role crossing professional boundaries; a second level nursing role (comparable to State Enrolled Nurses); and a role to lead nursing support staff. Concern over the assistant practitioner's role in mental health nursing has focused on the difficulty of introducing a new direct care giving role at a time of perceived lack of clarity of the purpose and role of mental health nurses themselves (Warne and McAndrew 2004).

#### **4.4 Education, career plans and views about regulation**

An important perspective in the whole question of HCSW regulation is how these staff themselves view their training and career opportunities and the desirability or otherwise of regulation.

##### **Accessing education and career opportunities**

There was some evidence that HCSWs were not always able to access the NVQ training they desired. Thornley (2000) found that both HCAs and NAs demonstrated a high degree of interest in acquiring NVQs and the potential recognition that these may provide; however, they often had to campaign hard individually, or collectively through Unison, to get access to NVQ accreditation. Some with NVQ level 2 felt that they were prevented by lack of resources or management disinclination from accessing an NVQ 3 and so some had opted for paying for access to NVQ training themselves. Unison's (2008) survey showed that two thirds of respondents were dissatisfied with the level of training offered to them and that two thirds of this group believed it was insufficient to enable them to reach their potential.

Recent developments however, have indicated that more formal schemes have been implemented for access to training and career progression to band 4 assistant practitioner posts. Some Directors of Nursing in the Spilsbury et al (2009) study identified the band 4 role as a route for career progression for support staff, particularly those already working in the organization and some trusts reported that this was already happening. A specific example is provided by University College Hospital London, as reported in a Royal College of Nursing discussion paper (RCN 2009). The scheme entailed ward sisters and charge nurses developing healthcare assistants within their ward teams over a two-year period accompanied by a higher education programme that led to a foundation degree. Following successful completion of the degree, they were then integrated back into their ward team at band 4 and entitled nursing assistant practitioners. The model was very much about developing assistants to nursing from the existing healthcare support workforce within each ward team (RCN 2009).

Several studies suggest that a proportion of the HCSW workforce aspire to registered nurse training. Just over half of those (52%) in the 1998 survey expressed this view (Thornley 2000); other studies report smaller proportions: 35% (Knibbs et al 2006); 41% (Unison 2008) and a range from 26% to 41% across four trusts (Kessler et al 2010). Gaining access to training was contingent on various factors: encouragement from the ward manager and to a lesser extent determination on the part of the NA (Knibbs et al 2006), and obtaining a secondment so that salary levels and employment rights could be maintained (Thornley 2000, Unison 2008). Aspirations varied by sub groups within the HCSW workforce: higher proportions of younger than older groups wanted to become nurses (Unison 2008, Kessler et al 2010) and a higher proportion of respondents from black and ethnic minority than white groups (Unison 2008).

### Views about being regulated

Two recent surveys of HCSWs show that the majority are in favour of regulation: 79% in Unison's 2008 survey and 99% in a MORI survey conducted for the RCN (RCN 2007). Eighty three percent of Unison's respondents thought one or more of the current regulatory bodies should act as regulator and whereas over three quarters thought any regulatory framework should be UK wide, 19% wanted to see the framework devolved to each country. The MORI survey (RCN 2007) found that the most popular model (51%) was a combination of the NMC and local employer, followed by the HPC and local employer (15%) and solely the NMC (18%) or HPC (6%). If regulation was to be introduced, four fifths of the Unison (2008) respondents felt that a phased approach should be taken with those considered a potential risk included first. Views were divided over whether regulation should initially be introduced on a voluntary basis with 53% in favour and 42% opposed (Unison 2008).

An employer's perspective on regulation emerged from Saks and Allsop's (2007) study of Chief Executives. Most respondents favoured regulation: more than three quarters supported direct regulation overseen by a supervisory body and a third thought employers should have more responsibility for regulation. The majority wanted a mandatory, not a voluntary register, formal education levels and agreed threshold levels for training and qualifications. There were concerns, however, that a register would introduce rigidities into deployment of support workers, supply could be curtailed if minimum qualifying standards were introduced and costs could be prohibitive for employers and employees. The problem of cost is also of concern to HCSWs themselves: 54% of the Unison 2008 respondents were opposed to HCSWs paying a registration fee for regulation with the majority believing that the government or employers should bear the start up costs of regulation. If HCSWs were to pay a fee, then 54% thought that it should vary according to salary scales, with 36% favouring a standard fee (Unison 2008).

## 4.5 Models of regulation for healthcare support workers

Here we consider two models of regulation for healthcare support workers: employer-led regulation and a licensing scheme.

### Employer led regulation

Work undertaken by NHS Quality Improvement for Scotland (NHSQIS 2008) comprised a pilot evaluation of employer-led regulation for healthcare support workers. The project sought to test four key elements of a potential regulatory system: a set of induction standards focusing on public protection: a code of conduct for HCSWs; a code of practice for employers; and a centrally held list of names of those HCSWs who met the standards (NHSQIS 2008). The project entailed healthcare support workers volunteering to take part in the regulatory process and workplace staff volunteering to support and supervise the HCSW. The two parties worked through a learning and assessment tool kit which included guidance for both of them to achieve the public protection induction standards. The standards were in part based on the Knowledge and Skills Framework (KSF). Once the assignment was successfully completed, the HCSW signed a declaration of commitment to their code of conduct and were then entered onto the occupational list. Concomitantly a code of practice was developed for employers.

A wealth of material has been produced in the form of the project report (NHSQIS 2008) and the concurrent evaluation of the project (Birch and Martin 2009). Here we focus on salient points that could form the basis of taking aspects of HCSW regulation forwards, some of which were noted in the DH (2009b) report on extending regulation to currently unregulated groups of workers.

#### *Induction Standards*

These were intended to help both employees and employers fulfil obligations to patient safety and public protection as part of a first step in developing a potential regulatory framework for HCSWs. The evaluation found that these standards were unanimously supported and hence recommended that they be mandatory. Although the standards were perceived as appropriate for clinical workers, they needed adapting for non clinical HCSWs. The learning and assessment toolkit needed to be written in a manner that could more easily be understood by a diverse group of workers. Further recommendations included mapping the standards against other frameworks such as SVQs. It was noted that the project had attempted to avoid duplication by using the KSF, but its implementation is patchy across the UK and as it is NHS specific will need adapting to the non-NHS sector.

#### *Codes of practice / conduct*

The code of conduct for HCSWs was unanimously supported and recommendations made that it be implemented. Reviews were needed of whether it should be included in HCSW job descriptions and of mechanisms for ensuring compliance to the code. The code of practice for employers was regarded as codifying existing best practice and should be implemented. There were mixed views about the framework for holding employers accountable for the code and further review of this was required.

### *Occupational register*

The evaluation indicated that stakeholders had mixed views about whether a national occupational list would be a proportionate response to the perceived level of risk and further work was recommended to assess its value over and beyond the standards and code of conduct. Further work was also needed to map links between the proposed occupational list and safeguarding schemes. Data recorded about individuals needed to be reviewed to ensure that sufficient information was available to support this model of HCSW regulation and access to and use of the list by employers from within and without NHS Scotland needed to be tested.

### *Perspectives on the scheme as a whole*

The scheme had many positive benefits. Of particular note was that HCSW participants felt that they knew more about patient safety and public protection and workplace supervisors felt that they knew more about the role of HCSWs. The employer's accountability framework made pilot staff more aware of relevant staff governance policies. Some difficulties were experienced over staff time and motivations. Fewer than expected HCSWs volunteered to take part in the project; reasons included the workplace being too busy, personal commitments and not perceiving a value in taking part. Workplace supervisors also needed more time and preparation to support and assess HCSWs and to see the benefits of taking part. Information about the regulation process needed to be made more widely available to all the different groups within the HCSW workforce.

The evaluation concluded that to roll out this pilot across Scotland, and hence by implication the rest of the UK, might carry substantial resource implications. Those itemised included: co-ordinating roles; making information widely available; workplace supervisor training and assessment; assessment arrangements for work areas with low ratios of workplace supervisors to HCSWs; flexibility to cover all supervisor and HCSW work patterns, including bank, weekend, night staff and short shifts; administration and materials costs, and disclosure applications for some workplace supervisors (Birch and Martin 2009).

The project demonstrated very clearly just how much work can be done at a local level to maximise the contribution of the HCSW workforce and to minimise the risk that they might present to public safety. The combination of induction standards and codes of conduct fit

well with the DH recommendation (2009b) that regulation should have a strong local component so minimising the need for top heavy nationally based regulation.

### A licensing model of regulation

In the US, a group of staff known as aides work in a wide variety of healthcare facilities: hospitals, residential nursing care homes, outpatient centres and individual and family services. Federal Government requirements exist for aides who work in nursing care facilities. They must complete a minimum of 75 hours State-approved training and pass a competency evaluation. Aides who complete the programme are known as certified nurse assistants (CNA) and are placed on the state registry of nurse aides. Additional requirements may be required but vary by State. We could find no studies demonstrating the specific benefits of licensing.

The US state licensed certified nurse assistant is of relevance to deliberations about HCSW regulation in the UK, since it is one of the options proposed for regulation of currently unregulated groups (DH 2009b). The key elements in the DH document include: ensuring appropriate standards based training for the role; securing adherence to a code of conduct; and ensuring that those whose conduct does not meet the required standard are barred from carrying out the role. Suggestions for operation of such a scheme include: Skills for Health defining qualifications and standards at a uniform level or several levels of ascending complexity and degree of risk; the system could be operated by a number of the existing regulatory bodies; and licensing could be voluntary or mandatory DH (2009b). The Health Professions Council has put forward proposals as to how such a scheme might operate for healthcare support workers (DH 2009b). At the time of writing, we are not aware that proposals for piloting a licensing scheme have been taken forward in a UK context.

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## 5. Assessing risks and benefits

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The review indicated that an unregulated workforce may present risks to public safety through:

- lack of controlled admission to the workforce through a centralised register.
- provision of care by a workforce for which education and training is not mandatory and that which is available is not standardised in terms of content, assessment and accreditation.
- provision of care which should be supervised but is not always in practice

We also considered whether there is any evidence that regulation would improve public safety and add benefits not achievable by non- statutory means.

No studies were found that have tried to quantify the total number of incidents in a given period of time in which care by support workers has been shown to have an adverse effect on patient care. However, there are well documented instances in which lack of regulation has meant that people who are unsuitable for work have been able to gain employment and/or gain employment elsewhere following dismissal from a previous employer (section 4.1). The evidence reviewed on the role of HCSWs indicates that they may be undertaking tasks for which training should be required but is not mandatory or, if available, is not standardized and consistent (section 4.2). Furthermore, evidence exists that some HCSWs may be carrying out tasks for which they should be supervised but are not. The tasks they were allowed to carry out depended not on their training but rather on: staffing levels, the policies of the trust in which they were working and perceptions of their competence held by registered staff (section 4.2).

From the evidence reviewed, it cannot be unequivocally concluded that unregulated support workers present a risk to public safety; it is likely that they do but not an absolute certainty. Attempts at identifying which group of HCSWs present the greatest risk to public protection seem unlikely to arrive at an unequivocal and generally accepted answer. Whereas lack of regulation in some settings may be more of a risk to patient safety than in others, there can be no guarantee that any particular group of unregulated HCSWs do not present a risk to public safety. As noted, the DH has recently argued that there must be evidence that regulation would improve public safety and add benefits that are not achievable by non- statutory means (DH 2009b). It is unlikely, however, that evidence can be generated that will demonstrate unequivocally that regulation would prevent risks to public safety. Certainly the benefits of a given regulatory regime cannot be demonstrated until it has been implemented. The difficulties in demonstrating benefits of regulation were made evident in a recent review of the regulation of teachers, social workers and other staff in social care (Cornes et al

2007). They found a lack of robust evidence on the outcomes and benefits of regulation in terms of improved practice and public protection.

Despite the problems in demonstrating that an unregulated workforce present a risk to public safety and demonstrating that regulation would bring benefits, it is equally unlikely that evidence can be generated that will demonstrate unequivocally that registration would not bring any benefits for public safety. On the basis of the foregoing therefore, we would argue that there is a strong case for regulation of some kind. It could be argued that a compulsory registration system to which all employers had access may lessen the likelihood of unsuitable people entering the workforce or, if dismissed, obtaining employment elsewhere in the sector. Regulation would pave the way for the development of some form of standardized education and associated competencies. This would clarify whether or not an HCSW was qualified to undertake tasks rather than this being dependent on Trust policies, staffing levels in clinical settings, or the perceptions of HCSWs and registered nurses of the wisdom or otherwise of a particular task being carried out by an HCSW. The benefits of regulation are indicated by the employer-led model of regulation piloted in Scotland in that HCSWs who had participated in the regulatory programme perceived that they were now more aware of issues of patient safety and public protection.

A possible approach to assessing benefits of regulation for the healthcare support workforce would be to analyse records of adverse incidents involving HCSWs, in an attempt to ascertain whether and how regulation would have prevented or mitigated the event. Attention was drawn at the meeting of experts to the various organizations holding such information.

A regulated healthcare workforce however, will not necessarily guarantee that a high standard of care will always be delivered. Recent reports into poor quality nursing care in some trusts have indicated that this could be attributed to regulated as well as unregulated staff and that lack of robust clinical governance was the main problem. Regulation would be part of the drive to improve the quality of care, not the sole answer.

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## 6. Key questions in developing models of regulation

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The project's second objective entailed identifying and developing key questions to be addressed in taking regulation forwards. The review and appraisal of existing resources led to the identification of six broad areas of questions:

- Taking forward the assistant practitioner role in nursing
- Developing roles and competency frameworks
- Choice of regulator and regulatory procedures
- Providing and accrediting education
- Professional and workforce implications of education
- Risks from the processes and outcomes of regulation

In this section we consider and develop the questions arising in each of these areas.

One of the challenges in taking this work forward is where to start in an area with many complex inter-relationships and no necessarily logical linear order in which to proceed. The order in which the questions are presented here appeared logical in developing arguments but, as indicated in the conclusions and implications section (8), we suggest that actions in several should be concurrent. In each section, the key questions and further work that might be required are highlighted and links made to other questions where appropriate.

### 6.1 Taking forward the assistant practitioner role in nursing

While the initial policy vision was that the AP role would be assistive and supportive of registered practitioners and entail carrying out protocol-based tasks under the supervision of registered practitioners, research reviewed for this project has shown that this is not always the case in practice (section 4.3). Thus work by Spilsbury et al (2009) and Wakefield et al (2009) demonstrated that some trusts saw assistant practitioners as having much more of a substitutive and/or autonomous role. As Wakefield et al (2009) observed, the role seems to be sitting between registered autonomous professionals and supportive healthcare support workers – “it is seen neither as a professional role due to its non registered status and lack of professional regulation and nor is it a traditional support role as APs are expected to do more than a traditional HCA” (p.293). At the meeting of experts, it was observed that a lack of clear boundaries between the work of nurses and those of HCSWs, particularly at the higher bandings, is partly a result of the title of nurse not being protected.

The status of assistant practitioners in nursing raises urgent questions for the NMC. Firstly, if this group of staff are carrying out protocol-based nursing tasks but are not regulated, then in

some respects, nursing is being de-regulated. Secondly, there is a potential risk to public safety by the kind of nursing tasks being undertaken by an unregulated assistant practitioner workforce and in the absence of guaranteed supervision by registered staff. So there seems to be a clear case for regulation of assistant practitioners in nursing. The RCN has recommended that the NMC should establish a register for assistant practitioners, initially on a voluntary basis (RCN 2007). However, the key question to be addressed is:

- should assistant practitioners be regulated as senior healthcare support workers or as second level nurses?

The possibility has been raised that a corollary of an all-graduate profession at the point of registration might be the re-introduction of a lower level of qualified nurse and that the role of assistant practitioner in nursing might form the basis of such a development (NNRU 2009b). Some directors of nursing and other senior personnel have been reported as holding the view that the role already constitutes that of a second level nurse but expressed concern that such a move might re-introduce problems that had been associated with enrolled nurses, the previous grade of second level nurse in the UK (Spilsbury et al 2009; Wakefield et al 2009; Spilsbury 2010).

If a decision is taken to upgrade the role of assistant practitioner in nursing into a qualified nursing role (perhaps with the title associate nurse) then the NMC is the appropriate regulator for this grade of staff. Moreover, it will be important that this is undertaken in a way that does not reintroduce problems of career and professional development experienced by enrolled nurses. Consideration needs to be given therefore to how such a post might fit into a career pathway from healthcare support worker to registered nurse and if a second level nursing qualification might increase recruitment from groups that could have been discouraged with the move to all degree nurses at registration. Concerns were expressed at the meeting of experts that re-introducing a second level of qualified nurse might undermine progress made on raising the status of nursing as a profession with a move to an all degree profession. It is of note however, that many OECD countries require a degree for registration as a first level nurse and also offer lower levels of qualification for different points on a nursing career framework (Robinson and Griffiths 2007). The problem in the UK has rather been one of having two routes to registration (a degree and a diploma) as a first level nurse.

Although, as Spilsbury et al (2009) advocate, further study may well be needed on the position of the AP role within the nursing workforce and particularly the extent to which the role 'supports, complements, or replaces some of the duties and responsibilities of registered nurses' (p.624); we conclude that a decision is needed as a matter of urgency on

whether the assistant practitioner in nursing should be regulated as a healthcare support worker or as a second level qualified nurse.

## 6.2 Roles and associated competency frameworks

One of the key starting points has to be deciding what roles the health service requires its healthcare support workforce to fulfil. These roles can then be developed as a set of roles at different levels of complexity, each with attached level of responsibilities and competencies. Decisions will be needed at each level as to whether specific tasks should be supervised and what the nature of supervision should comprise. When this point is reached, a judgement can be made about what level of regulation is necessary for each role and then a decision made about appropriate regulators in each case.

### Criteria for developing a competency framework

Key questions to be addressed in developing a role and competency framework include:

- What criteria should constitute the basis for determining roles and responsibilities for each level of HCSW?
- How should the development of a competency framework be taken forward?

Ideally we need to define tasks that are purely domestic; tasks that are core professional nursing tasks but which can be undertaken by substitutes (some requiring supervision and others not); and tasks that should only be undertaken by a first level registered nurse or midwife. Having done this, tasks can then be grouped into roles and then into bands. Each band could undertake all the tasks in the bands below it but not tasks on the bands above it. However, this is bedevilled by lack of clarity over a) the extent to which domestic tasks may have a nursing component and b) the fact that the title of nurse is not protected, resulting in difficulties in deciding on what are the core tasks that should only be undertaken by a registered nurse. This is regarded as less of a problem in midwifery since the title midwife is protected and so certain tasks are defined as the sole province of the registered midwife.

Work by others researchers may prove useful in informing the development of a continuum of healthcare support worker roles. Sandall et al (2007) provide a figure which shows changing proportions of ancillary tasks and midwifery tasks as maternity support workers move from band 1 to band 3 (no band 4 in midwifery). The presentation of preliminary findings from the work of Kessler et al (2010) indicate that findings of this soon to be published project are likely to be highly pertinent in taking a role and competency framework forwards. They propose clusters of HCSW roles based on analysis of what they were doing: auxiliary activities, indirect patient care, direct patient care, routine technical care and

complex technical care. These clusters were then plotted on two axes of low to high task complexity and low to high task diversity.

An additional component to developing a competency framework for healthcare support workers is the question of generic and specific competencies and the extent to which these are transferable across settings. So firstly, is there a range of generic competencies, presumably relating to domestic and basic nursing tasks, which are required in all clinical specialties in hospital and community settings? More specific competencies may divide into those that are transferable across certain specialties but not others, and then very specific competencies that are required for certain settings but are not transferable. At the more generic end of the continuum, there may be competencies that are transferable across health and social care and if so, there may be a case for a group of support workers equally able to work in either type of service.

A review that draws together all the work that has been undertaken on roles and competencies for healthcare support workers and maps the commonalities and differences would provide an essential basis for developing a competency framework. This should include current work in progress; for example work in Scotland on defining three levels of support worker and their associated educational needs; work on competencies being pursued by UNISON; and initiatives in the independent sector to develop a set of competencies for that sector. Such a review could also include mapping existing social care and health care competencies with the aim of identifying potential generic competencies. The problem is deciding on which organization should take a lead in moving a mapping exercise of this kind forwards. On the one hand, the body that will be charged with regulating HCSWs seems the logical place to locate this work; on the other hand, decisions about regulator depends to some extent on the nature of the roles to be fulfilled and thus may depend upon work around competencies. A start could perhaps be made by representatives of organizations likely to be involved in regulation, albeit in an as yet to be determined form, to constitute some kind of grouping under an independent chair, to undertake some initial work on developing a role and competency framework.

### The benefits of a role and competency framework

The development of a framework of nationally accepted graded roles and associated competencies would clarify issues of responsibility, delegation, supervision and accountability. This is currently a problem for registered nurses and midwives since they are regarded as accountable for the work that they delegate to HCSWs. Such clarification will also be relevant to roles within the support workforce; for example a band 4 being responsible for some aspects of the work of a band 3. However such structures only work in relation to current NHS pay bands. A competency framework outside current NHS structures would also provide the basis for taking forward expansion into unanticipated areas for which support workers could then be properly prepared and supervised if required.

A role and competency framework will facilitate transition of personnel between different nursing and maternity services, between public and independent sectors and between civilian and military workforces. At present, healthcare assistants and medical assistants who have worked in the defence forces do not have a qualification that is transferable to the NHS and hence their skills are lost once they leave the military workforce.

The development of a role and competency framework will also be an essential pre-requisite for developing and accrediting programmes of education for HCSWs.

### **6.3: Regulation: Mechanisms, procedures and choice of regulator**

At the meeting of experts, views were expressed to the effect that bringing the whole of the health and social care workforce into the kind of regulatory framework currently employed for professions such as nursing and medicine would be a huge undertaking in terms of costs and administration and certainly for some groups within these two support workforces would be disproportionate in relation to public safety. It was also noted that in an era of restricted finances, the Treasury may place an onus on cheaper forms such as licensing or on improving systems regulation rather than extended professional regulation. Moreover, the view of employing organizations will be critical given the state of public finances. Hence the whole process must be proportionate to risks entailed in the absence of regulation.

The precise nature of mechanisms for regulation will depend on decisions about what form of regulation is appropriate for each of the groups in the HCSW workforce and this will depend on competencies. However, initial observations can be made on some of the key questions to be addressed in deciding on a regulator and on some aspects of the process of registration and regulation.

- should HCSWs be regulated by a national body and/or local employing organizations?
- which of the current national regulatory organizations are most appropriate for regulating HCSWs and might this differ for separate groups of HCSWs?
- what factors should inform the development of regulatory mechanisms?

Is there a case for employer-led regulation?

The case for employer-led regulation has been advocated by National Health Service Quality Improvement Scotland, following the pilot study to examine how this might work in practice (NHSQIS 2008). As described in Section 4.5, the project demonstrated the amount of work

that can be accomplished at a local level in terms of developing induction standards and codes of conduct, albeit that this requires resources of time and money. At the meeting of experts, the point was made that this work should be an integral part of developing education and training packages for HCSWs.

Reservations have been expressed, however, about the proposal that registration should be on an employing organization basis and not on a national basis. For example how will a model without a central register be able to police practitioners when they change jobs and how can consistency in registers be ensured across multiple employers across multiple settings? How will employer-led regulation keep track of HCSWs who work independently or through agencies? A UK-wide approach is better placed to deal with engagement, consistency and mobility issues.

There is a related question of whether employers should be regulated as well as or instead of individuals. Employer regulation is seen as particularly important in the context of the independent sector comprising numerous small facilities and currently falling within the remit of the Care Quality Commission. While employer regulation may be essential to ensure overall standards it does not overcome the problems associated with lack of regulation for individual practitioners.

#### Choice of a national regulator

Debates about choice of a national body to regulate HCSWs centre on whether each component of the HCSW workforce should be regulated by the profession with whom it most closely works (the NMC in the case of HCSWs and other assistant practitioners who take on work traditionally undertaken by nurses or midwives) or whether all HCSWs should be regulated by the same body, most likely the Health Professions Council (HPC).

As noted in Section 3.2, decisions in relation to regulation of other support workers has been to opt for the regulator of the professional group with whom they are most closely associated: for example in dentistry, optical work, social work and physiotherapy. To follow this approach through would indicate that the logical choice of regulator for those HCSWs involved in nursing and midwifery is the NMC. For HCSWs closely involved in such work, regulation by another body such as the HPC (the preferred Unison option) would cut them off from the group they work with most closely. This, in turn, might make more difficult the essential work needed for registered staff and HCSWs to work together: developing a common code of conduct for registered staff and HCSWs; promoting improved team working; defining explicit team and individual responsibilities for patient safety and welfare; and offering protection to HCSWs in circumstances where they are asked to undertake activities for which they are not competent or feel unsure about (RCN 2007).

But the NMC as choice of regulator also poses a dilemma. While this choice seems to follow from the delegation of regulated nursing work to unregulated practitioners the issue seems

less clear cut for HCSWs who work alongside nurses or midwives but are not undertaking tasks that could be specifically defined as nursing or midwifery and which moreover could be equally relevant to clients requiring social rather than health care. Even if a division could be made between HCSWs involved in nursing or midwifery work and those who are not, involving two regulatory bodies might make it more difficult to develop an HCSW career pathway with stepping on and off points and the potential to move up a hierarchy of positions, and could also be administratively cumbersome. In these respects, a single regulator is more desirable.

The RCN proposal that a start should be made with the NMC regulating bands 3 and 4 assistant practitioners and perhaps bands 1 and 2 be regulated by employers (RCN 2007) is also fraught with potential problems. It could demoralise staff in bands 1 and 2 who might perceive such a move as indicating that they are not worthy of immediate regulation and cut across the notion of a career pathway from bands 1 to 4. Moreover, the problems that have been identified with employer-led regulation are just as pertinent to bands 1 and 2 as to bands 3 and 4 and may be more so in the context of the independent sector.

### What factors should inform the development of regulatory mechanisms?

If it is decided that some levels of HCSWs do not merit full regulation along the lines of that currently in place for the professions, then decisions will be needed as what kind of other approach might be appropriate and which body (ies) might provide it.

- Which organizations might provide a 'Light touch' regulation?

One option might be for all existing professional regulators to have a 'light touch' regulation option for groups of workers who support the profession but who do not warrant full regulation. Returning to the uni-professional case for regulation, this approach might be preferable to one in which all HCSWs are licensed either by a new body set up for the purpose or by one of the existing regulators.

- How might regulation articulate with current safeguarding procedures?

Unison have raised concerns, reflected in surveys of their HCSW membership (reported in Section 3.1), that HCSWs are on relatively low salaries compared with other groups in the healthcare workforce and that if they perceive the cost of regulation to be prohibitive, then this could deter people from becoming HCSWs in the first place or lead to attrition from the existing workforce if paid regulation becomes compulsory. It has been suggested that one way of minimizing costs to individual practitioners would be to synchronize the process of registration with safeguarding and having one fee to cover both. However, the two processes are complementary not exclusive in that safeguarding is dealing with suitability and not with competence.

- Should regulation be voluntary or compulsory?

Initial developments in extending regulation to health and social care workforces have been to introduce regulation on a voluntary basis. Thus in relation to the home worker component of the social care workforce, regulation is to be on a voluntary basis at least initially. The Scottish pilot of employer-led regulation also introduced registration on a voluntary occupational register, although take-up was reported as low, and such an approach has also been suggested by others ( Saks and Allsop 2007, HPC reported in DH 2009b).

The case can be made however that introducing registration on a voluntary basis will not prove cost effective in the long-term. Setting up a voluntary system will incur costs but might be avoided by just those people about whom there is most concern in terms of risk to public protection. Should voluntary regulation fail in this respect, and a move to compulsory registration become necessary, this is likely to be more costly overall than introducing compulsory regulation from the outset.

#### **6.4 Providing and accrediting education and training**

Defining roles and specifying associated competencies will need to be accompanied by the development of education programmes to enable HCSWs to meet these competencies and by decisions about how these will be provided and accredited. To some extent, decisions about which organizations should be the providers and accrediters of education may be linked to choice of regulator. In the meantime, consideration can be given to further work and key questions including:

- How might educational requirements be identified?
- In what formats will education and training of HCSWs be provided?
- How and by whom will education (and continuing professional development) be funded?

Although not mandatory or standardized, a wide diversity of educational opportunities is already available for HCSWs including the induction courses developed by the Scottish employer-led pilot study. As a competency framework is developed, existing courses could be mapped against these to identify where provision already exists and where there are gaps to be filled. Work could also begin on the extent to which registration as HCSW will need to be maintained by a programme of continuing professional development and what this might comprise for each of the bands of HCSW.

Whatever level of regulation and standardized training is decided upon as appropriate for different groups within the HCSW workforce, it will not be feasible to take all existing HCSWs out of the workplace for training purposes and so a range of work based training will be

required as well as off site courses. Both options may present difficulties in terms of time as indicated by the experience of the Scottish pilot study (Section 4.5).

Providing a mandatory training and educational programme for all HCSWs will require funding. Research reviewed in Section 4.4, indicated that HCSWs sometimes experienced a lack of willingness on the part of their employer to fund access to NVQ qualifications. If training becomes mandatory, clarity will be needed on the expectations of employers and individuals as how costs will be met. In particular, questions are raised about the motivation and willingness of employers in the private sector to fund the education of their HCSWs. An associated cost issue is the expectation that further accreditation/training and progression should be reflected in pay rises (Thornley 2000).

## 6.5 Professional and workforce implications of regulation

The implementation of regulation for HCSWs is likely to have a range of professional and workforce implications for both them and the registered staff with whom they work most closely. While not deciding factors in whether and how regulation should be taken forwards, these may have positive or negative effects on workforce composition and morale which, in turn, may impact on patient safety. Hence professional and workforce implications of regulation should be considered alongside decisions about the form of regulation. Questions include:

- What impacts might the regulation of HCSWs have on recruitment?
- What impacts might the regulation of HCSWs have on retention?
- What impacts might the regulation of HCSWs have on registered staff?

If all HCSWs are regulated, then this will be accompanied by the development of an associated framework of roles and competencies which clarify what competencies and associated training are required of each band of workers. This is a crucial component of the concept of a skills escalator which enables people to step on or off at specific points on a career pathway and be clear about what is required to move from one point to another. For HCSWs, this would provide not only clarity about pathways within the HCSW workforce but also clarity about pathways into work as a qualified nurse for those wishing to pursue this route. Section 4.4 provided examples of how this is already happening in relation to HCSWs wishing to progress to a band 4 assistant practitioner post.

It is not known whether regulation and greater clarity over career pathways will make healthcare support work a more attractive proposition than hitherto and whether it will attract different groups of people into the workforce. In particular, there is interest in whether regulating the healthcare support workforce will be seen as providing an alternative route into nursing as opposed to the soon to be instigated degree only route to registration. As

Thornley (2000) has observed, a healthcare support worker career pathway offers a different route into nursing, emphasizing experiential rather than academic off the job training, and may be more attractive to people who do not have traditional academic qualifications usually required for entry to a degree programme.

For those currently in the workforce, will regulation encourage people to stay? For most practitioners, regulation is likely to be accompanied by obligations to undertake additional training. Some of the evidence on social care workers suggests however that regulation might have negative impacts in that staff do not always want to undertake training and might leave if regulation and hence training were compulsory (Cornes et al 2007).

On the other hand the possibility of career advancement through the more structured pathways that will result from regulation may encourage retention. Providing guidelines on how to achieve progression will be needed for those aspiring to progression within the HCSW workforce and those aspiring to move from a HCSW band to a registered nurse or midwife post (Knibbs et al 2006). It should be recognized, however, that if HCSWs have expectations that regulation and training will facilitate career development and progression, then there are risks that they may become dissatisfied if employers are unwilling to provide resources in terms of time and funding for them to access the training required.

Current developments in nursing and midwifery argue for registered staff to increase the extent to which they supervise and lead the work of nursing staff below band 5 (e.g. Maben and Griffiths 2008). Although the capacity of registered staff to supervise and lead HCSWs is an issue independent of HCSW regulation, it may have impacts which should be considered. Newly qualified nurses and midwives need time to consolidate and develop their clinical skills and this may be compromised by demands of supervising the work of HCSWs. Moreover, if registered staff are to lead the HCSW workforce, they may require additional preparation at pre-and post-registration levels to undertake the demands of this leadership role.

## **6.6 Risks from processes and outcomes of regulation**

In the course of considering the key questions to be addressed in taking regulation forwards, we concluded that risks to public safety might also be presented from the processes and outcomes of regulation. Firstly, risks that might be a consequence of choosing a particular model/ or elements of a model of regulation as opposed to another. Second, there might be significant but unintended consequences of regulation, particularly in relation to decisions about workforce planning.

The foregoing account has identified three elements that have been advocated as part of models of regulation that may present risks to public safety. They are: risks from employer led regulation; risks from voluntary regulation, and risks from involving more than one regulator. Details of each were provided in Section 6.3.

One of the perceived benefits of regulating all HCSWs is that the associated legal and competency frameworks will define the scope of practice for each group within this workforce. From the perspective of employing organizations, this should clarify what groups of HCSWs they require to meet the needs of services for which they are responsible. Regulating the workforce, however, may lead to risks from what we have called ‘significant but unintended consequences’; in particular from decisions about workforce composition that might follow once HCSWs are regulated.

If some HCSWs remain unregulated, might current economic circumstances encourage employment of this group rather than the regulated group, since the former may incur lower salary and training costs? Secondly, if all HCSWs are regulated, might employing organizations see this as a justification for reducing the numbers of registered nurses? This question has been raised in particular in relation to the assistant practitioner role in nursing with concerns that there may be attempts to increase the numbers of band 4 assistant practitioners as a cost cutting measure, since they are cheaper to educate and employ than registered staff, rather than as a response to workforce pressures or to match patient needs (RCN 2009).

The extent to which employing support workers rather than registered nurses may be detrimental to patient safety cannot easily be quantified, but attention is drawn to the large volume of research on the relationship between ratios of registered nurses and patient outcomes. The literature suggests that decreasing the proportion of registered nurses may be associated with poorer patient outcomes (NNRU 2009a). A further area for consideration for patient safety is the implications of regulating assistant practitioners as second level nurses leading to economic pressures favouring an increase of this grade rather than the registered nurse grade. US research suggests that higher proportions of second level nurses are associated with poorer patient outcomes and, in the long-term, higher patient care costs (NNRU 2009b). Although outwith the specific remit of this work, it is worth observing that the introduction of a second level nurse is not necessarily without risks.

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## 7 Areas for further work

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The third project objective entailed making recommendations for further work. Initially this was couched in terms of recommendations for further research and scoping reviews. As the work progressed however, we concluded that in addition to further research and scoping reviews, there were some issues that could not be resolved in this way but rather required a decision, the initiation of action of some kind, or further analytical work. We have therefore considered further work in these terms.

### Decisions

Decisions about choice of regulator for HCSWs may be premature if taken in isolation from work to be undertaken on roles and competencies. Perhaps what is needed at this stage may be a decision to commit in principle to regulation and an exploration of how the different regulatory options that have been proposed might articulate with existing regulatory bodies.

- A decision is needed on how work on a competency framework work should articulate with current work on protecting the title of nurse since the two are interrelated especially between the higher grades of HCSWs and registered nurses.
- Should the assistant practitioner be regulated as a second level nurse or as a senior healthcare support worker?

### Actions

Developing a role and competency framework is linked to decisions about what degree of regulation is needed and which organization(s) should be the regulator for HCSWs. In the meantime, representatives of all the organizations likely to be involved in regulation, albeit in as yet to be determined form, might form a grouping of some kind to undertake some initial work on developing a role and competency framework.

Keeping abreast of developments in other professions seeking to regulate support workers, such as social care and teaching, may help inform debates about healthcare support worker regulation and provide opportunities for cross-professional actions.

### Reviews/research

Further, more focussed scoping reviews and/or research on the following subjects is likely to inform the process of taking regulation forwards:

- A review of adverse incidents involving healthcare support workers and an analysis of the extent to which these might have been prevented, could be undertaken if there is a view that the case for regulation needs to be strengthened.

- A review that draws together all the work that has been undertaken on roles and competencies for healthcare support workers and maps the commonalities and differences would provide an essential basis for developing a role and competency framework. Such a review could also include mapping existing social care and health care competencies with the aim of identifying potential generic competencies.
- A review of current provision for education and training should be undertaken alongside work on developing a role and competency framework. This would enable a mapping to take place between desired competencies and existing provision and thus identify gaps in educational provision.
- Research on whether regulation of the HCSW workforce is likely to increase or decrease its attractiveness to potential entrants and increase or decrease retention in the workforce.

## Analysis

Further analysis is needed to ascertain:

- How the process of registering with a safeguarding authority and a regulatory body can be synchronized to minimise organizational and individual costs.
- The extent to which there is a case for considering jointly the regulation of health and social care support workers.
- On-going analysis of costs entailed in various aspects of decisions of taking regulation forwards:
  - How to provide work-based and off-site training and education for HCSWs.
  - How a balance can be achieved between desirable forms of regulation for the various groups of HCSWs and the costs of implementing these.
  - How costs of regulation might be apportioned between HCSWs, their employing organizations and central government in a manner acceptable to all parties.

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## 8 Conclusions and implications for action

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Although the regulation of HCSWs has long been advocated, until recently little advance has been made on actions to take this forward; concerns were expressed at the meetings of experts that action might still not be forthcoming. In this final section, the conclusions of the project are drawn together and their implications for action, especially by the NMC, are considered.

### Main conclusions

The evidence on whether unregulated healthcare support workers present a risk to the public was reviewed in terms of uncontrolled access to employment, lack of standardized competencies and mandatory education, and lack of supervision of certain tasks undertaken by HCSWs. We concluded that while little evidence can currently be deployed to show that regulation would reduce the risk to the public that is associated with HCSWs, there was nonetheless a strong case for regulation, particularly arising from the de facto deregulation of professional work that is clearly associated with some HCSW work.

Consideration was given to the constituent elements of a model of regulation: the choice of regulatory body, mechanisms for regulation, the different bands of HCSWs, the development of a competency framework; the provision and accreditation of education; and the roles of registered staff and employing organizations in HCSW regulation. Six broad areas of questions were identified which need to be addressed in taking regulation forwards. One of these comprised the risks that might be presented to public safety by the processes and outcomes of regulation. Recommendations for various kinds of further work were made.

One of the main conclusions to be drawn is that several of the questions need to be addressed concurrently. Notwithstanding the need to adopt an holistic rather than a piecemeal approach to HSCW regulation, consideration also needs to be given to logical starting points for action; for example how can regulation be developed without knowing what competencies are required of the workforce in question. There are also some fundamental questions that would appear to require resolution before other decisions can be taken; for example deciding on the status of band 4 assistant practitioners before developing a view on an appropriate regulator for this group.

### Implications for action

Our brief was to consider implications of the project for action by the NMC. We appreciate that many of the decisions to be taken will involve other organizations as well as the NMC and in particular the four devolved administrations. As the regulatory body for nursing and

midwifery however, the NMC has a central role in providing advice and initiating action, particularly when the issue at hand is the regulation (or potential deregulation) of nursing and midwifery work. In the first instance we suggest that the NMC:

- Makes the case with other stakeholders for healthcare support worker regulation
- Initiates debates on the decisions to be taken
- Takes a lead in bringing together all those likely to be involved in developing a new role and competency framework
- Commission further reviews/research and further analytical work either as a sole organization or in collaboration with other organizations.

Regulation of the healthcare support workforce is of growing importance for the public, for registered professionals who work with them, for employing organizations and for healthcare support workers themselves. As this review has indicated, there is much diversity of view among the various stakeholders as to how this might be achieved in as effective and cost efficient manner as possible. Looking ahead, this is more likely to be achieved if there is consensus among stakeholders about the best way forward in relation to the key questions considered in this report. We suggest that the NMC has a key role in initiating discussions to achieve such a consensus.

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