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The Nature and Consequences of Support Workers in a Hospital Setting

Executive Summary

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Background

The modernisation of the NHS has propelled the support worker role to the fore. The role is seen as a vehicle for pursuing policy goals: as a relief – removing routine tasks from nurses; as a substitute – replacing nurses in the provision of some core nursing tasks; as an apprentice – providing a future supply of nurses; and as a co-producer – enhancing care quality by bringing to bear distinctive capabilities. The literature on support roles in health provides insights into these issues: on the personal characteristics of support workers; on the malleability of roles; on their degraded nature; and on the ambiguity of nurses' attitudes towards them. This literature has, however, been fractured, focusing on discrete issues and lacking an integrated analytical framework; it has also been uneven in terms of the issues covered and in the forms of investigation.

Aims

The project sought to provide a stronger evidence base for the assumptions underpinning the policy goals held for support workers in secondary healthcare, particularly healthcare assistants (HCAs). These goals were based on assumptions necessitating consideration of the following questions:

- Do Trusts view HCAs as a strategic resource?
- Who are HCAs?
- How is the role shaped?
- What is the impact of the role on stakeholders?

The research explored whether the nature and consequences of the HCA role in these terms could be explained by region, Trust or clinical division.

Methods

The study comprised three phases:

1. Interviews with senior figures from nine Trusts from strategic health authorities in the South, the Midlands and the North.
2. Four cases were selected, one from each region plus a London Trust, with a focus on the HCA role in general medicine and surgery. Each case used the following methods:
    - Interviews: 273 with HCAs, nurses and managers.

- Observation: 275 hours of observation covering HCAs, ward housekeepers and nurses.
- Focus groups: involving 94 former patients.
- Action research: collaborative projects in three Trusts on aspects of the HCA role.

3. Surveys were conducted in each Trust covering HCAs (n=746), nurses (n=689) and former patients (n=1651).

Results

Strategic resource: There was little evidence to suggest that HCAs were used as a strategic resource. Where considered by senior managers, it was mainly as a substitute within the context of skill mix reviews and the pursuit of cost efficiencies.

Backgrounds: Across Trusts HCAs shared characteristics: they were typically mature women with partners and children, and more likely than nurses to be embedded in the local community. They had a breadth of previous work experience, although they entered the role through a limited number of sector gateways.

The role: Analysis of survey data revealed five HCA role types, varying in the complexity and diversity of tasks performed. The most common combined the provision of direct/indirect care with the delivery of routine technical tasks. The distribution of role types was related to Trust and clinical division, with residual scope for individual job crafting.

Consequences:

- **For HCAs**. The compression of HCAs into pay Band 2 and the resultant misalignment of pay, qualification and tasks distorted the effort- reward bargain. Moreover, HCAs lacked an effective collective voice. However, they were satisfied with their jobs, many displaying enduring nurse aspirations.
- **For nurses**. Nurses valued HCAs, while showing ambiguity around certain role boundaries.
- **For Patients**. Patients often found it easier to relate to HCAs than nurses. They could not easily identify HCAs, but those able to were more likely to have a positive care experience.

Conclusions

Findings and policy assumptions:

- **Relief**. The standard HCA is more likely to deliver direct and indirect care than the nurse, and is generally valued for taking routine tasks away from nurses.
- **Substitute**. In taking on routine technical tasks HCAs are extending their role into traditional nurse activities. Some HCA types extend the role significantly beyond this point, often paid at Band 2 rather than 3. This raises the issue of 'cheap labour'.
- **Apprentice**. Many HCAs show an enthusiasm for in-role development, but this can be frustrated by weaknesses in the operation of Trust NVQ frameworks. HCAs have enduring nurse aspirations, but Trusts show little inclination to manage or address these expectations.
- **Co-producer**. HCAs have distinctive contributions to make to care. They find it easier to deal with certain difficult patients and more readily relate to patients than nurses; if the HCA role were made clearer to patients this contribution would be even stronger.

Further research:

- Exploring the nature and consequence of support roles beyond medical and general surgical divisions.
- Further examine the link between types of HCA and patient outcomes.
- Unpacking the deep structures, systems and values which explain the distribution of HCA by type and by Trust.

Disclaimer

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Addendum

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