

Health and Community Care

Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards and Listing in Three NHS Boards

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The national pilot, which ran in three NHS Boards in Scotland during 2007-2008, tested arrangements for an employer-led model of regulation and listing of healthcare support workers (HCSWs). The evaluation, commissioned by the Scottish Government Health Directorates (SGHD), aimed to assess the implementation, operation and potential impact of the pilot. The evaluation used a range of methods including: stakeholder and key informant interviews; individual case studies; surveys of participants, non-participants and supervisors; analysis of local site monitoring data and desk research. The findings, which are summarised in this report, will inform potential future roll-out of the employer-led model.

Main Findings

- The pilot, successfully run in three NHS Boards, was extended following considerable early delay to facilitate a full operational year.
- Recruitment to the voluntary pilot depended upon successful marketing at NHS Boards and a flexible approach was required to engage those working nights, weekends and short shifts.
- Almost one in six (16%, 470) of eligible healthcare support workers were recruited; the majority (87%, 407) were clinical support workers (nursing and allied health assistants) but few non-clinical support workers (63) were attracted to the pilot.
- The Workplace Supervisor (WPS) role emerged as key to the pilot's success, as a motivated WPS could recruit many HCSWs, but it could be difficult to secure their time for training and to undertake assessment of HCSWs.
- There was some evidence that the model had potential to improve patient safety and public protection; almost half of the participating HCSWs knew more about patient safety and felt more able to take action to keep patients safe; WPS felt better informed about the HCSW role in the healthcare team.
- The induction standards for healthcare support workers were supported by participating HCSWs (82%) and Workplace Supervisors (84%) with workshop delegates (72%) supporting mandatory status.
- The Code of Conduct for Healthcare Support Workers was unanimously supported by healthcare support workers, workplace supervisors and employers.
- The Code of Practice for NHS Scotland Employers was supported by the majority of stakeholders but there was a call to review the approach to monitoring compliance as the tested Board self-assessment and review process was considered to be too burdensome.

Background

The currently unregulated HCSW role has been changing and developing over the last decade and some staff are extending their skills so that they can undertake work previously done by registered professionals.

Consultation outcomes in Scotland on regulation (2004) and the standards (2006) indicated strong support for HCSW regulation and for the standards to be mandatory. Following submission to the Review of Non-medical Regulation (Foster Review 2005), Scotland undertook to test an employer-led model on behalf of the UK, within a voluntary pilot.

This testing of the national standards represents a first step towards helping both employers and employees in NHS Scotland fulfil their obligations towards patient safety and public protection as part of a future regulatory framework for HCSWs.

The employer-led model

The employer-led model comprised the national minimum standards for HCSWs with the addition of a list of HCSWs who met the standards, maintained as part of the pilot. The three elements of the standards are:

- A set of induction standards for healthcare support workers.
- A Code of Conduct for healthcare support workers.
- A Code of Practice for NHS Scotland Employers.

Aims of the Evaluation

The evaluation aimed to assess the implementation, operation and potential impact of the pilot. The overarching aim was to assess whether the model of employer-led regulation with the addition of a central occupational list had potential to enhance patient safety and public protection.

Methods

The evaluation comprised both formative and summative aspects and utilised a range of methods including: stakeholder and key informant interviews; individual HCSW case studies; three postal surveys (HCSW participants, non-participants and supervisors); analysis of monitoring data and desk research.

Findings

Implementation of the pilot

The Scottish Government Health Directorates (SGHD) invitation to Health Boards to participate in the pilot (July 2006) offered funding for retrospective Disclosure Scotland checking of existing employees and for a Local Pilot Coordinator (LPC) at each site, plus the support of a National Pilot Coordinator (NPC) based at NHS Quality Improvement Scotland (QIS).

The two initial pilots NHS Ayrshire and Arran and NHS Lothian commenced January 2007 and the third site NHS Lanarkshire joined later (July 2007). An independent health care site, Ross Hall hospital also took part but was not part of the evaluation. The pilot was tested with vulnerable client groups in children's, mental health and older people's services and across a wide range of urban and rural, hospital and community settings.

The pilot was extended from one year to two (January 2007-December 2008) following delay in early implementation, largely due to: withdrawal of the original third site (NHS Greater Glasgow and Clyde, early April 2007), slow recruitment of the National and Local Pilot Coordinators and slowness in establishing pilot steering groups. Initial guidance was well received but limited pre-pilot planning concerning the level of coordination, information, training requirements and the format of planned individual and Board level assessment processes impacted on the pilot.

QIS, with participating Health Boards, devised key processes both to implement the standards and to monitor compliance with them. These included:

- Training of Workplace Supervisors (WPS).
- Recruitment of HCSWs.
- Disclosure Scotland procedures.
- The learning and assessment toolkit to support HCSW progress against the standards.
- Monitoring of the Code of Practice for Employers – Board self-assessment and review process.
- Testing systems for an 'occupational list'.

The pilot was very resource intensive, requiring significant time to establish supporting structures, engage managers at all levels and identify eligible HCSWs. NHS Boards found some pilot processes more burdensome than anticipated and sites suffered from lack of administrative support. The pilot was facilitated by strong Partnership support at national and local level throughout.

Disclosure Scotland arrangements

The clarification of arrangements with Disclosure Scotland was very time consuming. Two new counter signatories were put in place at each site to facilitate monitoring of applications. It was found that not all HCSWs were legally eligible for Enhanced Disclosure as originally anticipated. The full potential burden on Disclosure Scotland was not tested as the number of applications was small. All sites had processes in place for dealing with undisclosed material.

Workplace Supervisors (WPS)

It emerged that the WPS role was key to the pilot's success as a motivated WPS could recruit many HCSWs. 227 WPS took part, the majority were willing volunteers who supported the standards (84%) but thought them more appropriate for new starts. Fitting the task into busy jobs was problematic and only half felt sufficiently supported with this. Most training was in a planned half day format but great flexibility was required by LPCs to run individual sessions to engage night and weekend staff.

Number of HCSWs involved

Almost one in six (16%, 470) of eligible healthcare support workers were recruited and 41% (193) of these had been assessed and entered upon the occupational list after signing the Code of Conduct Declaration.

Three quarters (73%, 341) of HCSW recruits were nursing assistants/clinical support workers, 14% (66) were unqualified allied health assistants (mainly occupational or speech and language therapy staff). Few (63) non-clinical staff were recruited.

The Recruitment of HCSWs

As HCSW participation was voluntary; the approach to engaging HCSWs or 'marketing' the pilot was critical to its success. Recruitment was most successful within the smaller Health Boards and facilitated by targeting of line managers.

Voluntary HCSWs participants were motivated by improving patient safety and the development opportunity but were concerned they might be too busy to take part.

Reasons for HCSW non-participation included: being insufficiently informed about or not seeing the value of the pilot, having other commitments, being too busy at work, being about to change job or retire.

Limited engagement of non clinical staff

All pilot sites faced difficulties in attracting and completing assessment of non-clinical staff such as portering catering, domestic and laboratory staff. The multiple reasons given included: poor national and local communication, the pilot not being 'sold' to these groups; non-recognition of the 'healthcare support worker' title, the voluntary nature and lack of attractiveness of the pilot to ancillary staff. For facilities managers other existing commitments took priority (e.g. the Domestic Services Framework Workbook) and the low WPS to high HCSWs ratio presented serious difficulties in resourcing supervisor time to support assessment.

Learning and assessment

The assessment toolkit for HCSWs, consisted of an oral and observation assessment process supported by HCSW and WPS handbooks.

HCSWs found assessment to be valuable, enjoyable and not overly burdensome but approximately half the HCSWs undertook some preparation in their own time. Consideration of prior achievements as evidence applied to two thirds of HCSWs but inclusion was not automatic.

HCSWs considered the pilot most appropriate for new starts however little feedback was received from new employees. HCSWs valued the certificate presentation ceremonies which emphasised appreciation of their role in the healthcare team.

The pilot found many difficulties with the tested learning and assessment process and materials. The majority of assessments were completed within two to three months as anticipated but multiple logistical challenges delayed completion in some cases, particularly ensuring HCSW/WPS meetings and completion of all paperwork.

All the supporting materials (induction standards, information pack, and assessment tool kit) required some revision to ensure accessibility and consistency of language, to remove some identified ambiguity and to remove duplication across associated performance criteria.

Stakeholders suggested repackaging the induction standards and assessment materials into a modular approach, with a core element plus different elements appropriate to different circumstances. A modular format might also enable different supervisors to undertake responsibility for different elements.

There was also need for further consideration of how the principles and standards might in future be consistently applied across sectors (including the independent sector) and how links across sectors might work.

WPS experience of formal assessment processes varied widely. There was huge variation in evidence recorded by WPS and there needed to be absolute clarity in the guidance given to WPS about describing whether and how HCSWs were meeting assessment criteria.

The pilot aimed to assess the fit of the standards with the Knowledge and Skills (KSF) processes. The fit remains untested in practice due to the early stages of implementation of KSF at pilot sites. There was a wide range of experience of both Personal Development Planning and Review and KSF across the three sites; just half the Workplace Supervisors were also KSF reviewers. Three quarters of WPS saw potential for the induction standards to fit with KSF.

A good degree of overlap between KSF outlines and the induction standards was identified but KSF cannot accommodate the behavioural aspects of some of the standards. It is anticipated that evidence gathered for the standards can inform the KSF foundation review.

Induction standards

The induction standards for HCSWs consisted of fourteen public protection statements, with supporting criteria. They were supported by participating HCSWs (82%) and WPS (84%), but thought more appropriate for new starts.

There was consensus to implement them with clinical support workers but more exploration was required on the way forward for non-clinical support workers. Discussion centred on issues of 'direct care', 'applicability' of standards and practicality of arrangements for assessment.

Four standards were not found to be easily applicable to non-clinical roles.

Code of Conduct for HCSWs

The pilot introduced a new Code of Conduct for HCSWs and on completing the assessment they signed a declaration agreeing to continue to work to the standards. The Code was unanimously supported by participating HCSWs (96%) and stakeholders. Stakeholders felt that the KSF review process might well be used to monitor the Code but that behavioural aspects of the Code would fit better under staff governance procedures.

The Code of Practice for NHS Scotland Employers & compliance monitoring

The Code of Practice was generally supported but there were very mixed views as to whether the accountability framework for employers as tested in the pilot (the Board self-assessment and peer review), was fit for purpose. The process was informative but considered to be too onerous upon NHS Boards and staff.

No serious gaps in human resource or clinical governance arrangements were found but there were challenges in applying a consistent approach to evidence for some criteria and in evidencing 'monitoring' of the standards. The early timing of the exercise meant it could not really address non-clinical workers, the standards fit against KSF or impact on HCSWs or patients.

The 'occupational list'

The technical and practical aspects of setting up a simple local 'occupational list' on the Scottish Workforce Information Standard System (SWISS) have been tested, but a variety of technical and procedural matters require further work before such a national list could be operationalised. The list as tested is limited to NHS Scotland employees and further work would be required to clarify how it might inform standards for workers who move across employment sectors.

Respondents remained divided as to the potential added value of implementing a national list over the achievement of the induction standards and Code of Conduct alone. A list would maintain an audit trail of a minimum level of achievement but much of this function could be provided by bringing the standards under the KSF review process.

In addition the Partnership Information Network (PIN) guideline on safer pre-employment checks for all is now in place and respondents felt that safe employment is dependent upon employers following good practice in exchanging references.

The disadvantages of an occupational list were perceived to be: it would be very bureaucratic, costly and disproportionate to the perceived risk; it would require legislation to underpin its mandatory status and address data protection and human rights issues.

Consultative Workshop

Day two of the first Scottish Government Health Directorates Regulation event (October 2008) focussed on the HCSW pilot and was attended by representatives from healthcare professions and frontline staff.

During a voting poll on future policy options, delegates expressed broad support for the Code of Practice for Employers (65%), the Code of Conduct for HCSWs (75%), for the standards to be mandatory for all HCSWs (72%), and the proposal for a positive national level 'occupational list'.

Workshop delegates felt standards would enhance the patient experience and saw the potential of the model of standards and listing to enhance public safety (68%); the standards were seen as providing assurance to the public of workforce competence.

Improving patient safety & public protection

Evaluation findings suggest elements of the model have potential to improve patient safety and public protection.

- Participating HCSWs felt they knew more about patient safety (44%) and more able to take action to keep patients safe (46%).
- The desire to improve patient safety and public protection was a strong motivator for both HCSW and WPS.
- The pilot made WPS more aware of HCSWs' vital role in the healthcare team.
- Awareness was raised of patient safety issues not covered in the Domestic Workbook.
- NHS Board knowledge of relevant Staff Governance Policies revised by board self-assessment and review exercise.
- Disclosure Scotland checks uncovered some (minor) undisclosed material.

Recommendations

The evaluation findings confirm support for the **induction standards for HCSWs** but indicate the need to review their applicability to non-clinical groups. We recommend:

- The standards should be mandatory and be implemented for clinical support workers.
- Review how the induction standards apply to non-clinical support workers.

- Explore possibilities for dovetailing the standards' requirements with those of Health Facilities Scotland/NHS Education for Scotland and Development Frameworks for support staff.
- Consider motivating factors for staff groups where regulation is not part of the existing culture and prepare such groups for undertaking assessment.
- Clarify the implications of not meeting the standards at Board and individual level.
- Clarify the maximum timescale for meeting the standards and provide practice guidance for HCSWs not meeting the standards within a given timescale.

The **format** of the induction standards and **assessment tool kit** requires review:

- Revise standards, potentially to a modular format to reflect 'core' and 'role specific criteria' (e.g. clinical or non-clinical support worker, standards requiring a shorter or longer time frame).
- Repackage toolkit to remove duplication, make fully accessible, more attractive and more manageable task for both HCSW and WPS
- Improve guidance to WPS on utilisation of evidence to meet assessment criteria.
- Map the standards with common SVQs and induction programmes to clarify applicability of prior evidence.

In relation to the induction standards 'fit' with the Knowledge and Skills Framework:

- Consider moving some behavioural aspects of the induction standards to the Code of Conduct.
- Support the maintenance of standards through the KSF development review process structure to minimise the burden on supervisors and Health Boards.
- Ensure any recommendations relating to KSF are in line with the 4 UK health departments partnership agreement.

The **Code of Conduct for healthcare support workers** was unanimously supported and the following can be recommended:

- Implement the Code of Conduct for HCSWs in its current format.
- Review how the Code of Conduct might be referenced in HCSW job descriptions for both new and existing staff.
- Review mechanisms for monitoring working to the Code of Conduct.

The **Code of Practice for NHS Scotland Employers** was supported as codifying already existing best practice, however stakeholders held mixed views as to whether the accountability framework tested was fit for purpose, and we suggest:

- Implement the Code of Practice in its current format.
- Review options for compliance monitoring.
- Explore the potential for the existing NHS Scotland Staff Governance Standard and review process to incorporate the Code of Practice.

Stakeholders hold mixed views as to whether **a national occupational list** would be a proportionate response to the perceived level of risk, and we suggest undertaking further work to:

- Consider whether a 'positive' means of acknowledging the achievement of the standards / code of conduct is required.
- Articulate the links between the proposed HCSW 'occupational list' and the Protection of Vulnerable groups scheme.
- Clarify the potential added value of a national occupational list over the standards and Code of Conduct; taking into account the outputs and forthcoming risk assessment guidance from the Extending Professional Regulation Group.

Roll-out of the pilot across all NHS Boards in Scotland might potentially carry substantial resource implications, dependent to some degree upon future arrangements within NHS Boards for the implementation of KSF, and for supporting maintenance of the standards through the KSF development review process. Roll-out would involve staff from across a wider range of services and might require a variety of approaches to engage potentially large numbers of new staff and possibly less well motivated existing staff. We therefore suggest NHS Board level resource may be required to cover the following:

- Local coordinators and a national role.
- WPS training and assessment.
- Assessment arrangements for work areas with low ratio of WPS to HCSW.
- Flexibility to cover all HCSW and WPS work patterns including bank, weekend, night staff and short shifts.
- Administration and materials costs.
- Disclosure Scotland applications, new and retrospective (including some WPS).

A clear national communications strategy is recommended to inform HCSWs and the public of the proposed way forward; including the anticipated timescale and proposals to bring existing employees into the model. Roll-out will also be enhanced by continued Partnership representation in all aspects of future development and implementation.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.



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