NIHR Service Delivery and Organisation programme

NHS National Institute for Health Research

The Nature and Consequences of Support Workers in a Hospital Setting

Ian Kessler,[1] Paul Heron,[2] Sue Dopson,[1]
Helen Magee,[2] Danielle Swain[2] and Janet Askham[2]

[1] Said Business School, University of Oxford
[2] Picker Institute Europe

Published June 2010

Project 08/1619/155

Address for correspondence:

Dr Ian Kessler
Said Business School
University of Oxford
Park End Street
Oxford, OX1 1HP

Email: ian.kessler@sbs.ox.ac.uk

This report should be referenced as follows:

Kessler I, Heron P, Dopson S, Magee H, Swain D. Nature and Consequences of Support Workers in a Hospital Setting. Final report. NIHR Service Delivery and Organisation programme; 2010.

Contents

List of tables

List of figures

Glossary of terms/abbreviations

Abbreviation	Term in full	Explanation of term
	Acute Trust	Also known as an NHS hospital Trust, provides secondary health services within the NHS and are commissioned to provide these services by NHS primary care trusts.
AfC	Agenda for Change	The 2004 collective agreement which established the current NHS grading and pay system for NHS staff. It harmonises their pay scales and career progression arrangements across traditionally separate pay groups. There are nine new numbered pay bands subdivided into points, similar to the old alphabetic Whitley Council 'grades' pay scales.
CQC	Care Quality Commission	Formerly the Healthcare Commission, it is a non-departmental public body established in 2009 to regulate and inspect health and social care services in England.
DH	Department of Health	The department of the United Kingdom government with responsibility for government policy for England on health, social care and the National Health Service.
FT	Foundation Trust	An NHS Trust that is part of the National Health Service in England and has gained a degree of independence from the Department of Health and local NHS strategic health authority.
KSF	Knowledge and Skills Framework	A competence framework to support personal development and career progression within the NHS, introduced as part of Agenda for Change
NMC	Nursing and Midwifery Council	The body set up by Parliament to regulate the nurse and midwifery professions.
NHS	National Health Service	The publicly-funded healthcare system in England.
NVQ	National Vocation Qualification	Work based awards in England, Wales and Northern Ireland that are achieved through assessment and training.
PDR	Performance Development Review	Integral to KSF, the approach for assessing individual performance.
	Project 2000	A scheme, introduced in 1989, that

Abbreviation	Term in full	Explanation of term
		formed the basis for the academic education of all nurses and midwives.
RCN	Royal College of Nurses	A membership organisation representing nurses and nursing.
	Secondary Healthcare	The service provided by medical specialists who generally do not have first contact with patients. The term is usually synonymous with 'hospital care'.
SEN	State Enrolled Nurse	Prior to the implementation of Project 2000, SEN students used to follow the first 12 months training of the state registered nurses (SRNs, now known as level one nurses), and then had another 12 months of training before sitting SEN exams and becoming registered nurses.
SHA	Strategic Health Authority	There are ten SHAs which form part of the structure of the National Health Service in England. Each SHA is responsible for enacting the directives and implementing fiscal policy as dictated by the Department of Health at a regional level.
	UNISON	The main union representing support workers in healthcare.

Acknowledgements

During this project Professor Janet Askham passed away. Janet significantly contributed to this work. During this project we have tried to meet the high standards she set throughout her academic career and we hope that this report is a worthy tribute to her memory.

We would like to thank all the patients, support workers, nurses and managers who generously gave their time to be interviewed. We are particularly indebted to the four Acute Trusts who hosted the case studies.

We also thank members of our advisory group[1] for their invaluable guidance:

- Gail Adams, UNISON
- Stephen Bach, King's College London
- Roswyn Hakesley-Brown, Patients Association
- Tony Halton, Department of Health
- Ros Moore, Department of Health
- Jane Naish, RCN
- Jim O'Connell, NHS South Central
- Deborah O'Dea, Healthcare People Management Association
- Chris Pearson, Skills for Health
- Jo Rycroft-Malone, RCN Institute
- Lynda Scott, NHS Employers
- Karen Spilsbury, University of York

[1] Job titles of group members are those at time of advisory meeting.

Executive Summary

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.

The Report

1 Introduction

Support workers have been a longstanding feature of the health service workforce. In recent years, however, their importance has increased. This is reflected in their growing numbers and in their stated value to policy makers and practitioners in pursuit of a variety of service and other organisational objectives. At the same time, this prominence has placed their role under increased public scrutiny, apparent in debates on its implications for patient care and, more specifically, on whether and how it should be regulated (1). Yet despite the general interest shown in support workers, the evidence base on their use and consequences remains patchy. This report presents the findings from a three year study on two key support roles in secondary healthcare, the healthcare assistant (HCA) and the ward housekeeper. The aim has been to broaden and deepen understanding of these roles and in so doing to provide a firmer foundation upon which policy makers and practitioners can develop the roles, as well as those who perform them.

1.1 Locating support roles: scale and definitions

As a generic role, the support worker can be found in a range of healthcare and social care sector settings. In a broad definition of the role, designed to cover these various service areas, Saks and Allsop (2) view support workers as those:

> *…who provide face to face care or support of a personal or confidential nature to service users in a clinical or therapeutic setting, community facilities or domiciliary, but who do not hold a qualification accredited by a professional association and are not formally regulated by a statutory body.*

This is a definition which leads the authors to suggest that around one million such workers can be found across the United Kingdom, a considerably higher number than any registered group of health or social care workers.

In a more refined definition, relating to staff specifically employed in the NHS, the Scottish Executive defines the 'Heath Care Support Worker' role as (3):

> *Those who provide a direct service- that is they have direct influence/effect on patient care/treatment/relationships- to patients and members of the public …This would include those in support roles to healthcare professions (such as care assistants) and those who provide ancillary services (such as porters and mortuary attendants).*

Using such a definition, the number of support workers in the NHS in England is best calculated by drawing upon those workers officially classified as 'supporting clinical staff' (4), a group sub-divided into those providing support to: doctors and nurses; scientific, therapeutic and technical staff; and ambulance staff. In 2008 the full-time equivalent (FTE) number of staff across these sub-categories stood at 284,000, a noteworthy rise from 220,000 employed in 1998.

The Nursing and Midwives Council (3), distinguishing healthcare assistants as a subset of health support workers, explicitly draws upon the definition developed by the Scottish Executive, tightening its focus to describe HCAs as:

> *Those who provide a direct service – that is they have a direct influence/effect on care/treatment to patients and members of the public and are supervised by and/or undertake healthcare duties delegated to them by NMC registrants.*

Under this definition HCAs would fall under the official category of 'supporting doctors and nurses'. This category does not completely overlap with the HCA role, comprising other groups of staff such as administrative workers. But considering those groups which fall under this heading and within the NMC definition, there has been a modest rise in HCAs over the last ten years: the FTE numbers increasing from around 110,000 in 1998 to some 114,000 in 2008.

With these HCAs spread across the health service, there is a need to establish numbers in a **secondary** healthcare setting. This is not a straightforward task: a breakdown of staff groups by healthcare setting is only provided as far back as 2005. Over the period 2005-8 secondary healthcare remained the main setting for the employment of healthcare assistants, but it is noteworthy that the numbers (FTE) went down from around 70,000 to some 64,000, suggesting some caution in proclaiming the inexorable rise of the HCA. Moreover this was a time when the number of nurses in this sub-sector increased, albeit modestly, from 170,000 to 173,000. In combination, these trends indicate that in 2008 there was not far short of three nurses to every HCA in secondary healthcare.

The various definitions of the support worker provide some clue as to the nature of the HCA role. They suggest that any characterisation can be related to intrinsic functionality – what post holders actually do – and to the way in which the role is managed. In terms of functionality, the notion of a support role begs questions about whom or what is actually being supported. The Saks and Allsop definition places considerable emphasis on service user support, as does the Scottish Executive definition, with the weight given to the role's 'direct influence or effect on patient care'. The NMC definition brings to the fore the HCA's relationship with the care professional. It stresses the HCA's role alongside and possibly in support of the nurse, implicit in the assumption that the latter delegates to the former. This closeness to the professional is crucial in affecting the possible contours of the HCA role: it remains an empirical question as to whether

and in what ways the HCA supports the nurse, and whether they deliver hands-on care, but it is this potential to work in harness with the nurse and to provide such care which distinguishes the HCA from those in ancillary health support roles.

In terms of managing the support role, Saks and Allsop stress the absence of statutory regulation and the scope to undertake the role without any accredited qualification. This is not intrinsic to the role but rather a default public policy choice. There has been much debate over whether and how support roles in health should be regulated, with a pilot project ongoing over recent years in the Scottish NHS to explore regulatory options. Notwithstanding these developments, the HCA role in secondary healthcare, as elsewhere in the NHS, remains unregulated in statutory terms. It is this absence of regulation in relation to a role that works so closely with the nurse professional and with the potential to provide hands-on care which generates such a wide and intense interest. It has encouraged a focus on who takes up the post, what they do and how they impact on different stakeholders.

This report mainly focuses upon these questions. The next two parts provide a backdrop to the project, setting out:

- Context: evolution, public policy and research
- Research approach: themes, methodology and data collection techniques.

The findings as they relate to the HCA role are presented in five parts covering:

- HCAs as a strategic resource
- HCA backgrounds
- The shape of the HCA role
- Consequences of the HCA role for post holders, nurses and patients
- Summary and conclusion.

The findings on the ward housekeeper role are separately set out in Appendix 1.

2 Context

2.1 Evolution of the role

The presence of a support worker alongside the nurse has a long history, central to an understanding of the current state of the HCA role. A nurse support role can be traced back to the beginnings of modern nursing. Stokes and Warden (5) highlight the presence of nurses' aides during the Crimean War, 1854-56, and track the development of the role over the following century and a half. This development has been punctuated by a number of key events. The establishment of nursing as a registered profession under the Health Care Act, 1919, failed to ensure complete closure for 'qualified' nurses, continuing to allow non-registered workers as part of the nursing workforce. In 1955 the 'nursing auxiliary' role was given formal recognition in the healthcare setting, but co-existed alongside a qualified assistant nurse. The assistant nurse qualification did not allow registration as nurses, but did lead to inclusion on a Roll of Nurses, and in 1961 to the designation State Enrolled Nurses (SEN). (6)

From the mid-1980s, a series of related developments propelled the nurse support role to the fore in terms of public policy and practice. The first was a re-organisation of nurse training launched in 1986, under the title Project 2000. This shifted training from an apprentice 'shopfloor' model to one rooted in formal theory and the 'classroom', reducing the opportunity to use student nurses as a nurse support on the ward. The introduction of a role for the first time labelled 'healthcare assistant' was explicitly seen as the replacement for this student nurse support. Introduced alongside the NHS and Community Care Act, 1990, the HCA was presented as a local grade for newly created Trusts to shape and reward, complementing the established national Whitley 'nursing auxiliary' grade.

Secondly, and entwined with the Project 2000 changes, the SEN role was phased-out, although National Vocational Qualifications (NVQ) in healthcare was introduced providing an alternative and perhaps more flexible form of accreditation for the nurse support role. With the passing of the SEN, a qualified layer of nurse support was removed, but a degree of formal hierarchy remained amongst the non-qualified nurse support workforce, linked to the size and complexity of different roles. This was reflected in the grading of nurse support roles as mainly grades A and B; the 2004 Agenda for Change agreement replaced these with Bands 2 and 3 and introduced a new catch-all title for this role: the Clinical Support Worker. The Band 2 role now spans points 1 to 9 on the new pay spine, giving a range of £13,200-

16,300, while Band 3 covers points 6 to 13 with a range between £15,200 and £18,200 (at 1.4.09 rates).[2]

A third development relates to a package of changes placing pressure on continued nurse engagement with direct patient care. New regulatory requirements, in particular the European Working Time Directive, enacted in 1998 and taking effect in the NHS in August 2009, have necessitated a radical reconfiguration of working hours amongst junior doctors, encouraging, in turn, the delegation of some of their tasks to nurses, such as taking bloods and cannulation. This has been accompanied by the emergence of a range of different specialist nurse roles, most commonly referred to as nurse practitioners, clinical nurse specialists, and nurse consultants (7). Again, these roles have been designed to take tasks off 'hard pressed' junior doctors. An RCN study (8) of over 700 nurses performing such roles found that most had been introduced in the last four years, with 60% of respondents being the first to fill them.

These developments sit alongside changes related to the modernisation of the NHS over recent years, similarly challenging the nurses' presence at the bedside. The emphasis on access targets has encouraged a focus on the efficient throughput of patients, with a concomitant requirement on nurses to deal with the procedural complexities surrounding admission and discharge. A more general strengthening of the NHS performance management regime, again in line with the achievement of targets, has also encouraged nurses to devote time to auditing various aspects of patient care and ward maintenance.

It remains an empirical question as to how far the registered nurse role has changed and the extent to which it continues to provide direct, basic patient care. At the very least it is a space that has been increasingly opened up to HCAs, as reflected in and acknowledged by statements from various commentators and policy makers. As the NMC (3) notes:

> *There are now significant changes in the way that services are delivered to patients. In particular following the General Medical Services contract and the European Working Time Directive, nurses and midwives and specialist community public health nurses are undertaking treatment and care that was once the domain of other healthcare professionals, notably doctors. Consequently this has led to non-registered staff members delivering some aspects of care previously only undertaken by nurses.*

As the government has recently noted (1):

> *Unregulated staff, such as healthcare assistants and other support staff are extending their skills so that they can undertake work previously done by registered professionals in order to meet patient needs.*

---

[2] The mean **basic** salaries for Band 2 HCAs stands at £14,800 and for Band 3 at £16,800. This compares to the Band 5 average basic salary of £23,800. Interestingly average **earnings** for Band 2 HCAs at £17,500 and for Band 3 at £19,550 take them over the respective band maxima.

A long history has, therefore, resulted in the nurse support role becoming deeply embedded in the nursing workforce. It is a longevity which has brought with it a considerable legacy, not only in terms of job titles – nurse auxiliary, nursing assistant, healthcare assistant, clinical support worker – still in common currency, but also in relation to the connection between such titles and the performance of specific tasks and activities; a relationship which remains somewhat opaque. As then Minster of State for Health John Denham (9) noted:

> *There is no fixed definition of what an HCA is or does. In the service itself, the term HCA is often used interchangeably with titles used for other staff who undertake similar roles and provide similar support, for example healthcare support workers, nursing auxiliaries and nursing assistants.*

At the same time, the direction of development in recent years is one in which the nurse support workers' significance to nursing has grown, in part a result of other support roles such as student nurses and SENs withdrawing, but also because the ability and willingness of registered nurses to stay within a traditional direct, basic care space has been increasingly challenged. As a result of these developments, and reinforcing them, policy makers have been attracted to the HCA role as a vehicle for the pursuit of various goals. This commitment to the role has, however, been far from unambiguous. The next section considers these policy goals alongside the residual reticence amongst policy makers to always acknowledge the centrality of the HCA to patient care.

2.2 The modern HCA role: policy objectives

The importance of the HCA role to the delivery of healthcare services in the context of the developments outlined has increasingly been recognised by policy makers. For example, in his report on the future of the NHS for the government, Wanless (10) noted that, 'alongside support for an extension of nurse-led services, there was general agreement that the next twenty years will see an extended role for healthcare assistants.' More recently the importance of the HCA has been re-asserted, the NHS Next Stage Review (11) noting that:

> *Key to delivering this overall programme are clinical support roles, for example, healthcare assistants. We will work with partners and the profession to ensure that employees in these types of roles are appropriately trained.*

Despite the growing importance of the HCA, there have been signs of a caution towards the role. Some years ago, the HCA was described by Thornley (12) as an 'invisible worker', and when the Secretary of State for Health noted in 2008 that, 'Our **nurses** do a brilliant job, often delivering very intimate care' [emphasis added] without any mention of the HCAs' contribution in this respect, it is tempting to suggest that HCAs still remain in the shadows. Indeed, the NHS Plan for England made no mention at all of HCAs (13), with this reluctance to acknowledge their role articulated when

the then Warrington North MP Helen Jones (9) raised the issue in the House of Commons:

> *Part of that modernisation [of the NHS] is our commitment to supporting and valuing our staff. In that context, we hear much about doctors and nurses… however other members of staff are also an important part of the healthcare team; without them our National Health Service could not function. Those include the category known as healthcare assistants, or in some trusts, support workers.*

An understanding of the public policy approach to the role and this ambiguity can be more fully gleaned from a consideration of the objectives underpinning its use. With varying degrees of explicitness, four main public policy goals can be distinguished, reflecting the role's use as a relief, a substitute, an apprentice and a co-producer (14). Each is briefly considered in turn.

2.2.1 Relief

The most prominent of the public policy objectives informing the use of the HCA has been to relieve nurses of 'routine' or 'burdensome' tasks, so allowing them to concentrate on new or core professional activities. This development has envisaged the HCA as available to take on some of the regular and standard chores related to direct and basic patient care, sometimes referred to as 'activities of daily living', such as washing, bed making and feeding. As the Department of Health (DH) (15) has noted, citing an example:

> *Extending the role of the HCA has saved many hours of qualified nursing time. For example developing the competencies of HCAs on the stroke unit at Bradford (NHS Trust) has saved many hours of qualified nurse time.*

The use of the HCA as a relief does, however, raise issues about what constitutes a routine or peripheral task, and where the professional core really lies. This is a situation complicated by the fact that what constitutes the nurse core and periphery might well have shifted in light of the broader public policy development outlined above.

2.2.2 Substitute

If the HCA as a relief is taking over more routine responsibilities from the nurse, the notion of the HCA as a substitute views the role as encroaching upon traditional core nurse tasks. This again raises questions about what constitutes the nurse core; within the context of holistic notions of nursing, even HCA responsibility for direct care might be seen as a form of substitution. Substitution also relates to more longstanding public policy debates, often revolving around skill mix practices: whether and to what degree unregistered HCAs might safely be traded-off against registered nurses in the composition of the nursing workforce. It is an issue which has often been linked to budgetary context, with the use of HCAs as a 'cheaper'

option to nurses a response to periodic financial pressures on the NHS (16). The recent past has been characterised by high levels of public investment in the health service. However, this should not distract attention from the financial difficulties individual Trusts might have faced over these years or from the imminent onset of a period of public expenditure constraint. The use of the HCA as a flexible and lower cost source of labour presents public policy makers with a dilemma: the tighter regulation of the role addresses the development of a high quality support workforce (see below) but runs the risks of erecting costly barriers to entry at the bottom end of the nursing workforce, so choking off a ready supply of employees.

2.2.3 Apprentice

As an 'apprentice', the HCA role has been used by policy makers to address two main aspects of workforce capacity: providing a supply of registered nurses, not least in the light of the periodic shortages, and facilitating the development of a more capable HCA workforce.

Although Trusts have traditionally provided secondment schemes to support HCAs keen to train as nurses, more recently the use of the support role as the source of 'grow your own' registered nurses has connected to a broader public policy agenda designed to encourage greater access to the health professions. This was reflected in a government-commissioned report by Alan Langlands (17) on gateways into the professions, work which was deepened in the health service with the creation of the Widening Participation Unit in the DH in 2005, *inter alia* seeking more integrated career pathways for support staff in the NHS (18). The most striking initiative in this respect has been the development of the DH Skills Escalator (15), introduced with the suggestion 'that in theory, staff can progress from cleaner or porter to consultant or chief executive.' (19)

This focus on upward HCA mobility dovetails with policy attempts to encourage the individual to develop within the role, becoming a more skilled HCA practitioner. The acquisition of NVQ levels 2 and 3 has been a longstanding means of encouraging this form of development, but in the last few years it has been linked to the more determined and formal use of competencies as the basis of in-role development. This is reflected in the competency-based gateways regulating incremental pay progression under Agenda for Change and supported by the Knowledge and Skills Framework. It is a development seen by policy makers as contributing to the HCA's ability to act as a relief. As the DH (15) has stated:

> *As existing staff develop into new roles on the skills escalator, so the time of more highly skilled staff can be used more effectively. For instance suitably skilled support workers could carry out some of the current task of registered nurses, freeing up these nurses to contribute more fully with their skills. The new pay system will recognise those roles and provide incentives for staff to acquire necessary extra skills.*

2.2.4 Co-producer

The final public policy objective informing the development of the HCA role views it as contributing in a distinctive way to the provision of healthcare: HCAs are co-producing by bringing to the ward team particular and unique qualities. These might be seen to derive from the nature of the role and the types of individuals performing it. As the then Health Minister John Denham (9) noted:

> *HCAs are an invaluable and important part of the NHS… they make an important contribution to the direct care of patients* ***as well as*** *supporting a range of professionals in a wide variety of ways. [Emphasis added]*

It is striking here that reference is being made to an HCA contribution to direct care 'as well as' to providing professional support. It suggests that HCAs have a distinctive contribution to make over and above such support. It was a view more recently and explicitly stated in the Next Stage Review (20):

> *A key priority for the Next Stage Review is the development of the workforce, including those in clinical support roles, to deliver high quality and safe care. The wider healthcare team is essential both to the modernisation of professional career frameworks and to the quality of patient experience. They have continual and regular contact with patients and provide essential support to multi-disciplinary teams in the delivery of care.*

The HCA role sits beneath the registered role in the healthcare occupational hierarchy and as such might be perceived as more accessible and less intimidating to the patient. Structured in this way, it might also be regarded as attractive to individuals with a different personal profile to other members of the ward team, one perhaps filled by people who more easily relate to and reflect the background of the patient.

In contrast to the HCA as a relief or a substitute, models which imply a significant overlap between HCA and nurse roles, as a co-producer the HCA is seen as providing added value to the quality of care in its own right. Again it is a conception of the role tempered by some caution on the part of policy makers: an unregulated role playing an increasing part in the provision of direct care brings with it potentially high risks in terms of reputation and other costs.

In summary, it is clear that the HCA role has increasingly been used by policy makers as a vehicle for pursuing a range of objectives linked to labour supply, to workforce structure and development as well as to service quality. The efficacy of the role in these terms is, however, founded upon a number of assumptions. These assumptions relate to four main research domains:

- The **strategic use** of the HCA as a Trust resource;

- The **background** of the HCAs, that is how they are acquired and the kinds of people who take-up the role;
- The **shape and nature** of the HCA role, in particular the range as well as the type of tasks it might embrace; and
- The **consequences** of the role for various stakeholders, especially the HCAs themselves, the nurses they work with and the patients they care for.

The next section considers the research literature and the analysis as they relate to these domains, so looking at the evidence base for the assumptions underpinning the public policy goals held for the HCA.

2.3 Policy assumptions and the current evidence base

Over the years, a significant body of research on the nurse support role in Britain and in other developed countries has emerged, with varying degrees of explicitness touching on the four domains of interest distinguished. This research has provided a detailed description of many aspects of the HCA role; it has been less forthcoming in seeking to explain how and why the role has developed and impacted. In reviewing previous research and how it relates to policy assumptions, this section mainly focuses on British findings; the idiosyncratic and path-dependent nature of the nurse support role in this country suggests the need for some care in assuming the applicability of research work from further afield.

2.3.1 The HCA as a strategic resource

The presentation of the HCA role as a means of addressing a range of public policy objectives assumes the propensity of NHS Trusts and other relevant institutions to act strategically in terms of workplace planning across the nursing workforce, and specifically in relation to the development and use of the HCA role. If the HCA is to be used to help modify the nurse role, to address future staffing needs or to improve the quality of the patient experience, it suggests the need for an explicit, coherent and planned Trust-wide approach to the role. Whether or not the HCA role is being considered by Trusts in these strategic terms remains unclear; this is in part a consequence of opaque systems operating in the planning of the nursing workforce, but also the result of limited research exploring this issue.

In the main, systems for planning the nursing workforce have operated at the regional level, typically linked to the commissioning of nurse training places, but subjected to regular change over the years, not least a consequence of frequent organisational modifications to this tier of the NHS. At present, such planning is principally undertaken by the Strategic Health Authority (SHA), 'with lead responsibility to support the assessment of workforce requirements within their geographic areas, in associations with NHS employers at Trust level.' (21) General workforce planning in the NHS has, however, been subject to considerable recent criticism, particularly by the House of Commons Health Committee (22), which pointed to the need

for a system better able to integrate medical and non-medical workforce planning and to deliver a more flexible workforce. This view is supported by the research of Imison et al (23), who, in reviewing existing workforce strategies and investment plans of SHAs, found that seven out of ten were investing less than five percent of their budget on training linked to workforce flexibility: new ways of working and new roles.

This set-up suggests that individual Trusts have had limited resources or space to explore the use and development of the HCA role, and as a consequence, a possibly depleted in-house capacity to do so. There have, however, been few, if any, attempts to address the strategic use of the HCA in the research literature. The closest the research community has come to dealing with this issue is work on skill mix issues at Trust level. This literature suggests that rather than adopting a strategic approach, Trusts have been opportunistic in their engagement with the HCA role, reflected in a shifting balance between registered and non-registered staff as a response to changing financial circumstances (24). This expediency has been seen to extend to the manipulation of grade mix (16), with some Trusts seeking to use locally graded and cheaper HCAs as a replacement for the nurse auxiliary grade to save costs.

Within the context of current workforce planning constraints, and given the absence of recent research, it remains worth considering whether and how senior Trust managers have engaged with the HCA role as part of a more strategic approach to the workforce. Has the current system squeezed out opportunities for Trusts to consider the role in these terms or is there residual scope to do so?

2.3.2 Backgrounds

If HCAs are seen as a potential source for future registered nurses, as a relief or substitute for nurses, and as providing a distinctive contribution to patient care, the background characteristics of those taking up the job become crucial: do those entering the role have the requisite skills, aspirations and motivation to give effect to these policy goals? Do post holders want to become nurses or to develop within the role? Do they bring to the HCA role capabilities from previous paid and unpaid work roles and a disposition which impacts on how they perform within it?

Over the years, an increasingly detailed picture has emerged of the personal characteristics of HCAs, particularly drawing on the regular surveys conducted by Thornley (12) and UNISON (25). Such surveys and others (26) have highlighted the gendered nature of the role, most post holders being relatively mature women, often working part-time and with ongoing domestic responsibilities. Some insight has also been provided into the aspirations of HCAs, the latest UNISON survey (25) suggested considerable interest amongst these employees in undertaking nursing or other professional training.

Data on the background of HCAs, however, remain limited in a number of respects. First, there is a paucity of qualitative data which might provide a

greater in-depth appreciation of the factors that lead individuals to the HCA role: what are entrants seeking from it and how do their lives beyond the hospital gates shape what they do within them? Second, there is little hard data on past working patterns of HCAs; on what kinds of sectors and occupations they are drawn from, and which ones may provide gateways into the role. Third, there is a marked absence of material on how local labour markets and the general demographics of an area affect the supply and kinds of people taking up the HCA role. Attention has been drawn to considerable regional variation in vacancy rates in a range of healthcare occupations within the NHS (27), while Elliott et al (28) note that 'the nature of characteristics of the local labour market [are] crucial in shaping Trusts' responses to [staff] shortage and in turn their competiveness.' Fourth, there have been very few attempts to contrast HCA backgrounds with those of the nurses: an important means of defining the HCA lies in distinguishing them from the nurse in background terms.

2.3.3 The shape and nature of the HCA role

In presenting the HCA as both a potential relief and a substitute for the nurse, policy makers are making profound assumptions, not only about the general form assumed by the role, but more specifically about its capacity to embrace tasks which range from the routine to the more technically sophisticated. The notion of an extended HCA role has long been acknowledged amongst practitioners. As Hardie (29) observed over thirty years ago in relation to the nursing auxiliary, 'work can vary from some basic nursing skills, such as bed making and maintenance of equipment, to dealing with complex interpersonal and technical situations.' However, within the context of recent policy pronouncements, questions are raised about the shape of the contemporary of the HCA role. These questions relate to the nature of the tasks performed and how these are packaged, as well as to the form assumed by any extension of the role.

Much previous research on the nurse support role has focused on the tasks and activities undertaken, considering them in a number of different ways. First, the HCA role has been explored in different healthcare settings, with a particular interest in general practice (30), intensive care units both within acute (31) and community mental healthcare (32), as well as in more general hospital wards (33-34,26). While these studies have adopted different methodologies, from the nationwide survey (31) to the in-depth case study (34), one of the more common findings relates to the ongoing fluidity, variation and in some instances uncertainty in the use role.

Second, researchers have explored the shape of the role by reference to the frequency with which different tasks are undertaken by the HCA, often with a view to identifying the degree of overlap with the registered nurse role. Survey work (12,26) has highlighted the propensity for most HCAs to undertake certain basic tasks such as bed making and patient bathing while also noting the performance of more complex and technical tasks associated with, for example, dressings and catheters. Indeed, Thornley (35) stresses a marked similarity in the activities undertaken by HCAs and nurses,

implying that in practice differences in the contours of the respective roles should not be overstated.

Third, there have been attempts to examine the shape of the role as viewed by various stakeholders. This work has tended to drift into the prescriptive; for example, ward managers in one large acute Trust highlighted the need to further extend the HCA role (36), while radiology service managers in the south of England stress their importance given shortages in radiographers (37).

Previous research, then, has provided important insights into the general shape of the HCA role in a number of different healthcare settings, while at the same time suggesting that it is not an easy role to 'tie down'; the role appears to take various forms, extending across a range of tasks in different combinations, sometimes overlapping with work of the registered nurses. It is a view of the role which opens up two key issues: one linked to the forms assumed by the role, and the other to the factors shaping these forms.

There is a need for a sharper conceptualisation and characterisation of the role which captures its different forms. What patterns can be distinguished in the shape of the HCA role? In the context of the general debate on the possible extension of the HCA role, where does the core of the role lie, and, given the longevity of the nurse support role, has this core shifted? Addressing such questions requires an in-depth evaluation of the tasks performed by HCAs, designed to pick up variation in a nuanced way. For example, while past research has often asked whether or not given tasks are undertaken, a more variegated picture might emerge if consideration was given to **how often** they were performed.

If the HCA role takes different forms, it follows that analysis of how and why these forms have emerged is also required. A distinction between structure and agency is useful in this respect. What is the balance between institutional context and individual action in shaping the role? In exploring the HCA role in different healthcare settings, the importance of structural context is implied but rarely explored; there are few attempts to compare the role between settings or between organisations in the same setting, or even between, say, different clinical areas in the same organisations. The limited attention paid to structure in these terms is surprising given a possible link between the institutional context and the HCA role. Healthcare setting and clinical area might well be expected to influence the type of patients cared for and the tasks therefore performed; while the different work systems, cultures and management styles of the Trust or of lower level organisational units such as the division or ward, might similarly be assumed to have an impact upon the nature of the role. The potency of individual agency against this backdrop remains an interesting empirical question (33): there is an implication, given the interest in the individual backgrounds and aspirations of HCAs shown by some researchers, that agency has residual significance, but few have investigated the link between agency, the shape of the HCA role and performance within it.

2.3.4 Consequences

1. For the HCA

The public policy objectives underpinning the use of HCAs have very different and potentially contradictory consequences for those individuals actually performing the role. As a relief, the HCA is presented as picking up the more mundane tasks which, while freeing up the nurse, conjures up the spectre of fairly degraded job. Moreover, in viewing the HCA as a substitute, questions are raised about the 'fairness' of a situation where HCAs are undertaking traditional nurse tasks on a considerably lower wage. On the other hand, as an apprentice, the HCA is seen as having opportunities for career development either within or beyond the role, holding out the hope of improvements in the present and future quality of working life.

Research on the degradation or enrichment of the HCAs' working life has placed greater emphasis on the former. Views on the nature of the degradation have, however, varied. First, a stream of research has emphasised an undervaluing of the HCA role over the years, seen as deriving from certain biases in formal pay and grading systems. Thornley (38-39) has noted the lack of sensitivity in such systems to the kind of tacit, caring skills which HCAs typically bring to the role, leading to a consistent under-rewarding. Second, work has highlighted certain grievances held by HCAs about working relationships. In part, this is reflected in a perceived misuse of the HCA by nurses (34) but has also been seen to derive from some uncertainty amongst nurses as to how to use HCAs efficiently and effectively (40). Third, research has suggested a more general disillusionment with the role, reflected in the most recent UNISON survey (25) which showed that around a third of respondents had 'seriously considered leaving the role', many because they 'felt under-valued by the employer'. Fourth, researchers have cast some doubt on the willingness and ability of HCAs to take advantage of the career development opportunities associated with the role, a function of the practical difficulties individuals face in undertaking further training (41). Research highlighting negative outcomes for post holders has tended to eclipse work noting more positive consequences. However, Knibb et al (26), using an established job satisfaction scale, report fairly positive HCA views on working conditions, while Cox et al (42), in a study on the Skills Escalator find some extension of career opportunities for NHS support workers, albeit unevenly distributed across the country.

The suggestion that the HCA role has mixed consequences for post holders encourages a further consideration of outcomes. This might involve a more thorough consideration of the factors which influence HCA work experience, while also elaborating on the ways in which impact is assessed. One measure generally overlooked by researchers relates to the emotional impact of the HCA role on those who perform it. Caring work as a form of emotional labour has attracted considerable research interest in recent years (43) and yet while nursing has consistently been seen as an example of such labour (44), HCAs have rarely been considered in these terms. There are strong grounds for arguing that the emotional consequences of

care work in an acute setting are likely to be as, if not more, intense for the HCA than for the nurse: with HCAs increasingly taking on the direct care work, the emotional fallout from such care is likely to fall disproportionately on those within the role.

2. For the nurse

The public policy objectives which view the HCA as a relief, a substitute and a co-producer also have contradictory implications for the nurse. These connect to some of the ambiguities underpinning the pursuit of nurse professionalisation. As a relief, the HCA would appear to be of straightforward benefit to the nurse. The literature on professionalisation has long highlighted the value of a lower order occupational group to the would-be profession. Abbott (45) views such support roles as available to professionals to take on 'dangerously routine work' which otherwise might dilute claims to knowledge-based expertise. As Hughes (46) has noted in a healthcare context, 'Nurses, as they successfully rise to professional standing, are delegating the more lowly of their traditional tasks to aides and maids.'

On closer inspection, however, a number of potential difficulties for the nurse flow from the HCA role. The first lies in the other policy objectives highlighted for the role. As a substitute and a co-producer, HCAs might be seen to represent a threat to nurses and their jurisdictions; in the case of the former by taking over their core tasks and, in relation to the latter by bringing distinctive capabilities to bear on patient care. In a policy context, these concerns have been reflected in a traditional reluctance on the part of the RCN to admit nurse support workers into membership. As Rye (47) noted some years ago, 'There is no doubt that if the RCN is to retain its credibility as a professional organisation, it cannot receive into membership untrained personnel who are not training for any of the statutory qualifications.' It is an approach which the RCN have only changed relatively recently, now admitting HCAs with an NVQ level 3 qualification.

The second difficulty for nurses resides in competing notions of nursing as a profession (48). As noted, the HCA as a relief supports a model of nurse professionalisation based upon the delegation of routine tasks as more technical and specialist tasks are acquired. However, for those who view claims to professional status as resting on the provision of holistic nursing care, the casting-off of the apparently routine becomes more problematic. It is such a concern which prompted the NHS chief nursing officer (49) to warn:

> *I believe that we are guilty of seeing caring as lower status as reflected in our keenness to delegate caring aspects of our role to others. Our action fails to legitimise the value of caring – as nursing develops we tend to take on the roles and tasks from the medical profession.*

This concern is also reflected in the ambiguity of the RCN to nurse engagement with direct, basic caring tasks as part of holistic care: as nurses readily take on advanced nurse roles with implications for their ability to perform such tasks, the RCN is voting against devolving the caring

component of nursing to HCAs. As the then General Secretary stated in the wake of this 2004 vote:

> *We [nurses] are assessing the patient, we are doing holistic care, we are checking their emotional state… I don't know how you can talk about caring and nursing. It's the same thing. Nursing to me is caring.*

The third potential difficulty for nurses with the HCA role lies in the realm of management and accountability. The HCA remains a member of the ward team who has to be managed within the context of ongoing nurse responsibility for patient care. The NMC code of practice is clear on this issue, noting that nurses are responsible for the delegation of tasks but not for the performance of the tasks themselves. However, in the mind of the busy nurse, this distinction might not always be easily drawn. Uncertainty and caution on their part would be understandable: HCAs are not regulated so denying nurses any default quality assurance on HCAs capabilities and it is after all nurse registration that is 'on the line' for any error in judgment.

Research on nurse engagement with HCAs has, with varying degrees of explicitness, touched upon some of these difficulties. There is some evidence to suggest that HCAs have indeed relieved nurses of certain routine activities allowing them focus on core professional tasks (51) – encouraging a positive view of the role (52). At the same time, there is also data to suggest some tension in the nurse-HCA relationship. McKenna (53) revealed that nurses were devoting a growing amount of time to inducting, training and supervising increasing numbers of HCAs, a finding echoed in a survey of UK nurses: McLaughlin et al (54) found 'some concern regarding RN delegation and supervision to nursing care assistant that occasionally detracted from RN duties.'

A number of studies have also highlighted continued nurse attempts to protect their occupational jurisdiction and to resist HCA encroachment in the form of substitution. This is reflected in ongoing 'boundary work' performed by nurses, for example, in the form of atrocity stories (55-56) about HCAs 'mistakes'; or in the way in which nursing roles are presented in HCA and nurse training and induction to retain a clear nurse-HCA demarcation (57).

These findings suggest a degree of ambivalence towards the HCA role on the part of registered nurses and their representative organisations, an orientation which might well reflect some of the tensions highlighted in nurse professionalisation strategies (58). It is an ambivalence which encourages further evaluation of the HCA from the nurse perspective: whether, when and why the role is viewed in a positive or negative light.

3. For the patient

For the patient, the double-edged impact of the HCA role lies in very different possibilities as to its effect on the quality of care. As a relief taking on much of the direct patient care from nurses and as a substitute taking on more technical tasks, issues related to HCA capability and the possible dilution of service standards emerge, often coalescing around concerns about safety. Yet as a co-producer, the HCA role, at a lower level to the

nurse and perhaps filled by those with very different sorts of backgrounds to the professional, has the potential for a less intimidating and more empathetic form of care. These assumed patient consequences of the HCA role have a weak evidence base, and once again the limited research undertaken has generated far from conclusive findings.

McKenna et al (53) are forthright in their concern about the use of HCAs, asserting that 'the increasing reliance on HCAs raises serious quality and safety questions'. Such worries find an echo in a survey of chief executives in health and social care organisations which found that over half (52%) felt that there was a 'considerable' or 'moderate' risk from the use of such employees (2). The most significant stream of relevant research has focused on the relationship between skill mix and clinical patient outcomes, raising some questions about the impact on the quality of care as more HCAs are used relative to nurses. This research has consistently shown a positive relationship between the richness of the skill mix and such outcomes (59-60), although there has been some criticism of such research, for example, its tendency to equate skill with grade and job title rather than exploring in greater detail the experience and capabilities nursing staff might bring to patient care (61).

Research on whether HCAs add value to patient care is even scarcer. Nonetheless, there have been suggestions that such workers bring distinctive competencies to caring work. James (62), for example, in her study of nursing in a hospice setting, stresses the skills nurse auxiliaries display in the context of emotional labour, which she defines in terms of managing the emotion of patients and their relatives: 'There is almost an inverse of status and skill in emotional labour… young staff nurses relied on the four older auxiliaries who were described as being the backbone of the unit'. James relates this nurse reliance on auxiliaries in part to the auxiliaries' greater work experience, but also to the auxiliaries' tacit capabilities to manage the emotions of others, developed in a domestic environment and effectively brought to bear in an employment context.

The absence of research on the consequences of HCAs for patient care in the light of policy assumptions is striking, particularly given the weight now placed on the role as the direct care provider. Basic but crucial questions have simply not been posed, let alone explored: whether patients can distinguish between HCAs and other members of the nursing team; whether patients develop a distinctive relationship with HCAs; and whether the nature of this relationship impacts on patients outcomes,. Equally noteworthy has been the absence of the patient's voice on this and other issues related to the HCA role. This project adopts a multi-stakeholder perspective as a means of providing a firmer evidence base for exploring the assumptions underpinning public policy goals for the HCA role, assumptions which relate to the strategic use of HCAs, who they are, what they do and what the consequences may be for different actors. The next part of the report sets out our approach to researching these assumptions.

3 Research approach

Building upon the foundations provided by previous work, our research approach was designed to:

- address policy assumptions related to the backgrounds, tasks and consequences of those performing the HCA role;
- not only to describe the role and its outcomes, but also to seek explanations for them;
- provide a more in-depth understanding of who HCAs are and what they do, so heightening their visibility as contributors to the patient experience, and as a consequence to Trust performance;
- present a comprehensive picture of the HCA role by drawing on various sorts of data and considering the issues from different stakeholder perspectives.

This part of the report is divided into four main sections aligned to these goals: the first sets out the research questions, along with an elaboration of how key terms have been conceptualised; the second clarifies the analytical framework underpinning the consideration of these questions; the third details the research methods used and the data generated; and the fourth outlines the descriptive and analytical narratives shaping the presentation of the findings.

3.1 Research questions

The research concentrated on the following questions:

1. **To what extent have HCAs been viewed as and used as a strategic resource by Trusts in secondary healthcare?**

This question sought to establish whether and how HCAs, as a discrete occupational group, had been considered and deployed by senior hospital managers in the pursuit of broad Trust objectives. This involved looking at whether the four public policy goals of relief, substitute, apprentice and co-producer found any resonance in deliberations and practice at Trust level. This might have been reflected in, for example, considered attempts to recruit and retain HCAs, to train and develop them, or to use them in innovative and flexible ways with the explicit aim of improving the efficiency and effectiveness of patient care.

2. **What are the backgrounds of those taking-up the HCA role?**

The background of those individuals taking-up the HCA role was considered in demand and supply side terms. On the demand side, the kind of people attracted to the role was seen as affected by the formal requirements of the Trust, as reflected in entry criteria, person and job specifications, and less formally, in the actual practice of those Trust managers responsible for

recruitment. On the supply side, various features assumed importance in characterising HCA backgrounds:

- **Personal profile**. Such features as age, ethnicity, domestic circumstances and links to the local community, were seen as an influence on how individuals engaged with the HCA role, the latent and tacit skills they brought to it, and what they were seeking from it in the context of broader life needs and interests. A comparison with nurses was seen as particularly enlightening in establishing whether or not HCAs were distinctive in these terms.
- **Career history**. The breadth, depth and form of previous work experience – paid and unpaid – provided a clue to the skills and capabilities brought to the HCA role by the post holder, as well as giving an insight into future career intentions.
- **Motivations and aspirations**. The aspirations and motivations were viewed as likely to influence how individuals embraced the HCA role.

3. What form does the HCA role take?

A number of means were used to explore the structure and shape of the HCA role:

- **Support orientation**. In asking who the support worker actually supports, three main candidates emerged in the case of the HCA: the nurse, the patient and the ward team. Clearly the three are related and indeed potentially complementary: in supporting the patient by carrying out direct care tasks HCAs are supporting nurses by relieving them, and at same time helping out the ward team. But it as an empirical question as to whether different actors place a particular emphasis on any one of these forms of support, with implications for how the HCA is viewed and treated. The findings on support orientation are presented in Appendix 2.
- **The 'good' HCA**. Beyond formal job descriptions, different stakeholders – HCAs, nurses, ward managers and patients – will have a view about what makes a 'good' HCA; the attitudes and behaviours they expected from the 'high performing' HCA. The findings on the 'good' HCA are set out in Appendix 2.
- **Tasks and Activities**. At the heart of exploring the form assumed by the HCA role are the tasks performed by the post holder: their substantive character, the frequency with which they are undertaken and their configuration within job boundaries. To facilitate a characterisation of the role in these terms, tasks and activities were bundled under the following headings:
    - Direct patient care: Tasks that address the patient's basic needs on the ward (eating, sleep, physical comfort) and involve direct physical contact of a non-technical or non-specialist nature.

- Indirect patient care: Direct patient care that is not of a technical or specialist nature and does not involve physical contact.
- Pastoral care: Providing general support to the patient or relative that is unrelated to their physical condition.
- Ward/Team-centred: Tasks that are one step removed from direct patient care, usually occurring away from the bedside and in communal areas.
- Technical/specialist care: Clinical/medical tasks and procedures that require training to perform.

A number of more specific themes related to shape of the HCA role were explored: first, the degree of differentiation and overlap between HCA and nurse activities; second, where the core of the HCA role lay and what form any extension of the role took; and third whether these tasks combined in different ways to produce different types of HCA.

4. What are the consequences of the HCA role for the three main stakeholders: HCAs themselves, nurses and patients?

For each of the main stakeholders, the HCA role has the potential to unleash both positive and negative outcomes. These outcomes are not necessarily mutually exclusive; they might conceivably co-exist in tension, suggesting some ambiguity towards the HCA role.

For the **HCA:** is the role a dead-end and degraded one, or does it provide opportunities for development and enrichment? These outcomes were explored by considering:

- how HCAs were managed, more specifically how they were treated in terms of their grading, performance management, training and voice;
- the treatment of HCAs by nurses and other actors at the ward level;
- HCA job satisfaction;
- the emotional impact of the role on post holders.

For the **nurse:** is the HCA of value, contributing meaningfully and effectively to their working life or is it a role which adds new burdens and risks to be managed? These consequences were addressed by looking at:

- how nurses used HCAs and how they were perceived to contribute to nurse activities;
- whether nurses had any difficulties in dealing with and relating to HCAs, and if so what form these took.

For the **patient**: does the HCA role provide a less intimidating, more accessible form of care to that available from professional staff or is it the source of a more diluted and uncertain source of care? These outcomes were looked at by assessing:

- whether patients could tell the difference between HCAs and nurses;

- whether patients developed a different type of relationship with HCAs and nurses;
- and if so, whether this difference mattered to patients.

3.2 Analytical framework

The analytical framework underpinning the pursuit of these questions comprised three main elements.

The first was related to whether there were contingent influences on the nature and consequences of HCAs role. There are grounds for suggesting that as a nationally resourced and regulated service, the NHS encourages a basic standardisation in service and work organisation. Such standardisation might be seen to foster similarities across the sector in terms of who is likely to take up the HCA role, what they do and how it impacts. A more contingent view might hold that the HCA role is sensitive to a number of influences which produce variation in these respects. The contingent factors might plausibly include: the region, for example with local labour market factors affecting the supply of individuals into the unregulated nursing workforce; the Trust, with some residual control over the formulation and implementation of policies and practices as they relate to their workforce; and clinical area, the form and outcomes associated with the HCA role being dependent on the kind of patients, care tasks and processes required in different sorts of clinical division.

The second element of the framework suggests an explanatory relationship between the key questions posed in this study. It might be argued that who HCAs are, in terms of their background, aspiration and motivation, influences the form or shape of the role, which in turn impacts on its consequences for different stakeholders. Such a perspective places greater weight on individual agency within or overriding the institutional constraint set by the NHS, the Trust or the division: the HCA role is seen as more malleable and sensitive to the capabilities and interests of those taking it up.

The third element is rooted in a stakeholder perspective. It is likely that HCAs, nurses and patients come to the HCA role with some shared aims, perhaps related to its contribution to care quality, but also some divergent interests, reflecting more specific group concerns and values. A stakeholder perspective encourages consideration of whether there is a consensus on the nature of the HCA role and its consequences, or whether the role has become a site of contestation subject to pressures from stakeholders with competing identity-based aims.

3.3 Research methods

The research was mainly focused on four case study Trusts drawn from different parts of England – South, Midlands, North and London. Originally the intention had been to focus in Trusts in the South, Midlands and the North. As the research progressed it became clear that the distinctive

nature of the London health economy required the inclusion of a London case study Trust.[3] The same multi-methods approach was adopted in each case: this was designed to generate a detailed and comprehensive picture of the HCA role in two clinical areas – general medicine and general surgery – and one sensitive to the views of different stakeholders. The fieldwork was undertaken in three main phases covering a thirty month period: spring 2007 to autumn 2009.

3.3.1 Phase 1 (spring 2007 to late autumn 2007)

The initial phase took the form of semi-structured interviews with senior figures from Trusts in the South, the Midlands and the North regions. These interviews were designed to address our first research question on the strategic use of HCAs. They also provided the basis for the selection of our case studies. A small number of these regional Trust interviews were conducted on completion of the case study fieldwork as a means of calibrating the general case study findings. The intention was to interview the nursing director, HR director and nursing staff representative from either UNISON or the RCN across the three regions. During this phase a total of 16 individuals across six Trusts in addition to those carried out at our case study Trusts were interviewed.

3.3.2 Phase 2 (late autumn 2007 to summer 2009)

This phase comprised qualitative case study fieldwork. The four Trusts, hereafter referred to as South, Midland, North and London, were studied sequentially and in that order, with three months being devoted to each. Background details on the case study Trusts are presented in Table 1.

Table 1. Case study sites

	South	**Midland**	**North**	**London**
Sites	Multi	Single	Multi	Multi
Size	Medium teaching	Large DGH	Large teaching	Medium DGH
FT status	Preparing	Preparing	Preparing	Applied
Finance	Clawing back	Turnaround	Fragile	Surplus
Workforce adjustment	Controls	Reductions	Controls	None
Local area unemployment	7%	9%	6%	6%
Local area BME	17%	24%	12%	26%

[3] The London Trust had also adopted an innovative approach to the accredited training of its HCAs, hence its potential value as an example of 'good practice'.

There was some variation in the structure, stage of development and catchment area of the four Trusts. In terms of structure, two of the Trusts – South and North – were quite large teaching hospitals, while the other two were traditional district general hospitals (DGH). With the exception of Midland, the Trusts had at least two sites, often at some distance from one another. They were at slightly different stages of development: none were Foundation Trusts but one, London, had submitted an application. As a consequence, London was the most financially robust of the Trusts. The others were less secure in these terms, Midland, in particular, facing acute financial difficulties in the recent past, resulting in workforce reductions. There were some noteworthy differences in the socio-economic locations of the Trusts: unemployment around Midland was relatively high, while the Midland and London cases were found in areas of high ethnic diversity: around a quarter of the local population was from black and minority ethnic (BME) groups.

The first Trust completed during this phase was effectively a double case (see Table 2), in terms of the volume of work undertaken: two of the hospital's three sites were studied in considerable detail. This allowed for a testing and sharpening of the research tools. In each case study, three wards were selected from both the medical and surgical divisions, and although there was some variation in the precise patient mix between these wards across the different Trusts, they were similar enough in these terms to allow meaningful comparisons within and between case studies. The chosen wards typically included an emergency facility, a medical or surgical assessment unit, and where possible (in three of the four cases) wards on two Trust sites were included.[4] A total of 29 wards across seven sites were covered in the research.

Table 2. Case study qualitative fieldwork

	South	Midland	North	London	Total
Hospital sites	2	1	2	2	7
Wards	10	6	6	7	29
Staff interviews	96	62	50	65	273
Ward observation	111	60	51	53	275
Patients interviewed/ focus groups	25	19	23	27	94

In each case the following qualitative research work was completed:

- **Interviews**. The aim was to conduct around 50 semi-structured interviews in each case study. This target was achieved in all cases; in three of the four it was significantly exceeded. These interviews included

[4] The second case study Trust was a single site.

around a dozen senior managers (executive directors, divisional managers and matrons) were interviewed per case to provide an overview of developments at the Trust and a corporate perspective on workforce issues. In each ward around six interviews were conducted covering three HCAs, a Band 5 and 6 nurse and the (Band 7) ward manager or senior sister (hereafter referred to as the ward manager). These interviews were wide-ranging, touching on all of the main themes covered in the research (interview schedules are available in Appendix 3). Nurses and HCAs were asked to fill out a short pro forma, providing some structured information on their backgrounds. The interviewees were mainly selected by the ward manager, but survey data (see below) suggest that in terms of background our HCA and nurse interviewees were generally similar to the wider population, suggesting that those interviewed were fairly representative of the ward HCA workforce. As Table 2 indicates, a total of 273 interviews were completed. All interviews were recorded and transcribed.

- **Observation**. Given that workers are not always clearly able to describe what they do at the workplace (63), a programme of observation was undertaken. In each case, a medical and surgical ward was selected, and two HCAs plus a Band 5 or 6 nurse were observed for one early shift.[5] Each employee was shadowed, the observer taking running notes on tasks undertaken (task definitions are available in Appendix 4), the time spent on such activities and the nature and form of contact with other staff members and patients. A total of 275 hours of observation were completed on 11 wards.
- **Focus groups**. Former patients were invited to participate in a series of focus groups at each Trust to gather their views on the HCA role. These focus group sessions lasted on average between 90 minutes and two hours (the focus group schedule is available in Appendix 5). The sessions were recorded and a full report for each Trust on deliberations was produced. Almost 100 patients across the four case studies took part in these focus groups.
- **Action Research**. Towards the end of each case study and in the context of the material collected, a topic related to the HCA role was chosen in three of the four Trusts as the basis for a small piece of action research. It can be seen from Table 3 that in South attention was given to customer service; in Midland, constructive challenge; and in London, a new emergency department technician role. An intervention, typically a training programme, was evaluated with a view to assessing its impact in taking these initiatives forward. Further details on the action research are available in Appendix 6.

[5] In our first case study the late shift was additionally observed. To control for task variation by shift across our case studies, only the early shift was subsequently observed. All observation analysis presented in the report is restricted to the early shift.

Table 3. Action research

Trust	Focus	Approach	Outcome
South	Communication and customer service	Patient panel focus group; ward observation; survey; support of training	Feedback incorporated into training
Midland	Communication and constructive challenge skills	Two day residential course; pre/post course surveys; follow up focus group	Implementation of new ways of working; improved levels of confidence with personal objectives
London	Emergency Dept Technician role	Pre training programme survey; focus groups; impact survey	Ongoing

On the basis of the qualitative data gathered, a full and substantial report was produced for each case study Trust. [6]

3.3.3 Phase 3 (spring 2009 to late autumn 2009)

The final phase of the research was devoted to generating quantitative survey data. The decision to conduct surveys after the qualitative research phase was influenced partly by a desire to develop an understanding of and a strong relationship with each of the Trusts before embarking upon a substantial survey activity. More importantly, findings from the qualitative phase fed into the questionnaire development, guiding their focus and informing item construction. Three surveys were carried out in each Trust, covering HCAs, nurses and patients. Response rates across all three surveys averaged 41% for nurses and 51% for HCAs and patients. In total, the surveys captured the views of 746 HCAs, 689 nurses and 1651 former patients (see Appendix 7 for a discussion of survey methods). A report with a full set of results along with extensive commentary and benchmarked analysis was provided to each Trust.

The surveys could not cover the wide range of issues dealt with during the qualitative phase of the study, so the focus was narrowed and sharpened. In the case of the HCA and nurse surveys, the aim, in part, was to gather descriptive data on aspects of our key themes: who HCAs and nurses were; what they did; and how the HCA role impacted on stakeholders. Appendix 8 provides a model of hypothesised relationships which aided survey development of the HCA and nurse versions.

The patient survey was focused on a number of basic issues, namely, whether patients could distinguish HCAs from other members of the ward team, and if they could, how they viewed them, especially relative to

[6] Typically the case study reports ran to 70,000 words.

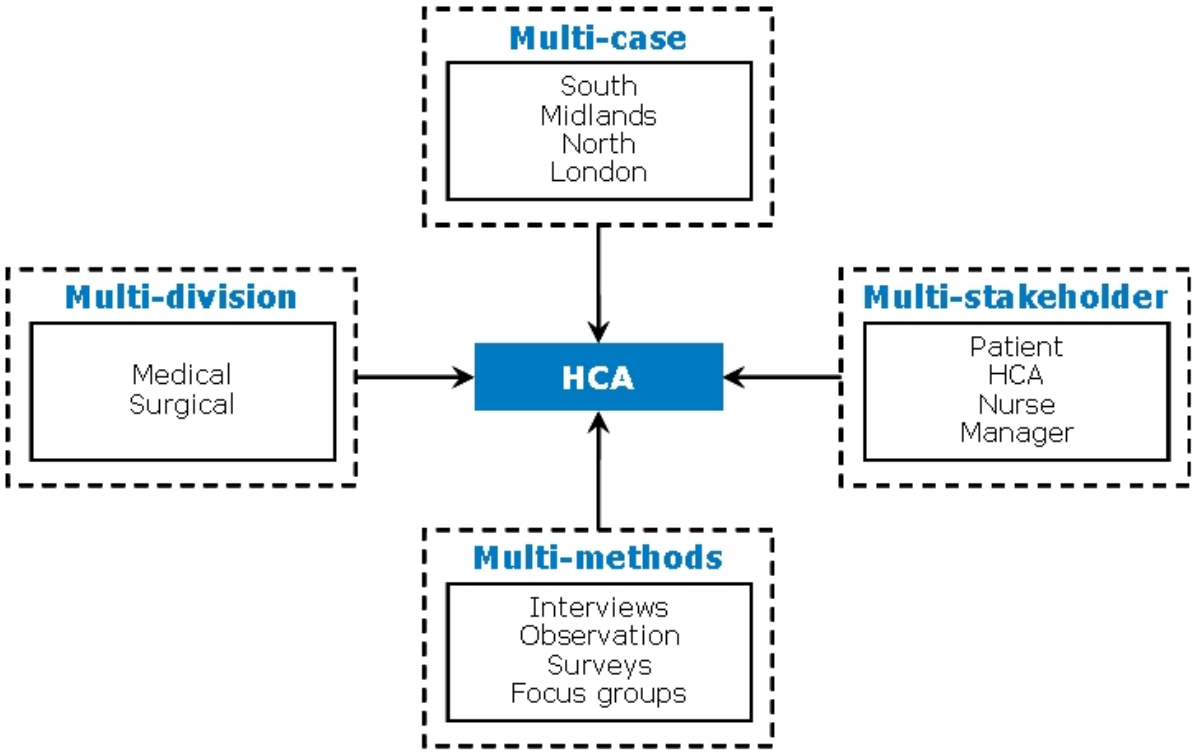
nurses. The patient questionnaire along with those for HCAs and nurses are available in Appendices 9-11.

The three research phases generated a rich and multifaceted data base. In presenting the findings, the qualitative and quantitative material derived from the four case studies is used and combined in a flexible way, maximising understanding and insight into any given theme: in some instances the qualitative material provides the initial context for the presentation of the more focused and structured survey data; in others, the survey data are presented upfront, the qualitative material being used to help explain the patterns revealed.

3.4 Key report themes and narratives

In summary, this project explored the nature and consequences of the HCA role in secondary healthcare from a number of different perspectives. These are set out in Figure 1 and highlight the multi-case, the multi-divisional, the multi-methods and the multi-stakeholder approach adopted to the questions: who HCAs are, what they do and how they have impacted. These multiple perspectives provide the key themes and narratives for the presentation and discussion of the findings. The findings revolve around certain similarities and differences linked to these four dimensions:

Figure 1. Multiple perspective approach



- **Multi-case**. If the findings on the role and consequences of the HCA are similar across the four case study Trusts, it would suggest that there are

some powerful sector factors driving such standardisation; if, however, differences emerge between the Trusts, it would hint at the influence of local factors on the role of the HCA linked perhaps to Trust conditions, policies and practices.

- **Multi-divisional**. Similarly, if the HCA role and its consequences are found to be similar across general medical and general surgical wards, sector standardising forces would again seem to be at play; differences between these divisions would, however, suggest that the role is sensitive to clinical area, a function perhaps of different patient conditions generating distinctive routines and role requirements.
- **Multi-methods**. The application of different research techniques in a case study context, often referred to as triangulation (interviews, surveys and observation) was designed to provide some confirmation of findings on the HCA role from contrasting methodological perspectives. The findings might, however, diverge, the source of such divergence perhaps lying in the nature of the research technique or in a genuine contradiction and ambiguity towards the HCA role.
- **Multi-stakeholder**. In seeking the views of different stakeholders – HCAs themselves, nurses and patients – one outcome is a consensus between the groups on the nature and consequences of the HCA role. However, equally plausible is a variation in views between the stakeholder groups, suggesting that perspectives on the HCA role might be shaped by divergent group interests and values.

The report now turns to a presentation of the findings.

4 HCAs as a strategic resource

It has been suggested that if the HCA is to be used as a relief, substitute, apprentice and co-producer, senior managers in Trusts need explicitly to consider the nature and deployment of the role in these terms. Trusts might be seen to address the role strategically in one of two ways, reflecting a strong and a weak definition of the term 'strategic': a strong strategic approach indicates a clear attempt to link the role in a proactive way to the pursuit of broader Trust goals, say related to care quality or patient access. A weak strategic approach suggests that the HCA role might well be considered at these senior management levels, but only in responses to more immediate pressures or in a manner much less clearly related to wider Trust aims. A Trust might be seen to take a third, non-strategic, option, with the HCA simply not considered at all as an issue at senior management levels.

This part of the report draws on interviews with sixteen senior management and union representatives across six Trusts in three different regions – South, Midlands and North – to consider whether and how they viewed and used HCAs as a strategic resource, and if so, in a strong or weak sense. The issue was explored in our four case study Trusts as well, but these data are used in the subsequent parts of the report. It is argued here that while typically valued as a resource, various constraints have limited a strong strategic approach to the HCA role by Trusts. A weaker strategic approach is, however, in evidence, with HCAs periodically being discussed and used by senior managers to address immediate needs and pressures. In general, this picture holds across Trusts, but there is some variation between them in perceptions and deployment of the role, a reflection of local conditions, organisational status and management style. Consideration is first given to the visibility and treatment of workforce matters at a senior management level; attention then turns to the planned use (or not) of HCAs as a relief, substitute, apprentice and co-producer.

4.1 Workforce issues at corporate level

Unsurprisingly, the main challenges facing Trusts were presented in terms of performance and finance. For the Foundation Trusts in this group the pressures around such issues often emerged as less acute, after all they had assumed the status of Foundation Trusts on the basis of robustness in these terms. As noted in one: 'The last couple of years have been good to the Trust in terms of performance and finance.' But this was not necessarily the case; a manager in another Foundation Trust stressed that, 'the finances are a huge challenge at the moment.' The preoccupation with such matters often drove out workforce issues as a primary concern at senior management levels:

> *North: You wouldn't find them [workforce issues] explicitly as a heading. We have a very, I guess we have a Trust Board that's been dominated*

by parts of our strategic agenda… I wouldn't suggest the Trust Board is dismissive or dismisses them in not discussing them. But if you looked at the agendas on the public website, they don't dominate the agenda.

Midland: There is a business plan… But I wouldn't say there's much in there about workforce.

At the same time, workforce issues did emerge unprompted as a challenge to Trusts in most of our six Trusts, albeit mainly in a weak strategic form. First, workforce issues arose as a reaction to local labour market conditions. This was the case in a northern Trust that was facing recruitment difficulties, especially amongst nurses. Second, they arose in the context of attempts to reduce headcount in response to financial pressures. This was apparent in a Midland Trust where it was stressed:

Midland: We committed to take seven hundred and fifty headcount out last year, but during the course of the year we took about half of that out… And balanced the rest with vacancy freezes etc.

Third, workforce issues were given prominence as Trusts sought to review skill mix, mainly in pursuit of cost efficiencies. This was apparent in a Southern Trust, where consideration of skills inevitably touched on support workers and their numbers relative to registered staff:

South: We've had a lot of discussion when the budget setting was being done this year to triangulate the establishment against the acuity and dependency tool that we were using and that led to a lot of, to discussion... The tool sort of tells you what your total establishment should be, but you then have to have discussions around skill mix.

In a related process, the re-organisation of wards in a Midland Trust and the introduction of patient care pathways led to a review of workforce number and skill mix:

Midland: Because of the new orientation of the wards and layouts now, and also because of the patient pathways that are being revisited and reviewed, it's likely that we're going to need around five hundred whole-time equivalent extra support workers by the time the new hospital is fully operational.

There were examples of a stronger strategic approach to workforce issues, but these were much less common. In one instance there was recognition of the link between workforce structure and broader organisational change:

North: We've got a bit of a dichotomy in terms of our capacity which, you know, we've always known would be around this time and that's in relation to continuing to manage an acute service whilst, at the same time, change every element of that service ready to go in to the new hospitals. So we've got a very big organisational development plan which is seeking to influence attitude, so that we don't move in to beautiful new facilities with the same old approach to some things. And with that comes the change in the workforce.

In another more striking example, a Midland Trust articulated a much harder link between workforce and Trust, reporting on this regularly at Board level:

> *Midland: At every single Board meeting there's an integrated performance report based on workforce aligned with clinical productivity and efficiency and also the operations and the finance of the organisation… I think they've made a conscious decision here… and that they felt because of the, the leadership issues, the quality issues, and then the impact that that had on morale and the culture within the organisation, that workforce was a priority.*

In short, general workforce issues remained downstream of matters related to performance and finance, only arising in the search for cost efficiencies or in the context of labour market pressures.

4.2 Policy goals and the HCA

In focusing more specifically on whether and how HCAs had been considered in strategic terms, it would be fair to say that the role did not figure with much prominence on the senior management agenda, either at Board or executive director level. This is not to deny the general value placed on HCAs by senior managers:

> *South: [HCAs are] invaluable, absolutely invaluable. I could take you to the ward that I was a ward sister of until three years ago and introduce you to some of the HCAs there who, you know, they are mentioned by patients in the thank you letters, they are acknowledged for the huge difference particularly in the psychological support to patients, more so in fact than some of the qualified nurses.*

Moreover there were exceptions to the neglect of the role at this level: the manager from a Northern Trust, considering workforce issues in the context of organisational change, goes on to note two important downstream changes:

> *North: One is the change in the pattern of healthcare, and therefore we will be wanting to use our healthcare support worker colleagues in a different way. And the second one is in relation to the affordability of the workforce for the future, which again drives potentially a change so that we look to more Band 1 and Band 4 healthcare support worker colleagues.*

There were, however, few instances of interviewees raising the development of the HCA role in an unprompted way as a challenge or workforce issue facing the Trust. Even when prompted, the HCA role did not emerge as a major focus of senior management interest. When asked if the role entered discussions at this level a manager in a Midland Trust noted:

> *Midland: In a Board, no. In the HR group and the workforce plans that get sent to the Health Authority, yes, but not in any great detail. That's the reason we've now appointed our workforce planning manager.*

It was view echoed in a Trust by a deputy chief nurse:

> *North: I wouldn't say they're regularly discussed [unregistered staff], I mean, but there is an HR element at every Board meeting where, you know, there's an HR report that talks about sort of some of these elements in some detail. But there's a nursing report goes to the Board, not as a nursing, you know, the chief nurse takes other reports to the Board but we have had a workforce paper within the last year, but it's not something that goes regularly as an active agenda item… I suppose when we talked about it last there was a real issue with nurse staffing within the organisation.*

While not figuring prominently at senior management levels, there were instances of attempts to use or to develop the role. These can be related to the use of the role as a relief, substitute and apprentice, although it was difficult to find any acknowledgement of the HCA as a co-producer. Again such attempts were in the main weakly rather than strongly strategic.

4.2.1 Relief

The role of the HCA as a relief, implicitly relieving the nurse of much of the direct and indirect patient care, came through in perceptions of the HCA role amongst senior managers across these Trusts:

> *South: They're very much there to support the trained nurses… But predominantly really they're there for the hands-on fundamental stuff. Our Trust has made the decision that healthcare assistants are not involved in assessment…*
>
> *North: They're [HCAs] the fundamental people that support the registered nurses to do that and support their role… So, you know, those people at care support level are very fundamental to providing our patient care, you know, particularly with regards to nutrition and those types of things.*

There was some acknowledgement of the growing importance of this role in the context of new performance measures related to the quality of care; if the HCA is increasingly accountable for direct and indirect care then the Trust's well-being becomes dependent on the delivery of these tasks:

> *Midland: The contact between the patient and members of staff a lot of the time is with the healthcare support workers. So some of your quality measures could be dictated by the quality of care provided by those healthcare support workers. So if that's not taken seriously in terms of infection rates and, and if you look at things like the inpatient survey, a lot of those results could be dictated by the quality of care provided by the healthcare support workers, not so always your doctors and your qualified nurses.*

In this Midland Trust it was clear that the HCA role had been very much developed in this respect:

Midland: We recognised that in the ward environments, you know, some of the audits were undertaken by healthcare support workers on, you know, "are you washing your hands?", and actually they're the ones that are stopping doctors who are wearing wristwatches, saying "don't wear that, do you understand that you can get an infection, you know, you can bring infection in to this environment". And they've been very much empowered to do that.

4.2.2 Substitute

It was, however, as a substitute that senior Trust management was most preoccupied with the HCA role. This interest assumed a number of forms. First, and as already implied, the greater use of HCAs relative to nurses figured prominently in the dilution of skill mix, with the explicit aim of reducing labour costs. This was stressed by Trust managers in the North and the Midlands:

North: There'll be some other drivers that will take us there [developing the Band 3 HCA roles], you know, I mean we've already said the driver of the recruitment issues, and I think there will also be financial drivers… because we'll need to take money out of the system and therefore we're needing probably to bring in people at a low band…Hard-nosed, isn't it, but it's the reality of the NHS at the moment.

Midland: Some of the things we did last year in nursing was we changed the shift patterns and that allowed us to take seventeen nursing posts out, by changing shift patterns. We balanced some of what we lost in terms of registered staff by introducing cheaper support worker type roles, so that allowed us to take the equivalent of posts out.

In the case of the former, Northern, Trust, this cost saving was achieved through the use of Band 3 HCAs with an extended role rather Band 5 or 6 nurses. However, the employment of more HCAs as a cost-efficient measure was also illustrated by their concentration in Band 2 posts. In almost all of the regional Trusts, the overwhelming proportion of HCAs was in Band 2; indeed in one Northern Foundation Trust, it was noted that Band 3 was hardly used at all:

North: We just have at the moment within our Trust, people that are Band 2 level care support workers and then we have our Band 5 registered nurses, and we've not got anything very much in between, if I'm really honest…

Interviewer: So you only have Band 2s?

North: Yes. I mean we would like to develop that [Band 3] but we haven't quite got to that stage yet.

The scope available to Trusts to use the HCA in this way might be related to the easy availability of such workers on the local labour market: the role is essentially unregulated, with Trusts appearing to impose extremely low barriers of entry into the role. Asked about entry criteria, a manager at a Southern Trust noted:

South: I haven't got anything specific… You know, for a Band 3 healthcare assistant and NVQ level 3 is desirable, for a Band 2 an NVQ level 2 is desirable. But it's really looking at the characteristics of the person and we wouldn't not take somebody who at interview seemed to have good communication skills. Because we would, you know, it's like in-house training, we'll teach them on the job kind of thing.

It is unsurprising therefore that none of the regional Trusts had difficulty attracting a plentiful supply of applicants to the HCA role:

Midland: We're always over, oversubscribed. Every time we advertise [for HCAs], inundated…

Second, a number of Trusts were seeking to use the support role as a substitute by developing Band 4 posts. Such an approach represents a form of dilution through the use of such Band 4 posts rather than registered nurse posts. As a manager at a Southern Trust noted:

South: We need to look at the skill mix in a different way, not just the sort of qualified/unqualified but a more three-way split with a middle ground of associate practitioner [Note: Typically a Band 4 post]… Or if it's not associate practitioner in the broad sense, is there something different.

The development of Band 4 roles is beyond the scope of this project. It is, however, now clear that support roles were being used as a form of substitution in pursuit of cost efficiencies in a couple of different ways: a predominantly Band 2 HCA workforce with few Band 3s reduced costs at the unregistered end of the nursing workforce, while the replacement of staff nurses with Band 4 support roles diluted and reduced costs at the registered-unregistered interface of the workforce.

4.2.3 Apprentice

The HCA role might be used in an apprenticeship capacity, both as a means of nurturing 'high performing' individuals within the HCA role and as a way of providing a future supply of 'grow your own' registered nurses. There were, however, few signs that Trusts had adopted a strong strategic approach to the HCA role in these terms through the development of supportive practices and systems. There were exceptions, most notably one of the Northern Trusts which had established a so-called 'apprenticeship model', seeking to establish clear career pathways allowing HCAs to move up and through the Bands. The intention was to recruit a cohort of 'apprentices', taking them through the different career levels:

North: We're aspiring to an apprentice healthcare assistant role and have developed a framework which will, which literally has just been shared and will be rolled out across the Trust in the next couple of weeks subject to full approval by the clinical body, in regard to progression through Bands 1 through to Band 4 and then hopefully in to nurse education…

Elsewhere, HCA training and development were rooted mainly in NVQ accreditation, operating with varying degrees of efficiency and effectiveness. A number of generic problems associated with NVQ training emerged, such as a shortage of NVQ assessors and individual HCAs finding it difficult to take time away from the ward to train:

> *South: It's [NVQ training] always been on offer, and NVQ level 3, but we haven't had the resources to allow all of our support workers to access it.*

More indicative of the unplanned approach to such training was the mismatch between training opportunities and development of the HCA role; in short, the availability of such opportunities had outstripped the scope to use acquired skills in a role given limited attention paid to it by senior management. The result had often been HCAs with a considerable range and depth of skills, but in an under-developed HCA role:

> *North: At the moment we do encourage staff to do an NVQ level 2 and level 3 training, I think our problem at the moment is the job role we're expecting them to do in the wards isn't requiring them to be by a level. What we need to do is look at the job roles… And bundle those in to something that requires them to be at a higher level for them.*

In the case of a 'grow your own' approach to future registered nurses, Trusts had often developed secondment schemes, allowing a small number of HCAs to embark on nurse training. These were beginning to wither, often for reasons beyond the Trust's control, for example, a consequence of SHAs withdrawing funding for such schemes:

> *North: We've had a good record in terms of people taking up professional training places from support worker roles. And that's one of the reasons, we're disappointed really in terms of the loss of the sponsored places for nursing, for example, in that that allowed you to be seconded in to the nurse training post on an equivalent of your salary and not actually take a bursary, which in fact might be a two thousand pounds a year drop, which on those sort of salaries would be significant really.*

Beyond such schemes there was little evidence to suggest that Trusts were evaluating the future demand and supply of registered nurse need, and exploring the development of HCAs as a means of addressing any shortfall.

4.3 Summary

The data collected from interviews with senior managers and union representatives from Trusts across a number of regions cast some doubt on the extent to which HCAs were being used and viewed as a strategic resource. This is not to deny the importance generally attached to the role at senior management levels, or the active consideration being given to the role. However, attempts to develop the role had rarely been explicitly linked to broader Trust objectives; rather they had been driven by more immediate pressures such as cost or labour market considerations. At best

this might be seen as a weak rather than a strong strategic orientation to the role. There was little evidence to suggest that Trusts had acknowledged or built upon the distinctive capabilities of the HCA as a co-producer. Certainly the HCA was being seen as a relief, but the use of the role as a substitute was often underpinned by the search for cost efficiencies. Finally the misalignment between the development of the role and training opportunities for individual HCAs had significantly undermined its apprenticeship capacity.

4.4 Issues for reflection

The findings in this part of the report suggest the need for senior Trust managers to consider:

- The relationship between the HCA role and the pursuit of broader corporate objectives.
- The development of a more consistent, coherent and transparent Trust approach to the use of HCAs.
- The recruitment and development of HCAs within the context of workforce planning systems for the nursing workforce.
- Optimising the distinctive contribution made by HCAs to care quality.

5 Backgrounds

The background of HCAs in the respective case studies is a function of demand and supply side factors. Who HCAs are depends on what the Trust demands in terms of numbers, capabilities and personal qualities. These requirements are typically embedded in Trust staffing or establishment levels; in formal job descriptions and person specifications; and in the managerial practice of those with responsibility for HCA recruitment. Who HCAs are also relates to the local labour market supply: the types of individual likely to respond, in terms of personal characteristics, past work experience, motivation and aspiration to the Trust's needs. This part of the report considers these different demand side requirements as they relate to HCAs and to the supply side responses.

5.1 The demand side

5.1.1 Staffing

Staffing requirements are related to skill mix: the balance between registered and unregistered nursing staff. While skill mix varied within the Trusts according to ward size and clinical area, all four case studies had a 'headline' skill mix ratio: in three of the Trusts this was a 70/30 registered/unregistered staff split, and in the other it was 60/40. These ratios fed through to affect staff numbers: so in South, with a 70/30 split, 672 HCAs were employed alongside 2,563 nurses; while in the smaller London Trust the respective figures were 361 and 770. Yet despite these headline figures, skill mix remained a lively policy space for senior management action.

Skill mix reflected historical data crudely linking staff numbers to ward size, which had often been overtaken by organisational changes. This had led to anomalies in the distribution of staff between divisions and wards, encouraging general attempts to sharpen such ratios, particularly by relating them more precisely to patient dependency and acuity. At the same time, the urgency of such attempts varied, largely reflecting the financial pressures faced by the Trust. In London, with its relatively sound financial situation, skill mix remained a low key issue; by contrast in Midland, a Trust involved in a major financial turnaround, skill mix had recently been used more aggressively by management to seek savings, along with a programme of planned redundancies. These changes were sought not through a straightforward dilution of skill mix, but through the imposition of a shared staff template across the whole of the Trust, so removing resourcing idiosyncrasies between wards and divisions, and specifically in the case of HCAs, reducing the number of Band 3 posts relative to Band 2.

At ward level, assumptions about skill mix ratios were enshrined in establishment levels, specifying in FTE terms, precise numbers of HCAs and

registered nurses. These were crucial in determining the staff budget, typically the responsibility of the ward manager. While fixing the total funds available for ward staffing, there was a degree of residual discretion available to the ward manager to vary numbers employed on different grades. This discretion was not often used in any Trust, often requiring approval by the matron, although there were instances of attempts to change skill mix, for example a ward manager in an emergency unit in London seeking to use funds available for HCAs to employ more Band 5 nurses.

Comparing skill mix between the Trusts is a difficult task given differences in ward size and patient mix. In trying to control for these differences, a general comparisons across the medical divisions can be made between those wards in three of the Trusts which comprised stroke patients. It can be seen in Table 4 that staff number per shifts and the skill mix ratios were fairly similar, although it is noteworthy that in contrast to South and Midland, in London there were more HCAs working the early shift than registered nurses.

Table 4. Skill mix ratio on stroke wards (registered/unregistered staff)

	South	Midland	North	London
Beds	23	15	n/a	22
Early	2/3	3/2	n/a	2/3
Late	2/2	2/1	n/a	2/2
Night	2/1	2/1	n/a	2/1

In the case of four broadly comparable surgical wards across our four Trusts, the skill mix ratios are again not greatly out of line with each other (Table 5). Indeed it is noteworthy that skill mix is richer for surgical than medical wards. However, the Midland surgical ward has a slightly richer skill mix than in the other three Trusts: although on the earlies and lates this richness is mainly achieved by having one less HCA on shift than elsewhere, a reflection perhaps of the fact that Midland was the Trust which had undergone to the programme of workforce reduction and a major skill mix review.

Table 5. Surgical ward skill mix ratio (registered/unregistered staff)

	South	Midland	North	London
Beds	25	28	30	30
Early	4/2	4/1	4/2	4/3
Late	2/2	4/1	4/1	4/2
Night	2/1	3/0	2/1	2/2

The number of HCAs on a ward establishment required to achieve these shift staffing ratios was found to vary quite considerably, both within and between Trusts. As already implied, this was partly associated with clinical divisions and the related richness of the skill mix; for example, in Midland where our ward level data are most reliable, five HCAs in total were employed on the general medical wards compared to nine on the general surgical wards.

The demand for HCAs was not, however, solely dependent on establishment levels and skill mix ratios. Many of the wards across all Trusts had HCA vacancies: of the 13 wards covered in London and the North, 11 had vacancies. Indeed vacancies of between a third and a half of the total HCA complement were not uncommon on a given ward. These vacancies were rarely a consequence of external local labour market conditions (see below) but more often reflected HCA turnover and the lag which often resulted in recruiting replacements. Such vacancies typically led to the use of bank or agency HCAs or staffing pressures on any given shift.

5.1.2 Recruitment

In all Trusts, the recruitment of HCAs was underpinned by corporate systems related to the advertisement of posts and the sorting out of the final details associated with an appointment. These systems impacted and were utilised in slightly different ways. Thus, the HCA survey indicated (see Table 6) some noteworthy variation between Trusts in how applicants found out about vacancies. The main source of information about advertised posts was the Trust or NHS website, with around half hearing about the job from this source, with a not insignificant minority of HCAs, close to a quarter, learning about vacancies from a friend or relative. However, websites were a particularly common source of information in North and London; word of mouth being more prevalent at Midland; while in North the local press remained ineffective or not utilised as a form of communication.

Table 6. How HCAs heard about their current job (%)

	South	Midland	North	London	p-value
A friend or relative	29	34	24	21	$X^2=20.80$, $p=.014$
Local press	21	16	9	21	
Trust/NHS website	46	47	60	58	
Job centre	4	4	7	1	

There were also some corporate differences in the tightness of entry criteria to the role between Trusts, which might have been more directly linked to local labour market conditions. Although in the main the Trusts did not have difficulty attracting applicants to HCA posts (see below), Midland was located in the area with relatively high unemployment (see Table 1) and could be a little more discriminating in its selection. It had instituted a

tightly structured and in-depth schedule for interviews to HCA posts, designed to explore past work experience:

> *Ward manager_Midland:We are quite fussy about what want we want… because it's quite acute so if they've no experience at all it's quite scary.*

> *Ward manager_Midland: You sometimes get people who are in nursing homes but want to work more in an acute setting, but dependent on how many jobs we've got and where they've worked, we can be a bit more selective.*

Beyond the formal advertisement for the role and the final details, the recruitment of HCAs in all Trusts remained a ward level process. While there were generic and broadly-drawn Trust job descriptions and person specifications for HCAs at Band 2 and 3, these were often fine-tuned to reflect local ward needs, and the short-listing and interviewing were all conducted by senior ward staff. Indeed there were occasionally instances of innovative practice, as in the case of a ward in London where an HCA was a member of the interview panel. More significantly, a broadly-drawn job and person specification applied at ward level left considerable discretion for ward managers to interpret and informally apply requisite entry qualifications. For example, at London which had formally stated a preference for applicants with NVQ level 2, many individuals were taken in without such a qualification in the expectation that this would be acquired whilst working at the Trust. This opened the way for a range of less formal, more impressionistic criteria to be used by those assessing applicants:

> *Ward manager_London: The last lot… we was looking for experienced nurses, however we took an applicant who's from, come from Woolworth's – never done care work before but interviewed very well, come across and had, although she had no hospital experience or care experience, she had qualities in different ways. She had customer care, she was empathetic, and we took her and she's doing absolutely wonderful. So I think it's on the given, on the given day.*

5.2 The supply side

In general, there was a plentiful supply of applicants for HCA posts across all four Trusts. Ward managers and others consistently noted the large numbers responding to advertised HCA posts:

> *Matron_Midland: It seems to be fairly easy [to recruit NAs] and the feedback I get from my [Band] 7s is that there seems to be a fair amount of people out there.*

> *Ward manager_London: Literally hundreds for every HCA post. So, so no, if they haven't been recruited in to that's probably because the ward sister has taken some decision not to, but no, it's not so difficult obviously we don't short list two hundred.*

> *Ward manager_North: We do get a lot of interest, because the last two that we took on, I think we had about forty applicants.*

This plentiful supply of potential HCAs does, however, need to be tempered in a number of ways. First, the local labour market conditions of the different Trusts did have some impact on the flow of applicants. It has been noted that in Midland, a relatively loose labour market provided the Trust with an opportunity to be more discriminating in their choices. In North, a city centre Trust with a somewhat tighter labour market at the time, there was an acknowledgement of the cyclical flow of HCA applicants:

> *Senior manager_North: Some of the people that we're recruiting in to the Band 2 posts at the moment in terms of their ability to actually grow and develop in to some of those more senior roles where you would want to be starting to have some academic ability in terms of that transition. I don't think that is there at the moment. But I think that is swings and roundabouts because I think as the local labour market changes, that hasn't always been the case. So I can see that shifting again that if we head in to an economic downturn within the city and other employment opportunities aren't there, then people who perhaps might not have looked at our, our post might choose to do so.*

Most interesting was South, where different labour market conditions were prevalent at the two Trust sites studied: in one, located in an area of high living costs and a fairly tight labour market, it remained quite difficult to recruit HCAs; in the other some twenty miles distant, both conditions were considerably relaxed ensuring an abundance of candidates. As a matron at the former site noted:

> *Matron_South: We have real trouble recruiting healthcare assistants, good quality healthcare assistants… at the moment our biggest vacancy factor is HCAs.*

Second, some features of the jobs were still perceived as unattractive, particularly in a tight labour market where potential applicants had options. Attention was drawn in particular to relative pay and its potential interaction with non-work pay benefits:

> *Senior nurse_North: Healthcare assistants, the issue is for me I think they're horrendously paid, I think the pay is absolutely awful.*
>
> *Ward manager_North: A lot of them are young people with, you know, are single mums or single parents with kids and there's, a lot of it's to do with benefits, you see, they've got to be really careful whether they're actually better off on benefits or working…They're trying to figure out whether they're actually, it's actually worth their while working, which most of the time it isn't. They're not paid enough, it's a basic Band 2.*

Third, a plentiful supply of applicants did not guarantee a high quality pool of candidates for the HCA role. Difficulties in short-listing were generally acknowledged, a problem exacerbated by the fact that those invited for interview often failed to show-up:

> *Ward manager_North: I had 63 applicants in two days, so we had to shut it straightaway because it was just too much. And so then I whittled it down to 17 from that and interviewed, only eight turned up from that.*

A fuller appreciation of labour supply can be gathered from exploring the backgrounds of those who actually became HCAs in our Trusts: who Trusts were successful in attracting to the role. Consideration is therefore, in turn, given to their personal characteristics, previous careers, motivations, work and employment patterns.

5.2.1 Personal characteristics

HCAs share a number of personal characteristic, and indeed features which distinguish them from nurses, implying that across the health service a certain type of person is likely to take up the role. There are, however, differences in the personal make-up of HCAs between Trusts, suggesting that local factors play some part in shaping the nature of the HCA workforce. Table 7 sets out the personal background details of HCAs and registered nurses.

In terms of **shared characteristics**, the following points emerge:

- HCAs are distributed quite evenly across the four age bands presented in the Table, but in general are relatively mature and certainly significantly older than nurses. While around a third of HCAs are 50 years or more, the proportion of nurses in this age range is much lower. This is reflected in the average age of the respective groups: while the mean age of HCAs 42.6, for nurses it is 38.4.[7]
- The overwhelming majority of HCAs are female, a feature they share with nurses.
- HCAs are much less likely to have Black and Minority Ethnic (BME) backgrounds than nurses.[8] In three of the four Trusts there is a statistically significant difference between HCAs and nurses in this respect. While around one half and sometimes considerably more of the nurse workforce in our Trusts had a BME background, the figure is invariably much lower for HCAs.
- A majority of HCAs, typically around three quarters, have a partner and children. Nurses are as likely to have a partner but less likely to have children.
- A noteworthy minority of HCAs, around one third, is the sole or main income earner. Nurses are more likely to assume primary earner status than HCAs.

[7] The finding that HCAs are typically older than nurses is in line with Care Quality Commission's (CQC, formerly the Healthcare Commission) National NHS Staff Survey data. As part of this study we undertook an analysis of the publicly released 2006 survey results by occupational group. A note on this analysis is included as Appendix 12.

[8] Again in line with CQC data.

Table 7. Personal background details of HCAs and nurses (%)

	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
Age:									X^2=6.82, p=.656	X^2=40.96, p=.000
Under 30 years	20	22	16	19	26	35	16	16		
30s	23	47	25	29	21	28	24	37		
40s	26	19	26	35	27	24	27	23		
50 years or over	31	12	33	17	27	13	34	24		
Female	84	89	95	90	93	91	91	85	X^2=13.27, p=.004	X^2=2.77, p=.428
Ethnicity: BME	24	48	17	40	10	12	43	62	X^2=40.56, p=.000	X^2=73.94, p=.000
Married/living with long-term partner	75	78	83	80	78	68	80	83	X^2=3.46, p=.326	X^2=8.94, p=.030
Children	73	61	78	68	71	41	77	71	X^2=2.50, p=.475	X^2=29.18, p=.000
Sole or main income earner	31	43	46	49	31	49	44	44	X^2=12.58, p=.006	X^2=1.88, p=.598
Attended local primary school	42	18	69	58	54	39	34	22	X^2=36.06, p=.000	X^2=71.53, p=.000

- A considerable proportion of HCAs had attended a local primary school. This was a much higher proportion than nurses across all four Trusts, and suggests that HCAs are more firmly embedded in the local community than their nurse colleagues.

At the same time, there were some noteworthy **differences between HCAs** in the four Trusts:

- The proportion of HCAs with a BME background varied significantly between Trusts. In London, for example almost half had such a background, while in North the figure reached only 10%. This pattern reflects the more general demographics of the two areas: these were the Trusts respectively located in areas with the highest and lower BME populations (see Table 1).
- Trusts varied in terms of how deeply their HCA workforce was embedded in the local community. In Midland, for instance, over two third (69%) of HCAs had attended a local primary school, while in London the equivalent figure was barely over a third (34%).

In short, HCAs in all four Trusts tended to be mature women, with partners and children, much less likely than nurses to have a BME background but considerably more likely to have a connection to the local community. However, some differences between HCAs in the Trusts remained: these related to variation in degree of ethnic diversity and longstanding connection to the community and suggest the residual influence of local factors on the personal backgrounds of those attracted to the HCA role.

5.2.2 Career histories

In general HCAs had diverse and often extensive career histories, suggesting that they brought to the role a breadth and depth of more or less relevant experience. These patterns were apparent in our HCA survey data, which revealed important similarities in HCA career histories in our cases, tempered by some variation. Table 8 sets out those sectors in which HCAs had previously been employed; the bracketed figures representing the last sector of employment before taking up the HCA role.

The Table highlights the following similarities across Trusts:

- HCAs have previously been employed in a wide variety of sectors. Of those sectors listed, only finance and the utilities emerge as spheres of limited work experience.
- Unsurprisingly, employment in the health and social care sectors are revealed as common areas of previous employment, with between a third and half of HCAs having worked there. Less predictable was the high proportion of HCAs with work experience in retail, close to half in most Trusts, and to a lesser extent in manufacturing and leisure, typically around a quarter. A noteworthy minority of HCAs, typically a third or so, had also been full-time unpaid carers in a domestic context.

Table 8. Previous employment areas of HCAs (%)[a]

	South	Midland	North	London
Health care	37 (19)	27 (14)	32 (20)	44 (29)
Social care	39 (24)	53 (47)	37 (28)	48 (33)
Education/Child care	24 (11)	12 (4)	13 (9)	29 (9)
Voluntary or unpaid work	14 (1)	17 (1)	11 (1)	17 (0)
Retail	47 (13)	43 (15)	46 (15)	32 (10)
Manufacturing	26 (4)	41 (11)	26 (5)	21 (5)
Leisure	21 (8)	27 (4)	28 (8)	20 (5)
Finance	6 (3)	4 (1)	6 (3)	9 (1)
Utilities	3 (1)	1 (0)	2 (1)	0 (1)
Full time carer at home	34 (5)	32 (2)	24 (5)	37 (4)
Other	19 (10)	6 (1)	9 (6)	8 (2)

[a] *Figures in brackets provide the results for which area of work was the last before working as an HCA at their current Trust.*

- Despite this breadth of work experience, there were only a limited number of sectors providing a direct gateway into the HCA role. The most common sector of employment immediately prior to taking up the post (as indicated by the figures in brackets) is social care, closely followed by health. Few of the other sectors are a 'springboard' directly into the HCA role; although many HCAs have work experience in retail, manufacturing and leisure, they are seldom the last sector of employment before taking on the HCA role. Striking is the fact that few HCAs move directly from full-time domestic care responsibilities to an HCA role: full-time mothers rarely move directly into the HCA role.

There were some differences in career histories between Trusts:

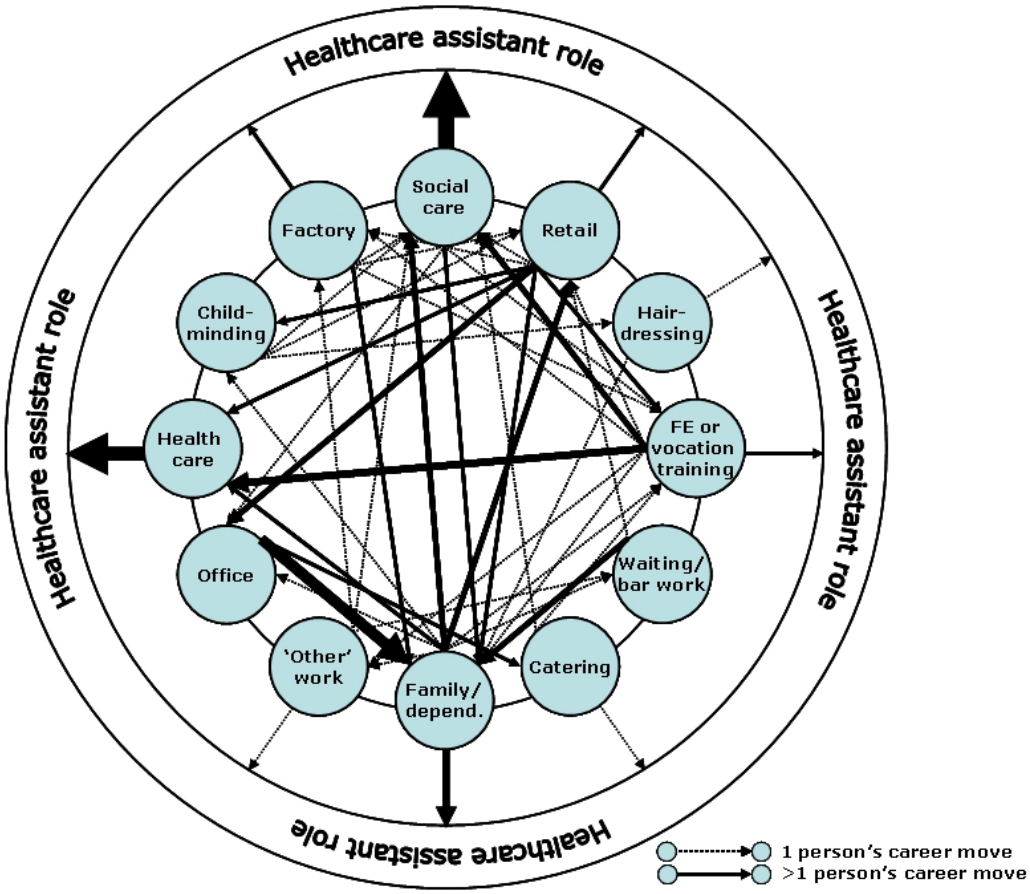
- A relatively significant proportion of HCAs in London, close to half, had worked in both health and social care; almost two thirds of HCAs working in one of these sector immediately prior to taking up the role, considerably higher than in South and North.
- Midland draws on a comparatively high number of individuals with previous work experience in social care, typically employment in a care home. Around half worked in this sector immediately before taking up the HCA role, a finding which ties in with the earlier observation that local labour market conditions allowed Midland to be fairly selective in its recruitment policy.
- HCAs at Midland were also much more likely to have work experience in manufacturing sector than those in other Trusts, a likely consequence of differences in the industrial structure of local economies.

Our qualitative data provided further insights into the career trajectories of those who took up the HCA role. When asked in interview to describe how their lives had unfolded since leaving school, individuals often presented a breadth of employment experience, often punctuated by time spent as a full-time carer. This is highlighted in the comment of one HCA:

> *HCA_Midland: A long time ago, I was fourteen when I left school. My first job, I worked as a waitress in a hotel with my mother, and then I went on to work in an office, then I got married, had a break, brought up five children, went back to work, about fifteen, about twenty years ago I went back to work. The first in school, I worked in school kitchens… Then I went in to the care profession, I worked at a residential home looking after people with Alzheimer's disease. I was a senior care there and then I came, then I applied for a job here, I worked in orthopaedics, like I say, for eighteen months, and then in to the heart centre.*

Drawing upon these qualitative data, it was possible to draft a map of the career journeys made by individual HCAs. The map for the HCAs at South is set out in Figure 2, using a slightly more refined set of sectors than covered in the survey, and with the thickness of arrows indicating the frequency with which a given path had been followed (the thicker the line the more HCAs had been down this path).

Figure 2. HCA career journeys at South Trust (n=30)



The map provides confirmation of the survey data in terms of breadth of experience and limited gateways into the HCA role. It highlights three additional points: first, it vividly illustrates the considerable movement across diverse sectors of employment; second, it suggests some more common and established routes – some of the thicker lines include movement from office work to having and caring for children and then from non-paid caring for children to paid work; and finally, it highlights that once the HCA role is taken up it is not relinquished – there are no arrows back from HCA towards another sphere of employment.

5.2.3 Motivation and aspirations

Those taking up the HCA role are motivated by a combination of 'push' and 'pull' factors. Across all Trusts there are examples of individuals who had become HCAs because they had been pushed out of previous jobs; typically they were frustrated by lack of opportunity or routine work:

HCA_South: I was working in Burger King and supermarkets; it wasn't fulfilling in any way.

HCA_Midland: Working with the nursing home it was good but that was it, there was no future for me, anywhere to progress, so I applied to the Trust.

In terms of 'pull', individuals were often drawn to the HCA job by an expectation of intrinsic rewards; the opportunity to undertake fulfilling work:

HCA_South: I quite liked the patient contact in the HCA role.

HCA_London: I wanted a bit more out of life, I wanted to make people better, to be honest.

HCA_Midland: Working in a hospital is recognisable, it's hard work but at the end it's the prize you get from the patients when you do something, it's a rewarding job.

The 'pull' of the HCA role also lay in convenience, not least in relation to the flexibility of the working hours – the possibility of part-time and shift working which aligned with domestic circumstances:

HCA_South: I didn't want to be an HCA; it was a job that I was familiar with and the driving impetus was that it fitted around my family hours; that it was available… It wasn't a role I looked for and it never has been. I was comfortable and I could earn a living and its something I'm okay at doing.

Most striking was the link between the individuals' motivations to become an HCA and broader life narratives. These life narratives provided a rationale for taking up the HCA role and signalled certain aspirations. Three narratives emerged across all Trusts:

- **A 're-connection' narrative**. The individuals' decision to become an HCA was driven by a desire to re-connect with a past in nursing. There

were examples of former SENs who had returned to secondary healthcare in an HCA capacity. More common were HCAs with an overseas background, who had trained and often qualified as nurses in their country of origin, and were using the HCA role to 'mark time' as they sought to gain registered status in the UK:

HCA_Midland: In the Philippines I was a registered nurse and then I worked in a hospital in the medical surgical ward there, one of the finest hospitals there.I've came here 2003, so at least nine years I was working in the hospital, and then after that, because my husband was hired by this hospital back home because his specialties are more on cardio as well. So…he got me and my family so I work here. And then before I work here I was working in one of the nursing homes in [local town]… for almost two years as well.

- **A 'caring narrative'**. A considerable number of HCAs had a recent care experience or episode, typically in their personal lives, which informed their decision to become an HCA. Looking after an elderly or sick relative or friend had provided a stimulus to seek more formal and regular employment in care work:

  HCA_Midland: Looked after my mum really at home… if I can do it for my mum I can do it for everybody else.

  HCA_South: My husband became ill in 1991 and I looked after him, he had terminal cancer. After he died I went back in to a salon for a couple of years work, but it had changed so much since I started salon work that I didn't like it anymore. And there was an advertisement in a local paper advertising an open day to a care home and Mum said to me why don't you go because you looked, you know, I'd looked after my husband.

- **An 'aspirational nurse' narrative**. Many had taken on an HCA role as a proxy for a career in registered nursing or as a stepping stone towards it. This was often rooted in a longstanding but unfulfilled desire to become a nurse:

  HCA_South: I always wanted to become a nurse but having very little confidence in myself, by the time I was twelve I'd convinced myself I was not going to be good enough for a nursing job and decided to go for something else. And then I grew up, I got my qualifications and so it sort of occurred to me, hang on a second I can do this.

  HCA_South: I've always wanted to do nursing, wanted to do the enrolled nursing, but… as they've phased enrolled nursing out and then you have to have five GCSEs and sometime even more than that to go to do nursing course, and I never had it... so I thought the next best thing was becoming a healthcare assistant.

The prevalence and potency of this last narrative as a rationale for becoming an HCA is further reflected in the survey findings. These reveal that in all the Trusts around half of HCAs had nurse aspirations prior to taking up the role (see Table 9).

Table 9. Nursing ambition *prior* to HCA role (%)

	South	Midland	North	London	p-value
Nursing ambition	43	43	47	59	X^2=6.82, p=.078

5.2.4 Work and employment patterns

The final section of this part considers HCA backgrounds in terms of their length of service at the Trusts, working patterns, the distribution between pay bands and formal qualifications held: this provides a work and employment profile of the current HCA workforce in our Trusts. These background details on the work and employment conditions of HCAs reveals some important similarities between Trusts, again tempered by some equally noteworthy differences. Table 10 sets out the working patterns of HCAs and again compares them with nurses as a means of establishing whether or not they are distinctive.

The Table reveals that:

- In terms of length of service, HCAs are fairly experienced: the average length of HCA service is nine years and only around a quarter of HCAs in any given Trust have less than two years service. In most of the Trusts around a third of HCAs have ten or more years service. In these respects, HCAs are not too dissimilar to the nurses, whose average length of service was also nine years. This is slightly at odds with some of the qualitative findings, which suggested that HCAs were perceived as the mainstay of wards, less likely to move than nurses and consequently more likely to be a source of ward-based knowledge and continuity:

  Manager_London: When I was a student nurse, the healthcare assistants were the ones that absolutely, you know, knew what was going on, were incredibly, usually stayed in one place for a long time, much longer than any qualified nurses so knew the running of the ward, knew what was expected, could, had that intuition, if you like, of, "Oh, you know, that patient's not quite right", sort of that, that sort of expert in people skills.

  Interviewer: And that's still an important aspect?

  Manager_London: Massively, yes, massively. I mean I think the continuity of healthcare assistants, because I think on the whole they do tend to stay in one place for a long time, it's massively important.

- HCAs were more readily distinguishable from nurses in terms of flexible working, particularly part-time working. Part-time working amongst HCAs was not especially prevalent, only around a quarter in each Trust works fewer than 29 hours a week. In all Trusts, however, HCAs are significantly more likely to work part-time than nurses, a finding which might be related to the greater childcare responsibilities of HCAs.

Table 10. Work background details of HCAs and nurses (%)

	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
Length of service:									X^2=21.43, p=.044	X^2=33.42, p=.001
Less than 2 years	29	24	25	14	26	19	27	25		
2 to 4 years	27	21	13	14	13	23	14	13		
5 to 9 years	21	36	29	37	24	21	29	33		
10 to 19 years	14	12	19	15	22	15	19	14		
20 years or more	10	8	15	20	15	22	11	15		
Part-time (up to 29 hours)	29	16	26	15	25	11	14	10	X^2=8.26, p=.041	X^2=3.30, p=.348
Shifts worked in last month:										
Early	82	80	77	66	61	67	84	82	X^2=25.22, p=.000	X^2=16.84, p=.001
Late	67	78	66	60	56	61	77	80	X^2=13.09, p=.004	X^2=26.14, p=.000
Night	44	65	63	63	68	64	68	69	X^2=25.20, p=.000	X^2=0.99, p=.802
All three shift types worked in last month	30	51	42	38	41	42	56	58	X^2=19.36, p=.000	X^2=13.50, p=.004

- Patterns of shift working were more idiosyncratic to Trusts. In three Trusts (South, Midland and North) working all three shifts is a minority practice amongst HCAs, a pattern they shared with nurses. However, whether HCAs were more or less likely to work all three shifts than nurses varied by Trust. Most striking was the one Trust, London, where the majority of HCAs and indeed nurses worked all three shifts. This finding relates to the recent introduction of an e-rostering system in London and suggests the efficacy of a local practice designed to standardise and regularise shift working across the ward team.

Table 11 presents the Banding and NVQ accreditation amongst HCA workforces in the respective Trusts. Once more, there are some important similarities as well as some striking differences between Trusts:

Table 11. Pay bands and NVQ qualifications (%)

	South	Midland	North	London	p-value
Band 2 [a]	80	82	90	82	X^2=8.69, p=.034
Band 3	18	18	8	16	
NVQ level 1	9	12	11	21	X^2=8.37, p=.039
NVQ level 2	23	58	43	70	X^2=67.12, p=.000
NVQ level 3	17	51	22	30	X^2=49.36, p=.000
NVQ attained at this Trust	37	58	57	69	X^2=14.93, p=.002

[a] *Band 1 (n=9) and Band 4 (n=1) have been omitted from this Table.*

Table 11 indicates that all Trusts have an overwhelmingly Band 2 HCA workforce: in three cases well below a fifth of HCAs were on Band 3, while in the fourth, North, Band 3 was very rarely used. In terms of NVQ accreditation, there is, however, significant variation between Trusts. South is a Trust where few HCAs have either NVQ 2 or 3, and even those who have acquired these qualifications were unlikely to have done so at the Trust. In contrast, almost three quarters of HCAs at London had an NVQ level 2, two thirds receiving it whilst at the Trust. Equally striking is the fact that over half the HCAs at Midland had a NVQ 3, out-performing London in this respect.

These differences in level of HCA accreditation can be explained by contrasting approaches to NVQs within the respective Trusts. Three such approaches were distinguished. First, and accounting for its low level of accreditation, South had effectively allowed their NVQ infrastructure to 'wither on the vine':

Manager_South: A lot of Trusts have strong support for NVQs… So they'll say, "Oh the government expects 80% of the workforce to have NVQ level 3 so let's do something about it"… but I think our Trust realised, "well if we don't do anything about it nobody's going to bother to chase this up, so let's ignore this one"… So I think a lot of Trusts do put their support around NVQs and then they'll have quite a few study days associated with that… So our solution is very different, it's let's write our own which are much more accessible for staff, much more, maintain competence and a structure to the development but don't tie people up in bureaucracy and paperwork like NVQ.

Second, North had retained a commitment to the NVQ model, but its approach was reactive and opportunistic:

Senior manager_North: We have an NVQ centre that functions within the, the organisation but, again, I think it's not consistency across the organisation in terms of being able to say that absolutely every support worker has gone through that. And that also connects with the Band 3 support workers that I think it's, it's more above staff at that level but if we've got people working at Band 3 then, that they've undertaken the NVQ 3, I think it is less robust for support workers working at level 2.

Third, in London and Midland a much more proactive approach to NVQs was in evidence, reflected in the higher levels of accreditation. London, for example, was a centre for NVQ accreditation and had displayed some innovation in providing online access to NVQ modular material:

Manager_London: They [HCAs] are all offered NVQ level 2 or level 3 and there is an expectation within the Trust that all healthcare assistants within [London] should have a level 2 or level 3 and it's in like their job descriptions.

These levels of NVQ accreditation, when combined with the distribution, do raise some interesting issues about the (non) alignment between tasks performed, pay banding and formal qualifications. These are returned to in considering the management of HCAs.

5.3 Issues for reflection

The findings in this part of the report suggest the need for Trusts to consider:

- Local labour market conditions: in loose, as opposed to tight, local labour markets there might be greater scope to recruit higher quality individuals to HCA posts.
- Emphasising the intrinsic rewards of the HCA role, in particular the scope to 'make a difference', as means of attracting strong candidates to the role.
- The limited gateways into the role: if Trusts are seeking individuals with more diverse work experience, they should seek to broaden their

recruitment efforts; if they are content with entry through these gateways they should adopt more targeted approaches to recruitment.

- The importance of online advertising as the main source of information on HCA vacancies.
- The aspirations of those selected for the HCA role as a means of more efficiently and effectively managing their career development.
- The different life narratives of those drawn to become HCAs as a way of assessing how they might engage with the role.
- Practices for delivering NVQ qualifications: where Trusts devote energy, focus and resources to NVQs, there are marked differences in the proportion of HCAs with NVQ qualifications.
- The consequences of narrowly concentrating HCAs within pay Band 2.

6 The shape and nature of the HCA role

It will be recalled that the project sought to explore the shape and nature of the HCA role in a number of ways: by examining broad perceptions of the role in terms of who the HCA was actually supporting; by seeking stakeholder views on what makes a 'good' HCA; and by considering the tasks performed by post holders, the form they took and their configuration within the boundaries of the role. A range of varied views was expressed on who the HCA was supporting and what made a 'good' HCA. These views and findings are reported in Appendix 2.

This part of the report concentrates on the substantive shape of the role.

The tasks and responsibilities of the HCA were typically set out in a job description. These were, however, invariably drafted in broad terms: in Midland, for example the Band 2 job description comprised over 20 separate tasks. In practice, the take-up and configuration of these and other tasks were determined by the interaction of a variety of workplace, structural and behavioural factors. This produced considerable variations in the contours and substance of the HCA role. As a manager in London noted:

> *Manager_London: Although there's some generic job descriptions, the senior sisters on the ward are again, rightly or wrongly, left to use their staff in the way that they want to. So you'll find across the Trust different HCA groups are doing different things and working in different ways. So some are more autonomous than others and have a, and have a wider skill set than others. So you have a resource, some people are going to be maximising that resource and others aren't.*

In trying to discover and understand patterns in the distribution of tasks and activities within the boundaries of the HCA role, three themes are explored in this part. The first seeks to explore where the core of the HCA role lies and how it might be extended. The second considers generic influences on the contours of the role. While recognising that the role is flexible and contested, the third reveals distinct patterns in the distribution of tasks, the foundation for different HCA types. These types are described, conceptualised and explained.

6.1 Searching for the core

There was a considerable degree of consensus across the Trusts that the core of the HCA role lay in indirect and direct patient care: in other words the essence of the role was seen as bedside and patient centred:

> *Ward manager_London: They provide basic nursing care, alright? They're there to help wash people, they are there to do jobs in an emergency. I don't think it's necessarily always part of their job to do observations, that's one of the jobs I think that gets, they get palmed off with.*

There were suggestions that the provision of direct care – washing and feeding – marked a shift in the core, with the more traditional nursing auxiliary typically confined to indirect tasks such a bed making and other ancillary tasks:

> *Manager_London: I think we're allowed to do an awful lot more than we ever were clinically and we're probably more, we're more informed than we ever used to be. I mean I think when I first started doing HCA work you were never there for a handover because that was the trained nurse's job, so you could go and deal with a patient that you knew absolutely nothing about. Whereas these days you're more involved with the care and I actually think that they've started to notice that HCAs do more of the care for the patient than sometimes a lot of the staff nurses do.*

It was equally apparent, however, that across the Trusts, the HCA role was moving to take on more extended tasks. Certainly the limits of the HCA role were clearly drawn in all Trusts: for example, the dispensation of any medications remained the sole prerogative of the registered nurse, but before this limit was reached, a range of more complex and technical such as taking observations, performing ECGs and taking bloods could be performed by HCAs:

> *Ward manager_North: [HCAs] do the observations on here. They're not solely responsible for the observations but I think the reality is that they do the observations more than the qualified nurses do now because of the turnover of patients and the paperwork and everything else that the qualified nurses do.*

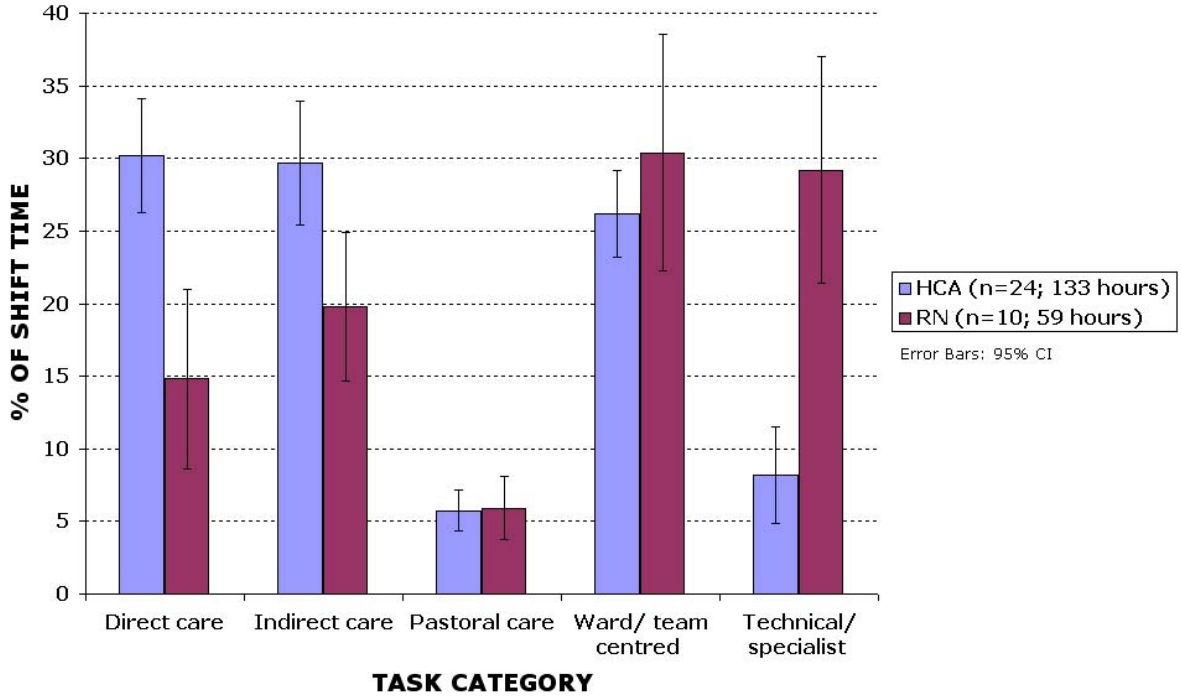
> *Manager_London: I mean as qualified practitioners' roles have changed with regards to taking on new skills, the same has happened for healthcare assistants. So, you know, a lot more has been expected of them [HCAs] with regards to things they now undertake, so it might be that they've been trained up to do venapuncture…*

The suggested move to an HCA core which revolved around direct as well as indirect patient care raises issues about the extent to which registered nurses have vacated that space. Hints at the development of a more extended role beg questions about the extent to which HCAs were taking on the more sophisticated nursing tasks. Our observation of HCAs and nurses at work provided a means of exploring just how similar or different the respective roles were in relation to these various types of task. Figure 3 draws upon our observational data to compare the relative proportion of the shift spent by HCAs and nurses on different types of activity. Definitions and examples of the five task categories are provided in Appendix 4.

The figure suggests that HCAs were spending a considerable proportion of their time on direct and indirect patient care: around 60% of the shift. While nurses had not completely deserted this ground, spending close to a third of their shift on it, they were clearly less engaged in such care than HCAs. Clearly, this time was used by nurses to perform technical and specialist tasks, a realm which despite discussion of an extended HCA role,

remained nurse terrain. Ward- and team-centred tasks, as well as pastoral care, appeared to be largely shared.

Figure 3. Observed shape of the HCA role: HCAs vs nurses (early shift only)



This general picture should not detract from the different forms assumed by the HCA role. As a manager from North noted:

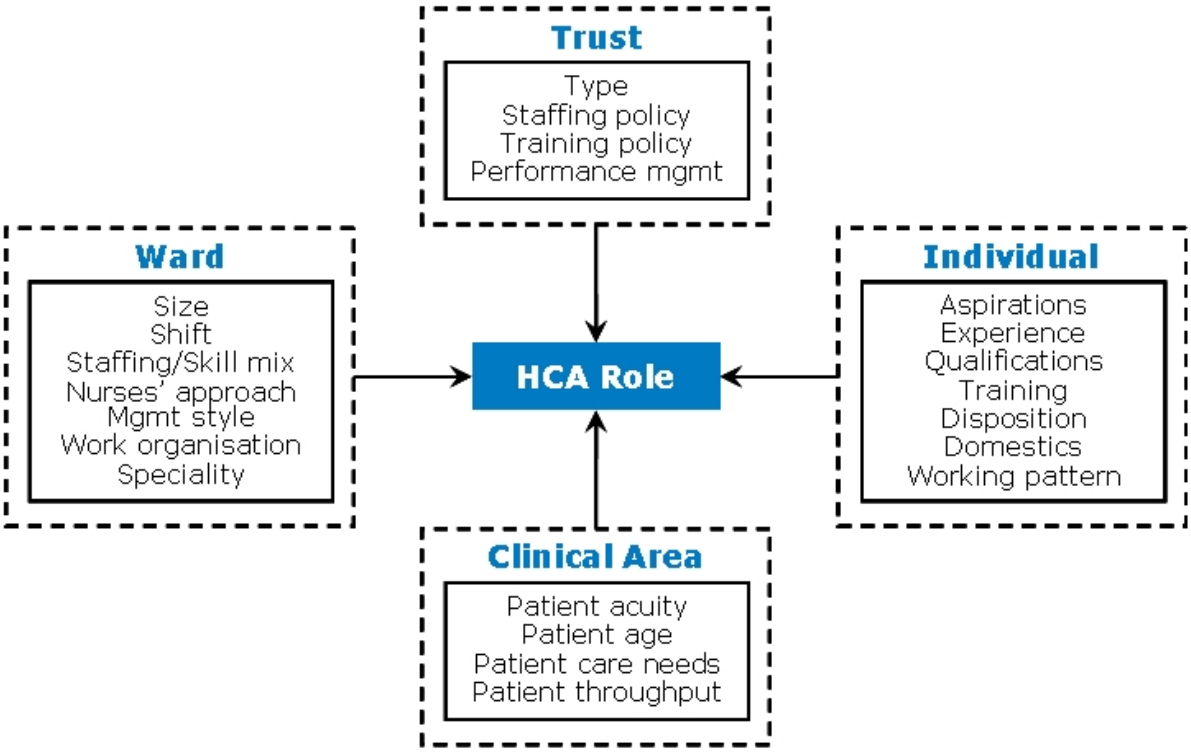
> *Ward manager_North: I think [the HCA role is] different wherever you ar and dependent on the skill sets of the individual. And then I think it's also down to how the individual's motivated and in terms of what they want to take on. Sometimes it's being clear what is the role, and that's different everywhere you go in relation to if you talk to somebody about a health, a nurse assistant in one place, a nurse assistant somewhere else, they're different. I think it's fine them being different if they're different for a reason, but you can be different in one medical ward to another, it can be the whim of the ward sister, those types of things. .*

This quote highlights the range of structural and personal influences on the shape of the HCA role. The next section considers these in a more systematic way.

6.2 Contingent influences on the shape of the HCA role

The qualitative research highlighted four sets of factors with a significant influence on the configuration of tasks performed by the HCA. These factors are set out in Figure 4. Those related to the Trust, the ward and the clinical setting might be seen as being predominantly structural; those associated with the individual imply a degree of personal agency. Each set of influences is considered in turn.

Figure 4. Influences shaping the HCA role



6.2.1 Trust

Any given Trust has at its disposal a range of policies and practices which might be used to shape the HCA role; substantive and procedural variation in the use of these levers between hospitals accounts for differences in the nature of the role. Most obviously, there is scope to develop job descriptions which set parameters to the role, but in a stronger sense, pay systems, training and performance management arrangements might be used to influence the willingness and ability of HCAs to perform certain tasks.

In contrast to many parts of the economy, the NHS has national systems, mainly articulated through Agenda for Change (AfC) and the Knowledge and Skills Framework (KSF), standardising the form assumed by these levers. This did not, however, detract from the possibility of using these levers to manage workforces in a strategic way in pursuit of Trust goals; indeed they were viewed by national policy makers as being designed for such a purpose. However, at the level of the Trust, these systems emerged as providing only a 'light touch' influence on the shape of the HCA role. This has already been highlighted in the discussion on strategic approaches to the HCA role. It is worth re-stating that across the four Trusts, the limited use of such human resource levers to shape the HCA role in the context of broader hospital aims ensured a highly permissive corporate regime; the effect was to allow other, lower level, forces to hold sway in the shaping the HCA role, sometimes in idiosyncratic and occasionally in disordered ways.

Beyond the clear rules on the dispensation of medication, as set out in broad job descriptions, corporate systems to regulate what HCAs could and

could not do were not greatly in evidence. In two Trusts – London and South – policy documents had been published on the management of the HCA role; indeed at South, a Code of Practice had also been produced for HCAs in 2002. These documents set out broad principles designed to regulate the shape and management the HCA role. In London for example it noted that the HCA 'will at all times…:

- recognise any limitations of competence and only carry out those tasks which are included in the job description for which formal training and assessment have been undertaken;
- be aware that they should make the practitioner aware if the task is beyond their competence;
- have responsibility for care delivery'.

However, there was limited awareness of these principles, and few if any attempts to monitor or enforce their application. As a manager of the London Trust noted:

> *Manager_London: Well what is a healthcare assistant allowed to do? Is it about accountability? Is it about they're not sure what they [nurses] can actually delegate? So I think a lot of problems are with their own issues. We've got a lot of young ward managers and maybe some of the issues related to that is they're not so sure what they can actually delegate, and maybe that's because they're not as experienced themselves.*

This corporate permissiveness was most in evidence in reviewing the relationship between the pay band, the NVQ qualification and the tasks performed by HCAs across Trusts. These elements were clearly designed to align with one another; by definition, a Band 3 HCA role involves the performance of a broader range tasks than a Band 2 post, with the acquisition of NVQ 3 a signal of what the HCA is capable of performing. In short, given differences in job size and requisite capability, NVQ 2 aligned with Band 2 and NVQ 3 with Band 3.

In practice, this alignment had largely broken down across all four Trusts. In terms of the relationship between Band and tasks performed, this is most obviously apparent in the concentration of over eighty percent of the HCA workforce into Band 2, suggesting that Band 3 is seldom used to differentiate the high performing HCA. To assume that this reflects a situation whereby the HCA role in the Trusts revolved around a small range of routine, low-level tasks would be a mistake. Under the Band 2 grading, the HCA role assumed diverse forms both within and between Trusts (see below). Suffice to say at this stage, there were Band 2 HCAs performing the kind of complex technical tasks normally associated with a Band 3:

> *HCA_Midland: We do the ECGs, the blood pressures, the monitoring of patients, that kind of thing, whereas normally in the hospital you'd be a Band 3 [sic], but [here on this ward] you're a 2.*

Ward manager_North: We'd looked at skilling some [HCAs] up to Band 3s and to be honest they, some of them do bloods and do ECGs now but they're still, the Trust still just pays them Band 2s.

Manager_London: I'm sure you will find Band 2s putting cannulae in or taking blood. And I don't, well whilst I'm aware of issues such as the Band 2s' salary and it does make me think, is it fair to expect somebody to take on those kinds of roles and does it feel a bit like some sort of exploitation?

The relationship between Banding and NVQ level had also becomes distorted:

Interviewer: What about the link between Banding and NVQ levels, I mean…?

Manager_London: Oh it's all over the place. It's all over the place, you've got Band 3s not doing what the Band… It's historical and, again, I think it's because there's that many different departments, that many different wards, they all have their own job descriptions. Again it's, "Oh you've been here so many years you need a Band 3", you know.

Certainly it was rare for Band 3 HCAs not to be at NVQ level 3. It was not, however, unknown. Across the three Trusts (Midland, North and London) with a viable NVQ system in place, almost a quarter of Band 3s did not have an NVQ 3. One HCA explained how she gained a Band 3 on the basis of experience, a plausible rationale but the removal of an NVQ 3 requirement for Band 3 posts introduced some opaqueness into the relationship between capability and band:

HCA_South: One or two people weren't happy that I was put up to Band 3 without achieving my NVQ, I've got it all on my experience and what I can do".

Matron_London: "I mean I would say… because of previous management we've got Band 3s in the department that haven't even got an NVQ. That's just what they were given at the time when they were taken on."

More striking was the situation where highly qualified HCAs with NVQ 3 were found languishing in Band 2. A disconnect had emerged because HCAs were willing and able to train, but with few Bands 3 posts, were often left with their NVQ3 and nowhere to go:

Manager_London: If I'm trained to NVQ Level 3 and I'm cannulating and I'm doing X, Y and Z, then I would expect to be a Band 3. But it hasn't necessarily followed historically and I think we're tightening up on that now but some people appear to have, when the banding came in, just to have been slotted in perhaps in to certain roles and you may find that a Band 2 is functioning at a higher level than some of our Band 3s.

Manager_North: We had many support workers who were at NVQ level 3 and had extended their roles for phlebotomy and cannulation and actually were holding their hands up and saying I should be a Band 3.

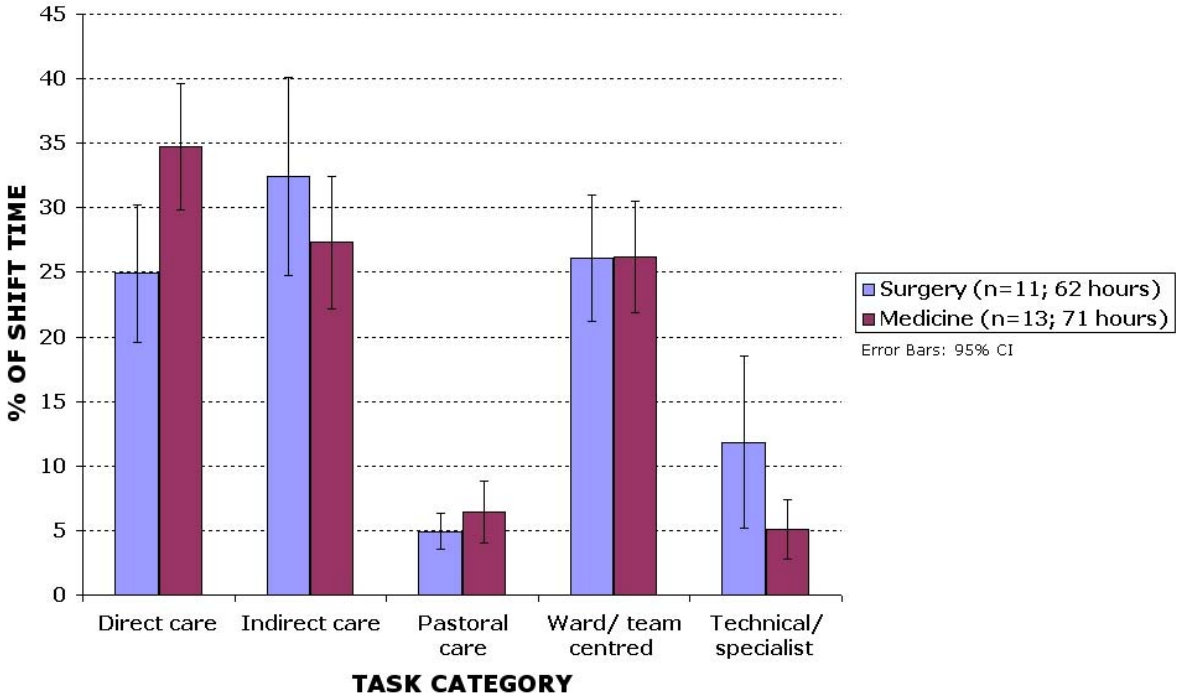
But what we said was, it's what the service needs is when we will implement Band 3.

The incidence of this situation did vary by Trusts. It was at its most prevalent in Midland, related perhaps to the re-structuring and skill mix review which reduced the number of Band 3 posts. In this Trust almost half (46%) of Band 2 HCAs had a NVQ 3. This compared with North and London where the equivalent figure was around 18%.

6.2.2 Clinical area

Differences between clinical areas – general surgical and general medical – in terms of the patients admitted and their conditions were seen to affect the nature of the HCA role. For example, a surgical ward will require considerable movement of patients to and from the theatres, the 18 week limit on waiting time is a target which filters down to place pressure on patient discharge; while in some wards with High Dependency Unit (HDU) step-down beds, patients were naturally very poorly, requiring a richer skill/grade mix. Medical wards, particularly those taking elderly patients, were likely to have a slightly higher age profile with more confused patients, needing considerable support.

Figure 5. Observed shape of the HCA role: surgery vs medicine (early shift only)



The analysis of the observation data provides some support for this view. As can be seen from Figure 5, HCAs in medical wards were spending more of their shift on the provision of direct care than those in surgical wards –

respectively around third compared to a quarter of their time – while HCAs were devoting more time to indirect and technical/specialist tasks.

Figure 6. Rhythm of the surgical ward HCA role (early shift, n=11)

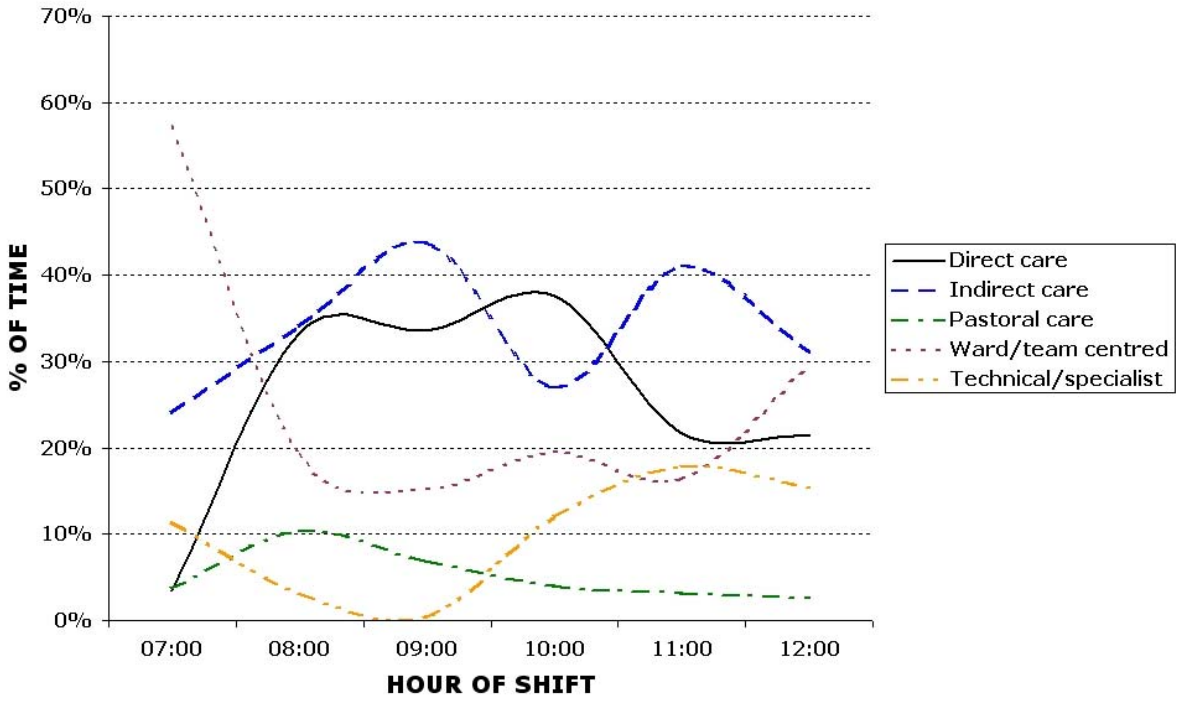
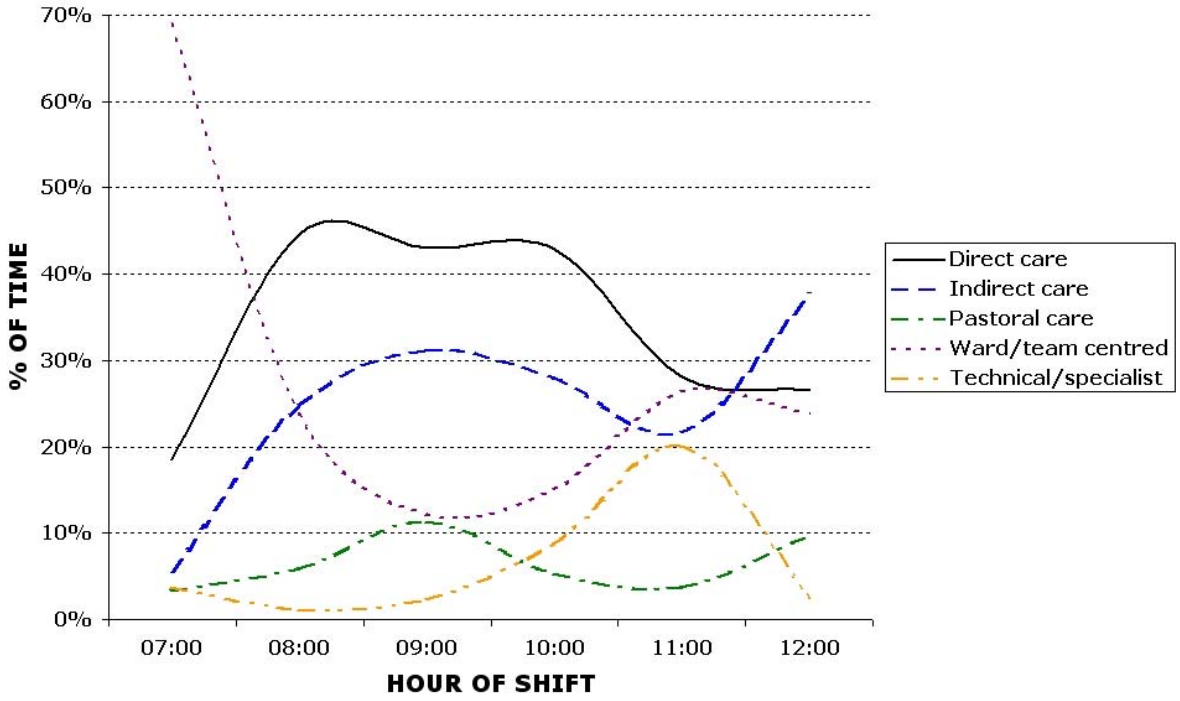


Figure 7. Rhythm of the medical ward HCA role (early shift, n=13)



More striking were divisional differences in the pattern and rhythm of the HCA role across the shift. Figures 6 and 7 present the flow of tasks across the early morning shifts respectively, in medical and surgical wards of our four Trusts. Each series of points plotted on these Figures indicates the proportion of time spent on the different activities by HCAs during their shift. The patterns present different rhythms of activity in the two clinical areas; after a handover period, a team activity, attended by HCAs in both clinical areas, on the medical ward direct care is quickly established and sustained as the key activity for much of the shift until nearer lunch when blood monitoring is undertaken. By contrast, on the surgical ward, a burst of direct care at the beginning of the shift associated with getting patients out of bed and washes, gives way to an ebb and flow of different types of indirect and team-related tasks.

6.2.3 Ward

The shape of the HCA role was heavily influenced by a number of features associated with the organisation and management of the ward. These features included the shift, work organisation, ward workforce and management style.

Shift

The structure and nature of a shift had a powerful effect on the shape of the HCA role; tasks and responsibilities undertaken were highly sensitive depending on whether the HCA was working on the morning, late or night shift. In the main, the respective shifts had a standardising effect, generating their own routines, requirements and interactions across all wards and areas regardless of speciality.

The early shift was generally perceived as the most intense, with HCAs required to help patients out of bed and wash them as well as embracing two meals times: breakfast and lunch; by contrast, the late shift overlapped with visiting times, ensuring a much greater interaction with patients' friends and relatives; the night shift was often the quietest of the shifts. An HCA working only nights, for example, would be performing a role shaped very differently to an HCA just working day shifts. There were also instances where working long days – in effect a double shift – was common practice, again the shape of the role for an HCA on a long shift would be very different for one working a single shift.

Work organisation

There was some variation in the organisation of work on the ward, which could impact on the nature of the HCA role. In general there were three models of work organisation: a fairly fixed model based on a team covering a given number of bays, the HCA working with the nurses as part of this team; a more flexible model, the HCA working in a more fluid fashion across the whole ward and with nurses as and when needed; and a bay-centred model, the HCA having responsibility for a single, given bay. These different models would shape the HCA role in very different ways, for example, the team model would see the HCA working with a more limited and fixed set of

patients and nurses than a flexible model; with responsibility for a given bay, the HCA would have a focused set of ongoing, monitoring tasks.

Ward workforce

At various times during any given shift, a range of occupational groups will be working on the ward alongside the HCA. The list of such occupations is quite extensive: housekeepers, ward assistants, cleaners, caterers, porters, student nurses, physiotherapists, phlebotomists, physicians' assistants, and occupational therapists. To varying degrees, the activities of these groups overlap with those performed by the HCAs: the student will be engaged in aspects of direct and indirect care; the physiotherapist might ask the HCA to help walk a patient; and as a matron at London noted:

> *Matron_London: [Ward name] have physicians' assistants as well which do all the cannulation and all the phlebotomy and catheterising and nasal gastric tube insertion. They're not qualified nurses, they've kind of evolved from a band, an HCA role and they are managed by the consultant clinician and they have, they have learnt skills in the technical…*

The presence or not of such groups on the ward had an impact on the tasks performed by the HCA: regular visits by a phlebotomist clearly reduced opportunities for then take blood, and as was highlighted in our observation:

> *Field note_Midland (Medical): It was noticeable how much more time the [HCAs] had because of the WA [Ward Assistant] doing the drinks round and breakfast. It meant they could rattle through their washes without interruption. The observee did remark that Wednesdays was her least favourite shift because the WA didn't work that day and as a consequence it was a lot busier.*

The use of these groups varied quite considerably between wards – physicians' assistants in London, for example, were mainly employed in the MAU; the use of student nurses was found to differ quite significantly between wards in any given Trust; physiotherapists were more in evidence on say Stroke Units than other wards. Depending on where and how these groups were used, the HCA role would be shaped at the margins quite differently. For example, on some wards student nurses learning about technical tasks, squeezed out opportunities for HCAs to perform such tasks, causing some HCA frustration.

Management style

A degree of agency in shaping the HCA role was apparent at ward level in the guise of ward manager's style of management. Ward managers varied in how supportive they were of the HCA role and its post holders:

> *HCA_London: You've got some really good members of staff over here, you know, a couple of fantastic senior sisters that you know will always encourage you to, you know, go on with your knowledge and everything.*

But unfortunately, which I suspect you get in every hospital everywhere, you get the ones who say the words, "HCA, dogsbody".

During observation, an instance was noted of a ward manager on a surgical ward teaching an HCA to carry out a new procedure – a bladder lavage – generating a change in the future shape of this HCA's role and there were a number of ward managers who indicated a desire to develop HCAs:

Ward manager_North: The extended things like taking bloods and ECGs… [HCAs] come to me and said they want to do that and I would support all of them doing it if they wanted to do it. I wouldn't push them into doing it because personally I think a Band 2, they're not paid enough for the responsibility, I don't think. But if they choose to do that and that's what they want to extend their role then I'm quite happy to support that.

At the same time there were other managers, who were less supportive of such developments:

Matron_South: My view at the moment is I don't want healthcare assistants doing anything that is an extended role. Purely and simply because actually I am, I need to improve quality and whereas the HCAs are off doing ops, they're off doing bloods, they're off doing cannulation, that's what they're focusing on. So my view at the moment is that I do feel quite strongly and all the HCAs and all the trained staff know it, that at the moment this is what I want my HCAs concentrating on. And you know, on an individual basis, I'm happy to discuss, you know, whether they want to go off and do a cannulation course. But I would need to be really clear and have that discussion with them that actually this wasn't going to take away from what we needed them there to do.

6.2.4 The individual

The shape of the HCA role was heavily influenced by a number of individual characteristics: disposition, capability and personal circumstances.

Disposition

HCAs embraced the role with varying degree of commitment and enthusiasm, being more or less willing to push its boundaries:

Nurse_North: Some [HCAs] are like more willing, they're more accepting of the role, they understand that, you know, this is my role and this is what I'm supposed to do, you know, I am here to help you, you know, I will wash people if you're busy, you know, I will take someone to the toilet if you are busy. Whereas some people resent the fact that you haven't got time and they won't do anything because you're not doing, you know, you're sat at the desk, you're writing but, you know, if you're caught up in a court of law in ten years' time you're not going to know that patient and you need to write what you've done. But they don't seem to understand that and like they'll go oh you sit at desk, that's all you do, you sit at desk, you write your notes, that's all you do.

The most striking example of disposition affecting the shape of the HCA role emerged in the case of the aspirational individual. These were HCAs with an ambition to develop their careers, who often sought to craft their job, taking on more tasks and seeking to extend the role. It was a pattern which could cause problems on the ward with aspirational HCAs taking on more complex jobs to the neglect of core care activities:

> *Nurse_South: Recently we had a healthcare assistant who was not working with us and he got very keen to do cannulation and blood letting and would, "I'll go and do that, and I'll look on the computer for the results" and blah, blah, blah and actually it's like you need to go and do that commode and strip that empty bed first, and you're kind of thinking, it's all very well learning these things but actually you are here to go and empty the skips and keep the trolleys stocked up, as well as do the extra role if you can.*

Capability

Most obviously activities undertaken by the HCA were sensitive to the capabilities of the post holder:

> *Ward manager_London: We try and treat them [HCAs] all as individuals and not every HCA is able to do everything and as much as others, so you have to value each person as an individual and you have to look at the strengths and the weaknesses on both sides…*

In part, capability derived from experience. Experienced HCAs often engaged in a broad range of tasks; longevity in the role had facilitated the formal as well as on-the-job acquisition of skills and an appreciation of routines:

> *HCA_London: The thing is, the longer you're here the more they ask you to do, the more people will just take you aside and teach you this little thing and, "Oh you can do that now". You know, and it's, it's very like that and as far as I'm concerned it's a teaching hospital, you're going to advance yourself the whole time, you're going to learn more, every situation you're put in you learn something, whether that's from something you do a hundred times. You know, I'm constantly with relatives of people that have died or something like that, but you learn something new every time, you know. So I don't know, it's quite a, it's quite a difficult one really, it depends.*

The link between experience and a broader role can also be traced, with the greater trust other team members have in the longstanding HCA:

> *Nurse_North: A lot of wards don't allow their healthcares to do observations but we trust our healthcares to do it. Ninety-nine percent of the time that's absolutely fine and they'll come and let you know if there's something untoward, they recognise if the observations are not quite right.*

At the same time, experience could be a double-edged sword, in certain instances narrowing the role; some older HCAs could become stuck in their ways and unwilling to venture beyond a well-established comfort zone:

> *Nurse_South: Well quite a lot of the ones who've been an HCA and are slightly on the older side tend to, they came in to it for the patient contact and the washing and the dressing and so on, and they tend to want to stick with that, that's what they're happy doing. And if that's what they're happy with, I don't think we have to push them to do it anymore. With the younger ones, they tend to want to learn to do the observations, the blood glucose monitoring, dressings and other things. So we will teach them that and the others, we will support them in what they want to do.*

Naturally, capability was also related to breadth and depth of training; formal accreditation of competence in certain tasks signalled to nurses HCA capability and sanctioned its use:

> *Ward manager_South: It depends what training they've [HCAs] been given… It's about responsibility for that patient, and whether somebody's got the background knowledge and training to be able to take on the responsibility.*

Personal circumstances

The other example of job crafting arose in relation to HCAs who sought to shape the role in the context of their personal circumstances, for example their childcare responsibilities. This form of crafting was most likely to be seen in bespoke patterns of working time. These took the form of only working certain shifts – say just nights – or preferring to work only long days, or only part shifts. In some instances personal responsibilities encouraged HCAs to seek extra hours:

> *HCA_London: …supporting my, my nephews and nieces in school back home, so I have to work hard otherwise I'm, it's like I'm working for two families, I mean my nieces and my nephews back home so, and my mum so, and she's not well so I have to send her some money…*

> *HCA_London: I can't work full-time because of my family circumstances; I have to be, you know, home at certain times for my children and in the morning, you know, I can't start at like seven o'clock. So if I find a proper job which is, you know, like suits my lifestyle and, you know, helps the Trust as well, then I will be happy to work, otherwise, you know, I will keep looking for it.*

6.3 Types of HCA

Having relied upon the qualitative material to consider where the core of the HCA role lay and the range of factors influencing its shape, this section mainly draws on survey data to explore the substantive form of the role, that is, the activities undertaken by the HCA and their configuration. The findings will be seen to confirm the malleability of the role, with tasks and

activities being combined in various ways and giving rise to different types of HCA. These HCA types will be presented as partly being structurally determined, closely related to Trust and clinical division; but a residual degree of agency will also be claimed, one of the HCA types distinguished bearing the hallmarks of individual job crafting. These HCA types are characterised and an attempt made to explain how and why they have emerged. A final mention is made about how these clusters relate to certain outcomes.

6.3.1 Characterisation of types

Cluster analysis was performed on the survey data which asked HCAs the frequency with which different tasks were undertaken (never, daily, weekly, monthly or annually). A technical note on the approach adopted can be found in Appendix 13. This analysis revealed five distinct HCA types, presented in Table 12.

Table 12. Task frequency by HCA cluster type[a]

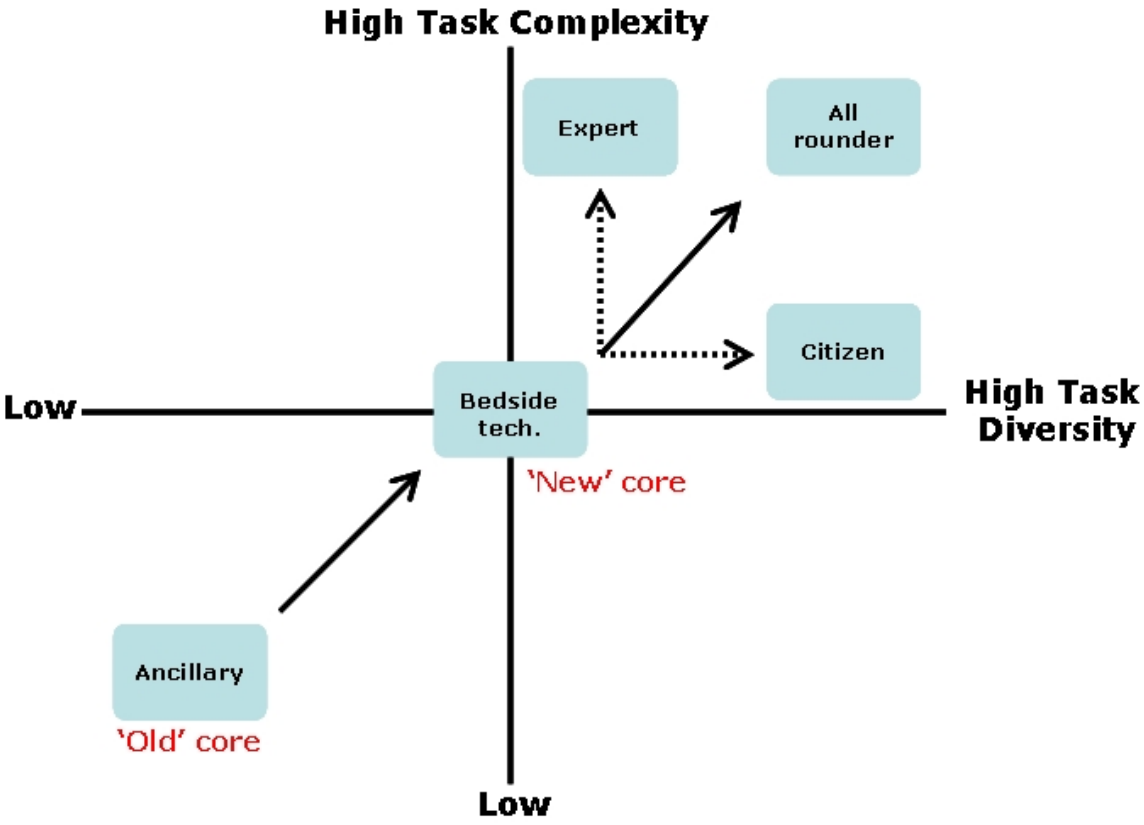
Task	Bedside tech. (n=205)	Ancillary (n=100)	Citizen (n=132)	All rounder (n=38)	Expert (n=63)	Nurses (n=689)
Bathing	daily	weekly	daily	daily	weekly	weekly
Feeding	daily	weekly	weekly	daily	weekly	weekly
Bed making	daily	daily	daily	daily	daily	daily
Collecting TTO	monthly	weekly	daily	weekly	weekly	monthly
Escorting a patient	monthly	monthly	daily	weekly	weekly	weekly
Stocking stores	monthly	daily	daily	weekly	daily	weekly
Observations	daily	monthly	daily	daily	daily	daily
Blood monitoring	daily	yearly	daily	daily	daily	daily
Simple dressing	monthly	yearly	monthly	daily	weekly	daily
Taking blood	never	never	never	weekly	daily	monthly
Female catheterisation	never	never	never	monthly	never	monthly
Complex dressing	never	never	never	monthly	never	monthly
ECG	never	never	monthly	weekly	weekly	monthly
Cannulation	never	never	never	monthly	yearly	monthly

[a] *Task mean scores have been substituted with their semantic equivalent from the rating scale to ease comparison. Mean scores are available in Appendix 13.*

The five types of HCA to emerge from the cluster analysis can be differentiated along two main dimensions. The first is diversity: the breadth of tasks of performed. The second is complexity: the degree of technical sophistication of the activities undertaken. Figure 8 shows how the clusters

are plotted against these dimensions. Each HCA type is labelled and described in turn below using this two-dimensional framework to facilitate the characterisation.

Figure 8. HCA types (task complexity by task diversity)



- **Cluster 1: the Bedside Technician**

  Cluster 1 has been labelled the 'Bedside Technician'. It is a role which revolves around the bedside provision of patient-centred direct and indirect care – bathing, feeding and bed making – which is undertaken on a daily basis. It also embraces the performance of routine technical tasks such as blood glucose monitoring (BMs) and observations, also delivered on a daily basis. This is an HCA which will carry out some other indirect care tasks including escorting patients and collecting discharge medicine (TTO) – but will never drift into the performance of more sophisticated specialist or technical tasks such as taking bloods and ECGs. Such a combination of tasks puts this HCA at the centre of our framework, performing at the mid-point in terms of complexity and diversity of tasks. It is by far the most common type of HCA, 38 percent of individuals fell within this cluster, and consequently might legitimately be seen as today's standard HCA model. As the standard model, it is particularly striking that it is not only performing direct and indirect tasks but also routine technical tasks as well.

Taken as the new standard model, it also is worth comparing the profile of the Bedside Technician with that of the nurse. Table 12 confirms that while nurses continue to make beds on a daily basis, they have stepped back somewhat, if not completely, from performing other direct and indirect care tasks. The nurses' centre of gravity is the routine technical tasks of BM, observation and simple dressings, all undertaken on a daily basis. Nurses also devote their time to the more technically sophisticated tasks such as taking bloods and cannulation, which remain essentially, if not quite exclusively, the nurses' preserve.

- **Cluster 2: the Ancillary HCA**

  Cluster 2 has been classified as the 'Ancillary'. This is an HCA who carries out only a restricted range of routine tasks – bed making and keeping stores – with any frequency. It is therefore presented in the framework as a low complexity and low diversity role. While the traditional, pre-1990 'nurse auxiliary' could perform a wide range of tasks, the Ancillary HCA distinguished in our analysis would appear to conform most closely to the underlying conception of this old auxiliary: supporting the ward team with the performance of fairly routine task, rather acting as a regular provider of hands-on care. Nineteen percent of HCAs fell within this cluster.

- **Cluster 3: the Citizen HCA**

  Cluster 3 has been named the 'Citizen'. The title derives from the fact that this type of HCA is performing not only a wide range of direct and indirect care tasks on a fairly regular basis, but also tasks with a strong team orientation. For example, in contrast to the Bedside Technician, the Citizen will collect TTOs, escort patients, and in particular keep stores stocked on a daily basis. Like the Bedside Technician, the Citizen undertakes BMs and observation, while more complex technical tasks remain unfamiliar territory. This combination of tasks places the Citizen as high on diversity but at a mid-point on complexity. After the Bedside Technician, it is the most common type of HCA, with 25 percent falling within this category.

- **Cluster 4: the All Rounder HCA**

  This cluster has been designated as the 'All Rounder'. It is the HCA type active across the full range of tasks. It retains the core configuration of tasks revolving around the direct and indirect care as well as some routine technical tasks. Its level of engagement in certain team-centred tasks such as keeping stores stocked is lower than for the Citizen, but it ventures with greater regularity into the provision of more sophisticated specialist and technical tasks. The All Rounder will therefore be taking bloods and performing ECGs with some regularity and even at times changing complex dressings. This is an HCA engaged in a highly complex and highly diverse set of tasks. It would appear to be a demanding role, the closest HCA to the nurse profile, and unsurprisingly, therefore, only a relatively small number of individuals, seven percent, can be found performing it.

- **Cluster 5: the Expert HCA**

  Cluster 5 has been called the 'Expert'. This HCA is not as heavily engaged in certain direct and indirect care tasks, particularly bathing and feeding patients, as most of the other HCA types. This type continues to perform the routine technical tasks of the other clusters but its expertise lies in an extension of the role to take on some complex technical task such as taking bloods and to a lesser extent ECGs. It does not perform as full a range of such tasks as the All Rounder but it does undertake some, such as ECGs, more regularly. The Expert therefore scores quite highly on the complexity of tasks undertaken but less so on the diversity of tasks performed. A relatively small but not insignificant 12 percent fell within this category.

In further characterising these clusters, a fairly plausible relationship emerges between HCA type, pay banding and NVQ accreditation: the more diverse and complex the HCA type the more likely the individual post holder is to be a Band 3 with an NVQ 3. This should not detract from the fact that complexity and diversity are not necessarily aligned with a higher banding or qualification, a consequence of HCAs being concentrated in Band 2 across all Trusts. As Table 13 indicates, a third of those in the most complex and diverse roles – All Rounders and Experts – were in Band 3. This clearly leaves over two thirds of those in the most diverse and complex roles in Band 2. Predictably lower proportions of Bedside Technicians, Ancillary and Citizen HCAs are in Band 3. Again, as might have been envisaged, the majority of All Rounders and Experts have an NVQ 3, although once more the fact that a third of All Rounders and almost a half of Experts do not have an NVQ 3 remains striking. Less surprising is the finding that only a small minority of those in the other clusters have an NVQ3.

Table 13. Pay Band and NVQ details by cluster type (%)

	Bedside tech.	Ancillary	Citizen	All rounder	Expert	p-value
Band 3	5	7	12	33	37	X^2=59.80, p=.000
NVQ 3	19	20	32	64	53	X^2=51.71, p=.000

6.3.2 Explaining types

Consideration can now be given to how and why these clusters emerge: are there patterns in the distribution of these types, and if so what explains these patterns? Drawing on the distinction between structure and agency, a relationship between clusters and the Trust and or division would suggest the influence of structure; a relationship between HCA type and the background characteristics of the HCA – say their aspirations and length of service – might imply the significance of post holder agency.

Table 14. Cluster type by Trusts (%)

	South (n=164)	Midland (n=133)	North (n=141)	London (n=100)	p-value
Bedside tech.	29	26	55	46	X^2=104.79, p=.000
Ancillary	34	18	2	17	
Citizen	25	36	13	25	
All rounder	9	5	9	5	
Expert	4	16	21	7	

Structure, in the form of Trust and division emerge as a significant influence on the distribution of HCA type. As Table 14 indicates, the profiles of the four Trusts in terms of this distribution are quite distinctive:

- South has a notable concentration of Ancillary HCAs: a third of its HCAs fall into this category, the highest proportion of any Trust. It also has a relatively limited proportion of its HCAs, just over quarter, in the Bedside Technician role, much lower than North and London.
- Midland has a particularly high concentration of Citizen HCAs, over a third, markedly higher than any other Trust. Midland is similar to the South in having a much lower proportion of Bedside Technicians than North and London but shares with North a noteworthy rump of Experts.
- North has a strikingly high proportion of its HCAs as Bedside Technicians, over a half fall into this category. This is much higher than in any other Trust, although it shares a significant concentration of HCAs in this role with London. It is also a Trust with a noteworthy group of Expert HCAs, close to a quarter, once more far higher than in any other Trust.
- London, as noted, shares with North an emphasis on the Bedside Technicians, close to half of its HCAs falling within this category. In contrast to North, however, the other significant concentration of HCAs can be found as Citizens rather than as Experts.

Trying to understand these patterns is not easy. It is tempting to relate the relatively high concentration of Ancillary HCAs in South to the demise of the NVQ framework in that Trust: in the absence of such a framework it arguably becomes less easy to signal technical capabilities, perhaps encouraging a withdrawal to the most basic of tasks. Other possible explanations remain speculative and not immediately apparent in the systems and policies adopted by the respective Trusts. There may be some latent factors related to organisational culture or management style which account for this distribution of HCA types by Trust.

Explanations of the divisional distribution of HCA types are more readily at hand. As Table 15 indicates, there is a significant difference in cluster membership across the two divisions. A higher proportion of medical than surgical HCAs are likely to be Bedside Technicians: respectively close to a

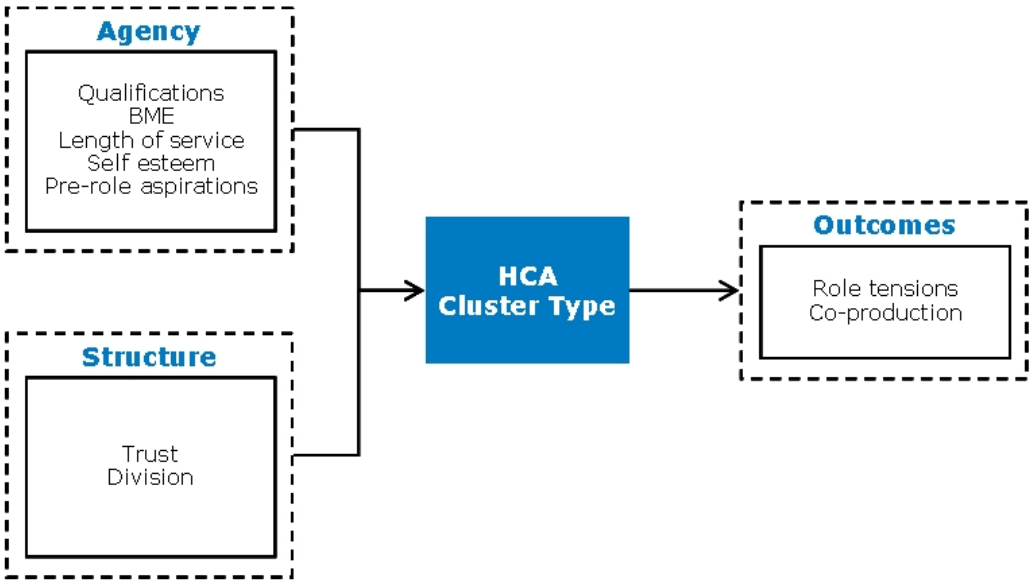
half compared to just over a quarter. Arguably, medical patients are more likely to be chronically dependent and somewhat older than surgical patients, requiring more intense bedside personal care. Moreover the high proportion of Citizens in surgery might reflect the greater movement of patient on the surgical wards, and hence the need for more escorting of patients, while somewhat higher throughput of surgical patients might necessitate the more frequent collection of TTOs by HCAs.

Table 15. Cluster type by division (%)

	Medical (n=364)	Surgical (n=174)	p-value
Bedside technician	43	28	X^2=23.80, p=.000
Ancillary	20	15	
Citizen	20	33	
All rounder	5	12	
Expert	12	12	

Figure 9 presents significant relationships between key variables and cluster membership.

Figure 9. Associations with HCA types



The influence of individual agency on the shape of the HCA role was a key analytical tenet of our study: it has been argued that who HCAs are in terms of their background and motivation might influence how they shape their role. The survey data provided a number of plausible relationships between these kinds of factors and HCA type, although perhaps not as many as might have been expected. These are now discussed in turn:

- Length of service at the Trust (see Table 16) was related to cluster, suggesting the importance of individual tenure. The Bedside Technician, Ancillary and Citizen HCAs were much less experienced than the All Rounder and the Expert. It can be seen that while around a third of Bedside Technicians, Ancillary and Citizen HCAs had less than two years experience, this was the case for barely 10% of the All Rounders and Experts. This suggests that Trusts used the former as 'starter' roles, individuals only moving onto the latter, more diverse and complex roles, when they had built up requisite experience and skills.

Table 16. Agency related variables by cluster type (%)

	Bedside tech.	Ancillary	Citizen	All rounder	Expert	p-value
Less than 2 years of service	32	36	29	11	8	X^2=36.64, p=.002
Nurse ambitions prior to HCA role	52	37	55	63	31	X^2=18.70, p=.001
Self-esteem (mean score) [a]	5.11	5.25	5.27	5.32	5.39	F=3.65, p=.006
Ethnicity: BME	20	23	31	18	12	X^2=10.97, p=.027
HCAs on ward carry out similar tasks to self	85	86	80	46	52	X^2=56.01, p=.000

[a] *Self-enhancement sub scale, measured on a six-point scale.*

- There was a link between self-esteem and HCA type. This was particularly apparent in the significantly higher levels of self-esteem reported by Experts compared to Bedside Technicians (see Appendix 14 for further details); a plausible finding given the greater confidence likely to be required when taking on more complex tasks.
- An aspiration to become a nurse on taking up the role was also associated with cluster. Those with such an aspiration made up a much higher proportion of the All Rounder than any other HCA type; almost two thirds (63%) of All Rounders had nurse ambitions, compared with barely a third of Expert and Ancillary HCAs.
- There was a connection between ethnicity and cluster. The Citizens comprised a markedly higher proportion of those with a BME backgrounds than other clusters: almost a third (31%) of this cluster type had an ethnic background compared to 12% of Experts. The reasons for this finding were less apparent and would benefit from further consideration.
- Finally, a couple of further pieces of evidence suggested the residual importance of post holder agency. The first emerged when drilling down into the distribution of HCA types by ward and more discrete clinical

areas: such an analysis revealed that while small in number, the All Rounder HCA is found across a wider range of wards and areas than the Citizen and Expert, who are confined more to particular clinical spheres. The All Rounder appears to be unconstrained and undeterred by structural factors associated with ward or area. This is confirmed by a second piece of evidence which finds a relatively low proportion of All Rounders claiming in the survey that HCAs are 'doing the same things on their ward': under a half (46%) of All Rounders note that HCAs on their ward carry out the same range of tasks, while the figure is over 80% for the Beside Technician, Ancillary and Citizen HCAs. The All Rounder emerges perhaps as the maverick who has broken free from institutional determinants by shaping a different role on the ward to that of her colleagues.

6.3.3 Types and outcomes

While the next part of the report deals in detail with the consequences of the HCA role for various stakeholders, it is worth briefly exploring whether these different types of HCA were related to any of the HCA outcome variables in the survey. There were some noteworthy and plausible relationships. All Rounders were significantly more likely to perceive role tensions with nurses than Ancillary HCAs, unsurprising given that the former rather than latter were pushing at role boundaries. Moreover, the Citizen HCA scored significantly higher on co-production than the Bedside Technician. This is perhaps less easy to explain, given that co-production related in part to care tasks: it might, however, reflect the greater ability of an HCA performing non care tasks for the patient to contribute in a distinctive way.

Notwithstanding these findings, stronger links with outcome variables might have been expected. One might reasonably have suggested a significant relationship between HCA type and job satisfaction: for example, the All Rounder was more satisfied than other types of HCA in being able to push the boundaries of the role or the Ancillary more dissatisfied in finding their role confined to more routine tasks. The absence of such links suggests two future lines of analysis. First there might well be grounds for the absence of such a link: for instance, All Rounders might have had higher expectations for the role, with the ability to shape it as desired not reflected in higher satisfaction but a cognitive acknowledgement that this was no more or less than envisaged. Second and closely related, the weak link between type and outcomes encourages the search for more refined measures allowing the relationship to be further explored: measures perhaps related to the personality and orientation of the individual to their role and additional attitudinal and behavioural outcome measures. In turning more fully to the consequences of the HCA role in the next part, the analysis moves away from HCA types to the presentation of findings which more generally relate to impact.

6.4 Issues for reflection

The findings in this part of the report suggest the need for Trusts to consider:

- The different perceptions of who the HCA is supporting and what makes a 'good' HCA held by ward team members
- Whether these perceptions accord with and are anchored in current job descriptions and person specifications for the HCA role.
- The different influences on the shape of the HCA role – Trust, ward, division and individual – and how these might be more explicitly leveraged to design to the role in desired ways.
- The particular importance of influences at ward level on the HCA role: for example, ward manager style and capability, the deployment of student nurses and the patterns of work organisation.
- The different forms assumed by the HCA role, especially the five HCA types distinguished. Assessment could be made of the following: how and why these types are distributed in particular ways within the Trust; whether this distribution is in-line with the intended HCA contribution at the Trust; how these types might be used as the basis for a more refined form of workforce and skill mix planning.

7 Consequences

It will be recalled that the impact of the HCA role on those groups with a stake in it was presented in terms of positive and negative scenarios, not necessarily mutually exclusive to one another. For HCAs themselves, the role might create a degraded ghetto or provide an opportunity for a more enriching working life. For nurses, the HCA role might lend valuable support or bring with it new burdens and uncertainties. For patients, the HCA might represent a more accessible, less intimidating source of care or may raise doubts about care quality and bring with it certain risks. This part of the report will consider the outcomes of the HCA role for the three main stakeholders in these terms, seeking to establish whether or how the positive and negative combine.

7.1 Consequences for HCAs

In exploring outcomes for the HCAs themselves, a number of criteria were used: the general management of HCAs; their aspirations and career intentions; their general 'likes' and 'dislikes' and more precisely job satisfaction and intention to leave; and emotional intensity and fallout. The picture to emerge suggests that across our Trusts and with some variation between them, the consequences of the HCA role for post holders are often emotionally intense and not always positive, particularly in the context of the effort-reward bargain and relations with nurses and other professionals. However, in general HCAs display a strong attachment to and enjoyment of their jobs, a finding reflected in high levels of job satisfaction and low intention to quit.

7.1.1 The management of HCAs

The management of HCAs, as assessed by Trust approaches to HCA induction, training, pay, performance management and voice, showed signs of some unevenness between Trusts along with some common, cross cutting patterns.

In all four Trusts **induction** was characterised by a common core, which revolved around a corporate introduction to all new starters across the Trust, followed by some additional mandatory training days and an extended period of a week or two shadowing a member of the team at ward level. Although HCAs typically felt well enough prepared to take on the role, HCA induction did vary between Trusts. For example, London devoted a number of dedicated days to HCA induction at corporate level, covering such topics as last offices, which was not found elsewhere.

In terms of **training** there were some generic concerns in the Trusts about the lack of dedicated training beyond NVQs for HCAs:

Nurse_Midland: The auxiliary training is tending to be just mandatory and anything new that they're introducing, there might be a study day on it, but that tends to be for everyone, not just auxiliaries.

Manager_London: The professional groups are quick enough at coming and saying we need a team-building day, but usually if it was a nursing team the, their HCAs would be within that group. But you're actually making me think, are these team-building days for nurses, are there HCAs there every time? I'm not sure, I need to check that out.

There were also some problems cutting across the Trusts with the model of NVQ accreditation. In part these were operational difficulties: a number of Trusts had difficulty finding enough NVQ assessors, while under staffing pressure, HCAs sometimes faced problems in finding time to attend designated teaching sessions. The work pressures were sometimes combined with personal difficulties in engaging with NVQ training ranging, from non-work constraints to the intimidating nature of a formal learning situation for some:

HCA_London: Very intense and quite hard-going You know, I'm a full-time mum, I've got a house to run and, you know, to try and study, I find it quite hard because it's like eleven o'clock at night before I can sit there and try and get my work out and then trying to concentrate when you're tired, you've had a, you know, you've been up since six, it's, it's quite tough.

The most significant of these problems however, related to the misalignment between formal qualifications, pay band and tasks performed. While already discussed, it is worth re-visiting because it represents a distortion of the effort-reward bargain arguably to the detriment of the HCA. As stressed this was particularly the case for the Band 2 HCA with an NVQ 3 qualification, a situation leading to one of two possible outcomes. First, the post holder might withhold the capabilities they have acquired in the absence of a 'fair' reward for them. There were signs of such a response, predictably in Midland:

HCA_Midland: You don't want to do it [undertake an extended HCA role]; you think well why should I, if somebody's getting the recognition for it, you know getting Band 3 and the pay, reward for it and we've got to do it at Band 2, where is it justified?

Matron_Midland: The staff have just crawled back in their shell now and thought actually I don't know what's coming round the corner, I'll just do my basic Band 2.

This response might also be reflected in survey data which reveal (see Table 17) a strong feeling amongst HCAs in all Trusts that they had the ability to carry out more complex tasks than they currently undertook.

Table 17. Propensity to extend the role (mean score)

	South	Midland	North	London	p-value
My potential is not fully realised in my current role[a]	3.59	3.61	3.58	3.32	*F*=1.52, *p*=.208
I believe that I have the ability to successfully carry out more complex tasks than I am currently doing	4.20	4.17	4.30	4.16	*F*=0.84, *p*=.474
I have enough to do in my current role without taking on more complex tasks[a]	2.53	2.77	2.77	2.93	*F*=2.60, *p*=.051
I am always looking for ways to extend my role	4.10	4.01	3.96	4.06	*F*=0.61, *p*=.607
SCALE: Propensity to extend	**3.84**	**3.74**	**3.76**	**3.66**	*F*=1.33, *p*=.265

[a] *Scoring reversed when item included in the scale.*

Second, the HCA might use their capabilities, motivated by an interest in the role and its intrinsic rewards, a situation which then begs questions about under-payment of capabilities used:

> *Interviewer: So although you've gone back to Band 2 from Band 3, you haven't changed what you do at all?*
>
> *HCA_Midland: No, in fact I'm doing a lot more. Because they think, you know, because people think, if they know you'll do it, you know so much, I think they'll sometimes, you know, I wouldn't say use, I think they, they're unfair, they put more on to you. I mean I'm the type of person I don't mind if I can, you know, if your staff nurses are good to you, so be it, but I think I am doing a lot more, you know, I think the only thing I'm not probably doing is drugs and drug rounds, everything else I'm doing as a staff nurse role.*

The disordered relationship between HCA capability and Banding was not helped by patchy application of performance management across the Trusts. Performance Development Reviews (PDR), a structured and formal means of evaluating performance with a view to identifying development needs, were completed unevenly within all Trusts.

With the KSF still settling down in all four Trusts, responsibility for such reviews was often delegated to Band 6 nurses looking after a team of HCAs for this and other management purposes. However, the extent to which PDRs were completed varied form ward to ward, with completion sensitive to such factors as ward manager style and perceived pressures on the ward. So in the London Trust one can find a ward manager who had successfully completed all PDRs for HCAs:

> *Ward manager_London: We've got it sussed, well we've got it sussed now. No, we do them all in sort of November/December time, they're full*

appraisals. I mean at the moment we're doing their mid-term PDRs to make sure that we're getting through the training and things, so… Everybody has their own folder which they make their portfolio out of now, and with things that they've done, they put it in their folder so they can show us and it's something to be proud of really..

While elsewhere in the same Trust there were HCAs who had been let down by the process:

Ward manager_London: I try but it's very, very difficult because we're so busy and manic, and every time we try and do it something happens.

London was not alone in facing such difficulties. This same contrast was found in North, with some ward managers finding PDRs problematic:

Ward manager_North: We have a system in place but sometimes it's tight, it is time-consuming and it does get pushed to the back row.

The uneven completion of PDRs was disappointing given that HCAs exposed to the process were often positive about it:

HCA_London: I think it [the PDR] can be quite good actually. Because I think sometimes you can get quite complacent in a job and it is nice to say well, you know, you need to sort of shuffle your shoes a bit in that area or if you're not doing well in that area, sort of have a little direct, a little directional push. You know, because sometimes I think you can get complacent and don't even know yourself, so I think sometimes that sort of thing is good.

HCA_Midland: And you do think oh it's a waste of time, but then she kind of makes it a little bit interesting, and then things where you're lacking, and you think, I haven't done this for a while, so she sends you on a course.

HCA_South: It's nice to hear some feedback on how we're all doing, you know, it's one of the those things you think you're going to hear bad feedback but they'd let you know, as you're going they'd stop you straight away and say you don't do that, that's wrong.

The positive orientation amongst HCAs to PDRs might reflect the opportunity it provided for a form of direct voice: the chance to talk to and receive views from the ward manager or a senior nurse. It was an opportunity perhaps seen as particularly valuable given the underdeveloped nature of other forms of HCA voice across all Trusts. HCA voice might be considered in a number of ways: as a direct or unmediated individual or collective voice expressed at ward, divisional or trust level; or as an indirect voice articulated and expressed by third party (union) representatives. It is an important distinction, but in both senses HCA voice was fairly weak.

While there were forums at Trust level where HCAs could express a direct individual voice, for example Midland at a regular, open staff forum, this voice was most likely to be heard at ward level. In general, ward systems of staff engagement were inclusive, with HCAs routinely present at handovers at the beginning of the shift, and invited to regular ward team meetings as

well as clinical days. How confident HCAs were in expressing their views at these meetings is more open to debate; on the shifts observed, HCAs were rarely seen as making an input into handover; moreover there were occasional signs that HCAs were intimated in making an input into ward meetings involving professionals:

> *HCA_London: It's only me and another girl, we went to the ward meeting and we were a bit, there was only two qualified and us two HCAs and it was, well we were, we weren't sure if we should have said anything afterwards because you're supposed to bring up stuff and… You know, we both sort of looked at each other and thought, "Oh alright, maybe we shouldn't have said", but we were just, you know, saying what we thought. There was a couple of things we brought up and, and sort of we got like shot down, and we sort of looked at each other and thought, "Well aren't we supposed to say", you know, or, "Maybe next time we won't say anything then, you know, if that's the case."*

Most striking was the absence of any form of direct collective HCA voice. Across the four Trusts it was difficult to find any form of dedicated meeting which allowed HCAs to meet as a group, articulate and express their views whether at Trust, division or ward level: only on two wards across the four Trusts covered was any attempt made to convene HCA meetings.

The general absence of an effective, direct HCA voice was hardly compensated by a strong representative voice. The survey revealed some striking differences in union membership between our Trusts (see Table 18): in Midland almost three quarters of the HCAs were in a union, whereas in the other three Trusts membership stayed well below a half and in South remained at a quarter. Despite these differences in density, the union organisation at all Trusts at best remained fragile. Each had a joint consultative or negotiation committee covering all non-medical staff at Trust level, but the individual HCA's connection to such machinery was tenuous. In large part this was a consequence of weak forms of ward representation in the Trusts; there were very few HCA union representatives in any of the hospitals, and union representatives were simply not a meaningful presence at wards level. Indeed, in Midland, the Trust with the highest union density, only four out of ten interviewed HCAs who were union members knew the name of their local representative.

Table 18. Union membership (%)

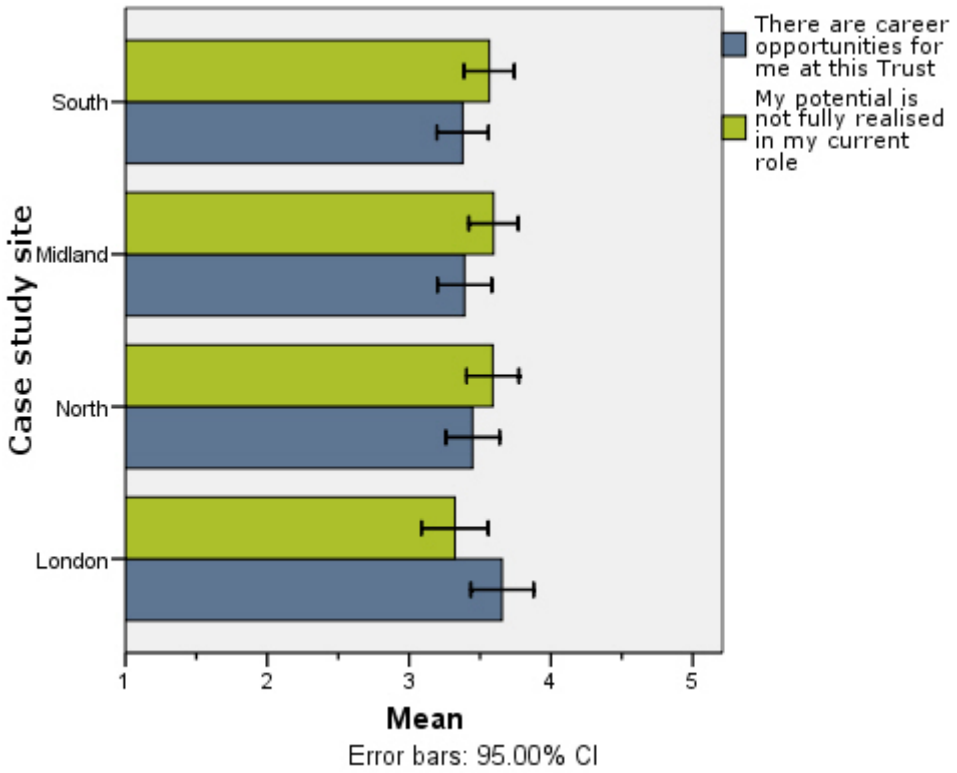
	South	Midland	North	London	p-value
Union member	25	70	44	37	X^2=69.01, p=.000

7.1.2 Aspirations and career intentions

One of the clearest indicators of whether the HCA role had a negative impact on the working lives of post holders was the extent to which it

provided a meaningful arena for the pursuit of career aspirations. The general data on this question were somewhat ambiguous. As Figure 10 indicates, there was moderate agreement across the four Trusts to the suggestion that 'there are career opportunities for [HCAs] at the Trust'. Indeed over half (54%) of the HCAs agreed or strongly agreed with this statement. However, the response to the suggestion that their 'potential was not fully realised' were at a similar level, and again over half (55%) agreed or strongly agreed with the assertion. It is a picture which implies some ambiguity on this issue.

Figure 10. Career opportunities and realisation of potential (mean)



A consideration of career intentions provides a somewhat clearer picture. Such intentions were reviewed in terms of whether the HCA was: seeking to develop within the HCA role, acquiring more capabilities and becoming a 'high performing' HCA; using the HCA role as stepping-stone to become a registered nurse; or indeed deploying it as a bridge to another profession or a job outside health and social care.

In evaluating HCA aspirations in the survey, Table 19 provides a fairly similar pattern in three of the Trusts (South, Midland and North): around half of HCAs see themselves still as an HCA in the future, around a quarter indicate that they will be nurses. In London, a significantly higher proportion (40%) of HCAs regarded their future in terms of registered nursing, a finding which might be related to the relatively strong 'NVQ culture' at this Trust and its relative financial well being.

Table 19. Aspirations of HCAs (%)

In the future I want to:	South	Midland	North	London	p-value
Continue in current job	56	61	48	45	X^2=29.30, p=.004
Train to be a registered nurse	27	26	26	40	
Train to be an allied health/social care professional	9	4	9	2	
Leave for job outside of health/social care	4	3	4	7	
Other	4	7	13	5	

Amongst those who viewed their future as HCAs, certainly there were some who were content to 'tread water':

> *Ward manager_North: None of the ones that have been here a while have shown any interest in sort of further developing professionally, and I think sometimes it might be a case of they come to work, they do what they've got to do and they go home, and if they think they're being pushed too much to do something they will say, and they will have a bit of a moan about it.*

However, other HCAs were clearly keen to develop within the role. In part this is illustrated in South where the degeneration of the NVQ infrastructure had not deterred some HCAs from acquiring new capabilities:

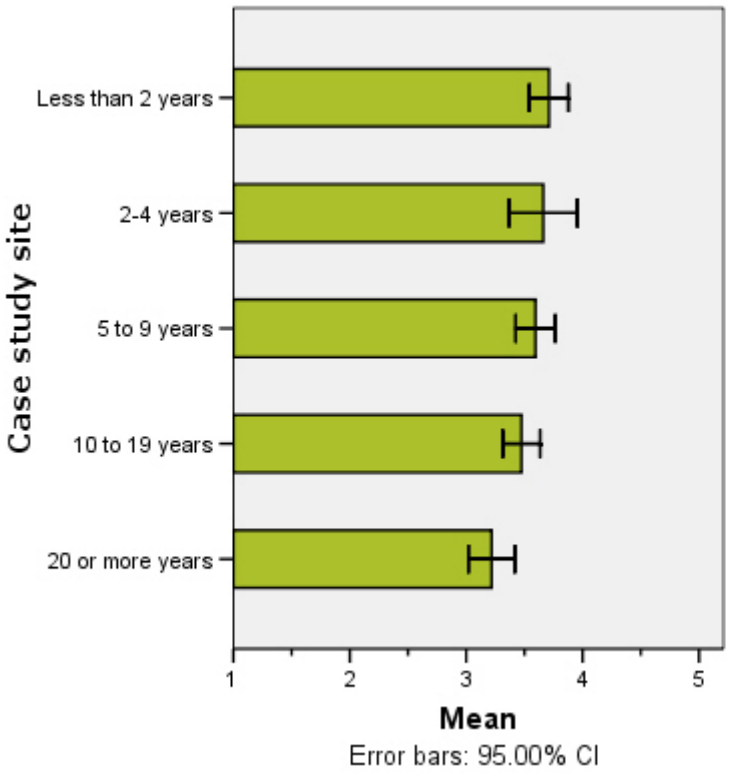
> *Ward manager_South: Recently, because some of the HCAs have not been given as much opportunity to do the NVQ 3; the Trust can't financially afford it so it's a very, very selective procedure and only a very few number every year are allowed to do it. So the HCAs are taking it upon themselves to do courses internally that will allow them to progress without necessarily doing the NVQ 3 per se.*

Harder evidence on the willingness of HCAs to develop in the role is provided by the HCA survey, and particularly in the propensity to extend the role (see previous Table 17). As Figure 11 indicates the average mean score on this scale amongst those who saw their future in the HCA role was moderately high, although it is striking that increasing length of service progressively dulled propensity to extend, significantly so for those with 20 or more years compared to those with two years or less service.

A number of reasons emerged to explain why the majority did not see the HCA role as a stepping-stone to registered nursing. Some HCAs enjoyed their current job so much that they did not want to become a nurse:

> *HCA_North: I'm quite happy to do what I'm doing because as far as I'm concerned I do just as much as they do and I think I'm valued just as much as they are. So, because if we weren't they wouldn't have us, would they?*

Figure 11. Propensity to extend the role by length of service (mean)



For others, working closely with the registered nurses had highlighted some of the 'downsides' of registered nursing, discouraging any move into this role:

> *HCA_South: Because I see all the crap and stress they (nurses) have to go through and all the responsibility and at the end of the day everything falls on their shoulders if they've done something wrong, and that is a hell of a lot to take and I really don't think I'd want that.*

In addition, there were a number of perceived barriers facing HCAs wishing to make the move into registered nursing:

- Lack of confidence:

  HCA_Midland: I don't see myself as confident enough to do something like that, you know, it's a big responsibility at the end of the day, give the nurses their due… I'm quite happy having all the patient contact really.

- Too old:

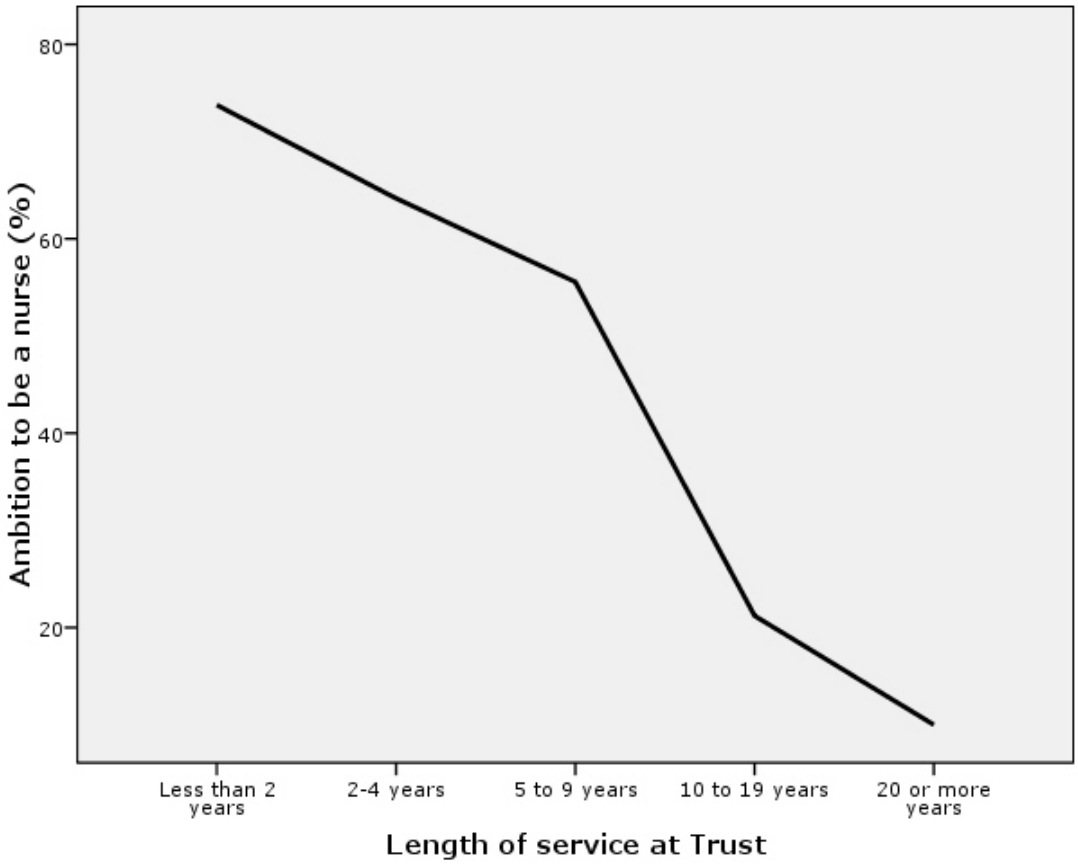
  HCA_North: Because the problem is with my age, the age that I am now and then it's a three-year course at the moment, and when I investigate about it you only get so much wage now, and with me, I have my mortgage and my finance in hand to consider. So I said if I do it I have to make sure I can maintain my bills, you know what I mean? So that's what keeping me baffling at the moment.

- Domestic pressures:

HCA_South: I've got a mortgage now so I can't afford to just go off because the degree, you hardly get anything [financial support]… So now I'm just sitting tight and I've recently got married, I'm thirty-four, so I want to concentrate on trying to have a baby first and then going and doing that rather than leaving it any later, so I'm trying to get my priorities right at the moment.

For those who saw their future in registered nursing, the enduring nature of this ambition was particularly noteworthy. As Figure 12 indicates, there was little attrition of ambition with length of service: for those with up to nine years service well over half of them retained the ambition to be a nurse. It was only when HCAs had been in post for ten or more years that this 'dream' began to wane significantly. There is some poignancy in this picture: deeply embedded, nurse ambitions are only uprooted after perhaps many years of disappointment.

Figure 12. Current ambition to be a nurse by length of service[a]



[a] *Base:HCAs who entered the role with nurse ambitions (n=252).*

7.1.3 Likes and dislikes

The problems highlighted in managing HCAs and some of the ambiguity revealed about career opportunities did not feed into the general view on

the attractiveness of the HCA role. In broad terms, HCAs greatly enjoyed their jobs; indeed when asked about their 'likes' and 'dislikes', some had difficulty identifying any dislikes:

HCA_North: I enjoy my job. I enjoy most of it, there's not anything I can particularly say that I dislike about it.

HCA_London: I do enjoy my job, that's why I'm working here and I manage my life with two small kids and full-time work because I want to do it, otherwise I just would resign.

HCA_London: I think I enjoy everything, even though sometimes when it's too busy it's like, I enjoy the work. To me, I enjoy everything, I enjoy all what I do, I enjoy what I do, yes.

Most of the 'likes' identified were patient-centred, revolving around the intrinsic reward associated with caring for others and 'making a difference':

HCA_Midland: I enjoy my patient, patient's relative and talk to them and all this, you know, a patient has got a problem. Yes, I enjoy talking with them. And I meet people, I enjoy it, and I meet different, different people.

HCA_London: When I give my best care to the patient and when the patient then says, "Oh thank you love, thank you", you know, I enjoy it, I know I've done my best. Yes, I have done something for that patient, especially when they appreciate, you know, and sometimes they will even say to maybe some of the staff are very good so I enjoy that.

These patient-centred 'likes' were confirmed in the survey, which indicated that by far the most enjoyable task indicated by half of respondents (52%) was bathing patients, the activity which involved the closest and most sustained contact with patients. (A full set of results are available in Appendix 15).

This enjoyment of the role was also reflected in general levels of job satisfaction and intention to leave. As can be seen from Table 20, with the exception of pay, the mean scores on aspects of their treatment are above the mid-point, in some cases considerably so, in all Trusts. Indeed on the strongest indicator of intention to leave – leaving as soon as another job is found – mean scores in all hospital are very low, suggesting little serious intent to leave.

This generally positive view of the role should not, however, detract from concerns raised by HCAs about their working lives, often related to relations with nurses and other professions, as well as to their institutional treatment.

Table 20. Job satisfaction (mean score)

	South	Midland	North	London	p-value
The recognition I get for good work	3.37	3.13	3.34	3.10	*F*=1.98, *p*=.115
The support I get from my immediate manager	3.72	3.52	3.66	3.51	*F*=1.14, *p*=.331
The freedom I have to choose my own method of working	3.67	3.58	3.70	3.55	*F*=0.78, *p*=.505
The support I get from my work colleagues	3.90	3.90	3.78	3.70	*F*=1.39, *p*=.244
The amount of responsibility I am given	3.52	3.55	3.71	3.57	*F*=1.24, *p*=.294
The opportunities I have to use my skills	3.36	3.42	3.63	3.50	*F*=1.96, *p*=.119
The extent to which the Trust values my work	2.99	2.84	2.73	2.96	*F*=1.83, *p*=.140
My level of pay	2.36	2.41	2.27	2.42	*F*=0.52, *p*=.666
SCALE: Job satisfaction	**3.36**	**3.29**	**3.35**	**3.28**	***F*=0.40, *p*=.750**

Table 21. Intention to leave (mean score)

	South	Midland	North	London	p-value
I often think about leaving this Trust	2.28	2.22	2.68	2.43	*F*=4.51, *p*=.004
I will probably look for a job at a new organisation in the next 12 months	1.99	1.96	2.23	2.04	*F*=1.96, *p*=.119
As soon as I can find another job, I will leave this Trust	1.84	1.85	2.13	2.01	*F*=2.70, *p*=.045
SCALE: Intention to leave	**2.14**	**2.29**	**2.39**	**2.35**	***F*=3.52, *p*=.015**

The following such concerns emerged form the qualitative research with some regularity.

- Lack of recognition and respect:

  HCA_London: The thing I hate the most is we are not supported, not one little bit, we're not paid or respected for the work that we do do, because what I do now is what a nurse did three years ago, four years ago, and everybody gave them respect for what they did and paid them for what they did. So now three/four/five years on that I'm doing exactly the same role, why am I in a Band 2 and getting no respect for it?

HCA_South: I don't think we're as respected as much but, you know, you quite often hear people go, "Oh she's only an HCA" or, you know, "Oh that's an HCA's job", and that's a little bit degrading sometimes..

- Being the 'dirty workers':

  HCA_South: Sometimes, yes, the bells might be going and you know that it's probably someone wanting a commode, but it's, they [nurses] might just say, "Well can you get it", and it's like, "Well what's the matter with you, what are you doing?" "Well I'm doing my writing." Well I'm on another patient in another team so, you know, it's not even my team so really shouldn't, you know, lots of nurses do that and it does get on the HCA's nerves.

- Being the 'workhorse' and 'dumped on':

  HCA_North: The only thing I hate doing and it's not really my role though, it's just something that gets dumped on me quite often is bed, you know when patients go home and you've got to clean the whole bed space and stuff.

  HCA_London: The only downsides really is when you do get a trained member of staff who just think you are a, a dogsbody.

Other dislikes mentioned more selectively included the following.

- The behaviour of patients and relatives:

  HCA_North: The violence, the part, you know, some, some of them [patients] can't help it but you're still to look after them

  HCA_London: The least thing I like are the relatives. hey just, they just bombard you and some of them are so aggressive, you know, and you really do try your best and, you know, it's not always good enough and, you know, you just think, sometimes you think why do I bother, you know.

- Intense work pressures:

  HCA_London: Stress, stress, stress, stress, stress, honestly. Yes, no, I just think it's, sometimes it's just so stressful, you know, and people, as I said, sometimes you're rushed off your feet, you're running round like a lunatic trying to get things done and, as I say, if the numbers aren't there, you know, the staff isn't there. Staff shortages:

  HCA_North: The only time I don't like about the job is really when I came on they were short-staffed and then the ward is busy, that's the only time I don't really like the job. Because you're rushing and you don't have time to do stuff, you're just rushing and doing everything, that's the only time I don't like it, when we're short-staffed.

7.1.4 Emotion at work

The HCA role emerged as emotionally intense, both in terms of the need for HCAs to manage their own emotions and those of others on the ward, in

particular patients and relatives. The consequences of this emotional intensity on the working life of the HCA, and indeed on their broader well-being, were, however, far from straightforward. An assumption that emotional intensity either degraded or enriched the HCAs' work experience was too simplistic, failing to account for the myriad ways in which HCAs engaged with emotionally-charged situations. The consequences of emotional engagement were found to be contingent upon the circumstances surrounding an episode or event, and mediated by the ways in which the HCA coped with the situation.

In interview, HCAs were asked whether they had become particularly attached to a patient, and to recount their experiences of an emotional-charged situation such as dealing with a dying patient and with last offices. The stories told left little doubt that working as an HCA could have a profound emotional impact. It is worth reproducing one such story to illustrate this point; many more could have been presented:

> *HCA_North: At the time I didn't think it was real. What happened was [nurse's name] had said to m,e "Oh this lady's really unwell", and… she asked me if I minded sitting with her; because she didn't have any family with her or anything, and she said that she could possibly die and how do I feel, you know, if I feel uncomfortable about doing it then don't do it, but she thought it would be a good learning opportunity. So I went and sat with her because I didn't mind… and as I was stroking her hand she did die and it was like it weren't real really. And I helped clean her and, and then when they wrapped her up… in the sheet, the thing that got to me most was actually covering her face, you know, wrapping her head up. And… I kept looking because I kept thinking I could see her breathing, and I was thinking, "Oh". Anyway I finished that shift… at three o'clock and… I had an appointment to try on wedding dresses and my mum was meeting me in the shop. And I went in and I was fine, I didn't feel upset or anything, but then when I started talking about it and I told my mum, I just burst into tears. And I just explained to her that it was when I wrapped the lady's head up that that's, that's what really got me really. I don't know why.*

Such experiences and engagement with death and dying were not frequent. During our observation, there were typically dying patients on a ward, but there were only two shifts where patients died (two in quick succession on one shift) and one shift where there was a cardiac arrest. Nonetheless, such events remained an ever-present possibility, and emotional engagement was not solely confined to such situations.

The emotional response to dealing with death and dying amongst HCAs was found to be heavily dependent on the circumstances and on individual coping strategies. A number of circumstances were highlighted as shaping the HCA emotional reaction to such a situation: the age of the patient, the patient's length of stay, the predictability of the death, connections with personal experience, and the level of support available.

- **The age of the patient**. Emotional intensity was heightened where the patient was young:

  HCA_South: A few years ago somebody who was relatively young, in their 40s died, I fortunately wasn't here for the incident but I helped lay him out and that was, shocking is probably too hard a word, because I didn't know him, but that was unusual and that was probably something else to deal with.

- **The patient length of stay of the ward**. The longer the stay the more staff had come to know the patient, feeling the death more keenly:

  HCA_Midland: If they've been with you a long time and pass away or something, it can be quite sad... sometimes you can't help your feelings.

- **The predictability of the death**. The more sudden the death, the greater the emotional impact:

  HCA_Midland: I'd been in that morning and I'd said to her [the patient] "Blimin' hell you look ever so well today"… And I was chatting to her, she was fine… then I just finished giving my last dinner out and the crash alarm went off... She was in the chair and she's just slumped and they tried to resuscitate her a couple of times. I mean she was a good age, she was ninety-four I think. And I felt awful because I sat there and thought I'd just been speaking to her literally just over an hour ago and she was fine… that was the last time that I properly had a cry.

- **The extent to which an episode connected with a personal experience**. Such a connection could produce a more emotionally intense response:

  HCA_Midland: It never gets any easier but you learn to cope with it different, and that's the only way I can put it. It's like after I came back to work after my daughter died, I mean she was twenty-three so I found that, well obviously really hard, and when I first came back to work I could not deal with a dead body.

- **The level and nature of support available on the ward**. The support from other HCAs and ward colleagues could mitigate the effects of an emotionally-charged situation:

  HCA_Midland: I ask [new HCAs] to come in with me [to last offices]… But there's one thing I always say to them: "If any part of that time that you don't want to do anything and if you think I can't do this, just tell me"; I let them go out, I'll get somebody else; because it's not a nice job and not everybody can handle it.

The impact of these emotionally intense episodes was mediated by a number of coping strategies: the same event could have very different consequences depending on how the HCA interpreted and sought to rationalise the situation. The following coping strategies were identified: continuation of care, talking with the deceased, getting used to it, keeping an emotional distance and seeing the patients as being at 'peace'.

- **Continuation of care**. A number of HCAs managed by viewing last offices as a continuation of care; the final care act they could perform for the patient:

  HCA_London: If you've nursed that patient or if you've been involved in that patient's care, when it does come to the end it's quite a nice thing to do in some respects because you've done the final, you know, you've done the final bit.

  HCA_North: It's awful but also it's nice to know that you, and also if you're there towards the end of someone's life, to know that you made it as nice as possible and be able to say that to the family.

- **Talking to the deceased**. HCAs sometimes continued talking to the deceased patient as if they could still hear and were still present:

  HCA_London: I talk to them, I like to do my best for them and in my eyes it's the last thing I can do for them, so I want them to look and smell lovely. And all the way through I talk to them as if they're still with us. Some you get quite attached to and it can be quite heart-rending, but in my mind they're at peace now, they're out of pain. So sometimes it's the better thing, and you just say your goodbye and even when the porters come to get them, they're quite fussy – be gentle with them, don't bang their head, we're there to help all the time.

  Patient_Midland: And then our [HCA] came… she sings a lot because she goes to church and it was [the HCA] who went to him and got him prepared for when the relatives came… you couldn't see nothing, you could just hear [HCA] laying this man out and singing… she was lovely.

- **Getting used to it**. HCAs differed as to whether familiarity with death softened its emotional impact over time. Some felt 'you never got used it', others suggested that it became somewhat easier to control emotional response with experience:

  HCA_North: It's like obviously now and again, when I first heard that somebody had died I did get upset, but I thought well it's the way of life now, got to cope with it. So I've coped really well since. Because I think if I'd, if I had got attached, if I did get too close I wouldn't have been here, I'd of left by now, so. But you do get slightly close, but not too.

- **Keeping an emotional distance**. Some HCAs dealt with situations by keeping their emotional distance. This was rationalised in slightly different ways: for some it was linked to professionalism – an expected requirement of the job; for others it was more a matter of self-preservation – being continually drawn into situations would be too emotionally draining; for yet others direct engagement was seen as an interference with other peoples' concerns:

  HCA_London: I do tend to distance, I don't like to get too involved. I mean I think sometimes you can get a bit too involved and I don't think that's professional, it's me, it's, I'm just that type of person. I, you know, I think sometimes the girls do get a bit, you know, like they kiss

and cuddle them and I sort of, it's just me I suppose, I'm just, I don't think you should do that. But yes, be polite to people and, you know, show compassion and all that, but I don't think you should get, well I don't know, I just don't think it's right, but that's me.

- **Patients at peace**. Some HCAs managed by consoling themselves that the patient was no longer in pain, that they were now at peace:

  HCA_North: [On] odd occasions you still think about it depending on what situation that patient has died in. And if they've sort of gone to sleep or it's been a patient that is terminally ill, it's, I think it's easier because they're not suffering anymore, you know, and who knows what happens afterwards.

7.2 Consequences for nurses

In exploring the consequences of HCAs for nurses, in particular the balance between the positive and the negative, consideration was given to whether and how nurses valued HCAs and to the nature of any tensions between them. The picture to emerge suggested a slight disconnect between the qualitative and quantitative data: the former strongly endorsed the significant, positive HCA contribution to the nurses' working lives; the latter provided more qualified results.

7.2.1 The value of the HCA

In interview, there was a strong consensus amongst nurses in all Trusts that HCAs added value to their working lives. The following statement from a nurse is fairly typical, the general view being that HCAs were an essential part of the ward team and crucial in facilitating the performance of the nurse role:

Nurse_London: There's big positives to having them [HCAs]… We couldn't do our jobs without them being there to support us, and I think because of like financial situations, there isn't the thing to have trained nurses and I don't know whether a unit like this would run as smoothly if it was just all trained nurses. I don't know how to put it into words, but they're a big asset for doing the things that I, perhaps I would like to do, you know, but I've got to, I've got other things that I have to do like the paperwork and things like that. Whereas they, they haven't got that to worry about and can go and do, just do the little things, you know, that make the patients' stay a bit more comfortable really.

In elaborating on how and why HCAs were valued by nurses, the following HCA contributions were highlighted: relief, partner, mentor, pair of eyes and co-producer.

- **Relief**. Nurses felt HCAs relieved them of certain routine tasks, so allowing them to concentrate on other priorities:

  Nurse_London: We've got some really good HCAs, it makes me feel that sometimes I can, you know, I can't find the word. I can concentrate on

some of the things I do, it might be with the paperwork that, you know, that you have to catch up, and I feel that I can concentrate on that a bit more without worrying about things not being done on the ward, without worrying about the obs. not being done or something like that. If you've got somebody that you really trust and I think, you know, it does take a lot of, a lot of strain away from you.

- **Partner**. If the use of the HCA as a relief involved the delegation of tasks to HCAs, the nurses' use of the HCA as a partner was based upon nurse and HCA working together on a task; this might take the form of the two undertaking the same activity together, such as making a bed together; working in tandem as a team:

  Nurse_North: They are very helpful, because they help us. Like when we are doing admissions, when the patient arrive on the ward the first thing they do, they do the observations while I'm checking what's wrong with the patient, and then when they give me the observations I look at them and then see if the patient needs a doctor just there and then.

  Nurse_North: When I need help like washing a patient, the other nurse, maybe we're only two nurses on the ward, the other nurse is busy, I will just ask the healthcare to help me.

  Another example of partnership working was picked up during research observations:

  Field note_North (Medical): The Band 6 coordinator gruffly barked at a patient to get out of bed after which the observee [an HCA] was quick to come over and explain in a more gentle and persuasive manner; a good cop/bad cop routine?

- **Mentor**. HCAs, particularly those with experience, were sometimes the repository of ward practice and norms, and could be an important source of informal and formal knowledge and guidance for newer nurses and indeed student nurses:

  Nurse_London: It's actually good to have HCAs on the ward, they know a lot of things, loads of things. When I first started as a newly qualified they actually helped me a lot to go through my ten months here, because they've been there quite long and they know what they're doing. They are professional, they play a good role in the ward and they know what they're doing, and I'm very happy to have them around. They are very knowledgeable, they know what they are doing.

  As noted during research observation:

  Field note_North: At the nurses station where the observee [an HCA] recounted how she helped comfort a patient earlier on in the shift by talking him down through his anxiety and tears by getting him to talk about his earlier years. My impression was that this wasn't an example of ego-posturing or bragging, but rather the observee taking the opportunity to pass on experience to a young [student nurse]. Might incidents such as these have powerful normative influence on the future

behaviours of young student nurses as they set about learning their 'craft'?

- **Extra 'pair of eyes'**. HCAs were seen to have a value to nurses in providing another pair of eyes: this might take the form of keeping a watch brief on patients and or spotting important changes in the patients' conditions which could be reported back to the nurse:

  Nurse_South: If you know that person [HCA] really well and you've worked with them a long time… and you know that they've got a feel for certain things and they can come back to you and say, you know, "I've been to see Mrs so and so, I don't think they look as well today as they did yesterday, you know, I just gave them a wash and they're not acting like they were yesterday". And, you know, certain HCAs can pick up on certain things and they've done the job for a long time, and they make your life a lot easier.

- **Co-producer**. As a co-producer the HCA was seen by nurses to add something distinctive to nursing. This contribution took different forms. In practical terms, it was noted during one of our ward observations that a nurse called upon an HCA with the same ethnic background as a patient to translate: the patient could not speak English. In a more general sense, HCAs could sometimes uniquely elicit information and responses from a patient; the nurse could then use that information and take it forward:

  HCA_Midland: When I've done it, when I've assisted with, had assistance with the wash with the nurse as well, the patients, they do tend to talk about their problems more, especially if they've got some kind of relationship going with the auxiliary in front of the nurse then, so the nurse can pick up on.

In our surveys we decided to focus on the main forms of support provided by HCAs to nurses as revealed in the interviews: the relief, the mentor and the additional pair of eyes. The HCA role as co-producer is dealt with below in the part of the report looking at patients. While nurses in interview were generally effusive about the HCA contribution in these terms, the survey results were somewhat more mixed. As can be seen from Table 22, there was moderate support for the HCA as a relief, albeit with some variation between the Trusts. There was much weaker support amongst nurses for the HCA as a mentor, again with some difference of view between Trusts. The measure of the HCA as an additional 'pair of eyes' did not scale particularly well (alpha=.48), but the separate items suggested only mixed nurse support for the HCA in this capacity: moderately strong on the statement on the HCA as a 'pair of eyes'; much weaker on the HCA spotting something that might have been missed.

Table 22. Value of the HCA to nurses: relief, mentor, another pair of eyes (mean score)

	South	Midland	North	London	p-value
HCA as relief:					
HCAs carrying out direct care tasks has made my life easier	3.75	3.75	3.89	3.63	*F*=1.54, *p*=.203
It is easier for me to get essential paperwork done with a HCA on the ward	3.43	3.53	3.83	3.13	*F*=9.65, *p*=.000
Being able to delegate to a HCA makes a positive difference to my workload	4.01	3.92	4.07	3.93	*F*=1.23, *p*=.299
SCALE: HCA as relief	**3.73**	**3.74**	**3.94**	**3.57**	***F*=5.34, *p*=.001**
HCA as mentor:					
HCAs will often be the first to show student nurses how to do things on the ward	2.14	2.81	3.00	2.79	*F*=19.27, *p*=.000
Newly qualified nurses will often look to HCAs for advice	2.63	2.97	3.19	2.94	*F*=8.60, *p*=.000
HCAs often help newly qualified nurses 'find their feet' on the ward	3.19	3.26	3.40	3.30	*F*=1.32, *p*=.268
SCALE: HCA as mentor	**2.66**	**3.01**	**3.20**	**3.01**	***F*=14.17, *p*=.000**
HCA as another pair of eyes:					
I can rely on HCAs to let me know when there is something wrong with a patient	3.29	3.63	3.77	3.40	*F*=7.33, *p*=.000
I regard HCAs as another pair of eyes on the ward	3.89	3.84	3.98	3.91	*F*=0.50, *p*=.680
A HCA will sometimes spot something that I have missed	3.23	2.82	3.05	3.12	*F*=6.03, *p*=.000
SCALE: HCA as another pair of eyes	**3.47**	**3.42**	**3.60**	**3.47**	***F*=1.59, *p*=.191**

7.2.2 Tensions

In general, the qualitative data suggested that from a nurse perspective the relationship with HCAs was not particularly problematic. When asked whether there were any tensions within HCA, a simple 'no' was not an uncommon response from a nurse. If probed further, examples given generally related to personality clashes rather than anything that related to HCAs as a group. However, some tensions were raised and observed. They

included the following: 'them and us', misconceptions, accountability and role boundaries.

- **Them and us**. The divide between nurses and HCAs on some wards, albeit a small number, should not be overlooked. It has been noted that there were important differences in the backgrounds of nurses and HCAs as well as in the tasks performed. In some cases this gave rise to a 'them' and 'us divide:

  Nurse_North: I don't really like ward meetings, it just turns into a big bitch fest. It does. But this one, we had a ward meeting and by the end of it I felt like slitting my wrists, I'm like what do I do that's any good ever, do you know? They [the HCAs] had a list! And a staff nurse asked a healthcare to do a blood sugar and the staff nurse heard her go, "Well that could go on the list as well". "Well, if you can't, you don't want to do the obs, you don't do blood sugars, why should you do all the washes? Well what the hell else can you do on the ward?" Do you know what I mean? "Well what do you want to do? Do you want to sit down and I'll bring you a cup of tea? Because that's not going to work". It is very much them and us. It's shocking.

- **Misconceptions**. There were some nurse concerns about HCA misconceptions about the nurse role. In not always being engaged intensely in direct and indirect care, nurses were aware that HCAs sometimes viewed them as 'lazing about'. This could cause some frustration amongst nurses who saw this as an HCA failure to appreciate the responsibilities and pressures they faced:

  Nurse_North: People like talk and talk and talk, like they know there's a lot of negativity between the healthcares, they feel like they're, well skivvies really, that's what, the term they've been using and like they're making all the beds, they're seen as being like beneath everybody else and they're made to do all the work. But I don't think they specifically understand what we've got to do. I mean they've got observations, you know, they've got to wash people and observations, but we've got the medications, admissions, discharge, there's things they can't do which we need to do.

- **Accountability**. The most tangible nurse tension related to the issue of accountability: both the HCAs' accountability for their work and how this affected nurse accountability. The former was reflected in nurse concerns about the ability of HCAs to understand and interpret the consequences of their actions: it was one thing to undertake an observation; another to know that there was a problem.[9] This broadened into a deeper worry about the absence of any national regulation of HCA activities. This concern was seen to overlap with worries about the nurses' own accountability for the HCA; in the absence of such regulation

[9] The reason why some of our Trusts had introduced a scoring system to alert HCAs to any problems related to observations.

in the form say of HCA registration, nurses were denied a form of quality assurance over the capability of the HCA:

Nurse_London: They need some sort of regulatory body or something so, you know, because at the moment it's like if they do take bloods or they do do a plaster, that's like, you know, as a registered nurse asking but we, we are overall accountable for, for that, you know. And it's, you know, even though they've gone through the course and everything, you know, we have to constantly, you know, monitor them because it's our registration on the line, you know. And I just, I just think that if there was some sort of regulatory body for them, you know, that would, you know, their profession, they could use all these skills that, you know, they've been trained to do but can't use in practice, you know, and, you know, they'd be able to use them in practice and they'd be, you know, accountable. And I think, yes, as a nurse, I think that would increase the standards.

While nurses generally appreciated the formal limits of their accountability as set out in NMC guidance, with responsibility for the delegation of the activities but not their performance, there were residual complications in this relationship. For example, as already implied, the weakness in Trust systems on the shape of the HCA role left some doubt as to what could legitimately be delegated:

Manager_London: I think they're [nurses] jumpy because they're unsure on what they will be held accountable for. And I think that's where it gets… and I think it works different with different nurses as well. There's some staff nurses out there that are quite happy for the HCAs to go off and do all these things. There's others go, "Hold on a minute, you know, I'm accountable for that".

Moreover, for some, the line between responsibility for delegation and responsibility for the task itself was a thin one: if an HCA performed poorly should the nurse have been aware of this possibility before delegating? Rightly or wrongly, there was a degree of sensitivity to this issue and a sense of vulnerability amongst some nurses:

Nurse_London: You have to be aware that you're responsible for your own practice and everything but now everybody's thinking you've got to protect your registration. I've heard that phrase said so many times in the past year, I've got to protect my registration, so that you have to be watching what other people are doing; what the doctors are asking you to do or what they're asking the healthcares to do or what the healthcares are doing. Because at the end of the day if, if you're working with a healthcare and they go off and do something that they shouldn't do and it comes back to bite you, you can't say well I didn't do it, because actually you're supposed to be supervising the healthcare.

While important, these concerns should not be overstated. Our survey developed a three item scale on whether nurses viewed HCAs as a 'burden', asking some quite direct questions on whether nurses were worried about delegating to HCAs and concerned by HCA understanding

of what they were doing. As Table 23 notes, there are some significant differences between Trusts, with nurses in South and London significantly more likely to view the HCA as 'burden'; however, in all four Trusts the means scores are low, suggesting only weak support for this view.

Table 23. HCA as a burden (mean score)

	South	Midland	North	London	p-value
Managing a HCA on a shift is a burden	1.94	1.88	1.55	2.15	*F*=7.78, *p*=.000
Being accountable for the delegation of tasks to HCAs is a constant worry for me	2.41	2.39	2.25	2.57	*F*=2.28, *p*=.079
I am always confident that HCAs fully understand what they are doing on the ward [a]	3.36	3.35	3.53	3.42	*F*=0.96, *p*=.412
SCALE: HCA as a burden	**2.33**	**2.30**	**2.09**	**2.44**	***F*=5.02, *p*=.002**

[a] *Scoring reversed when item included in the scale.*

- **Role boundaries**. Tensions over role boundaries might be envisaged at different ends of the spectrum of nurse activities: at the more complex and technical extreme, HCAs performing an extended role might be seen as encroaching on core nurse activities; and at the other, basic care extreme, HCA dominance might be seen to challenge nurse claims to the provision of holistic care. The qualitative fieldwork revealed little nurse concern about HCA activities at either end of the spectrum, although the occasional story was told which illustrated strains at the boundaries of the two roles. At the more technical end, an HCA highlighted the limits of the HCA role in an episode related to female catheterisation:

  HCA_London: So we took the decision to re-catheterise her because the trained nurse we wanted to talk to was in a meeting. Well we actually got carpeted for that, but afterwards when we did our rationale and said look, the reason was we didn't feel the bladder wash out was good enough, it didn't go in, to me it had only gone up the tube [10ml], it had got no further, this lady was going to have a problem, and surely it's our responsibility to make sure she was OK for going home. So on that aspect we overstepped the mark because we needed to have a trained nurse's OK, but on our defence, our patient needed that doing.

  At the other end some concerns at the flight of nurses from direct care were raised:

  Manager_London: Our healthcare assistants do a lot of the hands-on care. It sort of goes against the grain for me because I was trained when actually the nurses, you know, we did all the hands-on care as well. And

I don't like this idea, healthcare assistants, don't get me wrong, they absolutely have their place, they're really valuable members of the team, but I don't like to see trained nurses completely standing back and not getting involved in hands-on care which, you know, I think potentially sometimes can happen. You end up, you know, you're, perhaps you're only doing the ward rounds or you're giving out medicines or, you know, communicating with relatives, doing the multidisciplinary team meetings which are all very, very important…

More noteworthy were the findings from our surveys which explored role tensions. Nurses and HCAs were given a list of statements on who was most likely to perform certain routine, direct and indirect healthcare tasks. As Table 24 indicates, a clear pattern emerges across all Trusts suggesting different nurse and HCA views on who engages with these activities: while nurses continue to see themselves as carrying out many direct and indirect care tasks, HCAs in contrast regard it as more likely that they carry out these activities. For example, it can be seen that there is moderate support amongst nurses for the suggestion that they will answer a buzzer before an HCA and usually empty a patient's commode. However, there is little support from HCAs for these assertions, implying rather that it is they who typically do this type of work. These are findings which suggest that nurses and HCAs have very different conceptions about their respective roles when it come to the delivery and direct and indirect patient care: while nurses continue to hold the view that they remain heavily involved in such activities, HCAs, for 'better or worse' see this as their territory.

7.3 Consequences for patients

The consequences of the HCA role for patients has been presented as revolving around a positive outcome which views the patient as engaging with the HCA as a more accessible form of care, and a negative outcome based on the patient viewing such engagement as compromising care quality. In unpacking these outcomes, three main issues were considered: whether patients could distinguish between HCAs and nurses; whether patients had a distinctive relationship with HCAs; and whether the identification and nature of the relationship with the HCA mattered in outcomes terms. This was an area of the study where the data were at their richest: qualitative data were available on HCA and nurse interaction with patients, while nurse and HCA survey material shed light on the relative incidence of caring behaviours and capabilities in dealing with different types of patient. Moreover, qualitative and quantitative data from patients provided a strong user perspective on how they viewed and engaged with HCAs.

The picture to emerge was complex, but had a strong underlying message. The complexity in part related to some disconnect between the HCA and nurse qualitative and quantitative data: the interviews presented a

Table 24. Role tensions (mean score)

	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
A nurse will usually answer a patient's buzzer before a HCA[a]	1.84	3.13	1.99	3.08	1.94	2.96	1.79	3.23	*F*=1.26, *p*=.288	*F*=1.69, *p*=.168
It is usually a nurse that will empty a patient's commode[a]	1.83	3.35	1.95	3.13	1.94	3.13	1.68	3.46	*F*=2.28, *p*=.078	*F*=3.78, *p*=.010
Nurses rely on HCAs to do all the 'heavy' work	3.54	1.80	3.70	1.81	3.36	1.85	3.78	1.78	*F*=2.97, *p*=.031	*F*=1.83, *p*=.908
SCALE: Role tensions[b]	**3.96**	**2.44**	**3.92**	**2.53**	**3.82**	**2.59**	**4.09**	**2.35**	***F*=2.55, *p*=.055**	***F*=3.02, *p*=.029**

[a] *Scoring reversed when item included in the scale, thus scale mean reflects 'tension' from the HCA point of view.*

[b] *Two-way ANOVA main effects: Role, F=1194.07, p=.000; Trust, F=0.11, p=.955*

consensus on the HCAs having a much closer relationship with the patients than nurses, while the survey material painted a more qualified picture. This disconnect was also apparent in the patient data. The focus group findings provided strong support for the view that patients engaged more positively with HCAs than nurses: although patients often had difficulty distinguishing HCAs from nurses, they found it easier to relate to them. The patient survey again suggested a more nuanced picture; patients indicating that on certain issues they still preferred to deal with nurses. The strong message to emerge, however, was that in all Trusts where patients could distinguish HCAs they had a markedly better care experience.

7.3.1 Distinguishing HCAs

Trusts sought to distinguish HCAs and other categories of staff in a number of ways. Most obviously, variously coloured uniforms were used to identify different occupational groups, and often the range of grades within those groups. In addition, staff often wore badges setting out their name and job title, and on a more selective basis some wards had pictures with job titles of the ward team members at the entrance to the ward.

These attempts to identify HCAs and other staff members were, however, problematic, not least because they served a number of purposes, not all of them designed to facilitate patient engagement with staff. For example, badges were often difficult for patients to read, but were mainly designed with certain internal security issues in mind. More significantly, variously coloured staff uniforms sought not only to help patients distinguish between different staff groups, but also acted as an internal signalling device and means of fostering Trust values and attitudes. This was illustrated in London, where in justifying the recent introduction of HCA uniforms very similar in colour to those of nurses, the manager showed a greater interest in creating a sense of inclusiveness amongst HCAs than in helping patients tell the differences between nurses and HCAs:

> *Manager_London: I would want to make efforts to pull the healthcare assistant body closer to registered nurses. For example, we've recently changed our uniforms and we've taken them out of purple and put them in to blue, which was traditionally a nursing uniform colour, because we felt it would send an important message to healthcare assistants about how integral to the nursing remit they were.*

At the level of practice, the difficulties of patients being able to identify HCAs by uniform were compounded in part by certain ward idiosyncrasies. For example, in one ward where the Trust had recently changed the colour of the HCA uniforms, some continued to wear the old uniform, because it was ‘cooler in summer’, while a third group wore scrubs because they simply looked ‘cool’. Confusion in a number of Trusts was likely wrought by the sheer diversity of coloured uniforms on display at any one time in any given ward. Research observation revealed the following uniforms on

display during just one ward shift and this does not include a number of roles who wear 'civvies' such as doctors and social workers:[10]

- Ward manager (dark blue top with white piping)
- Band 6 nurse (dark blue top with dark blue lapels)
- Band 5 nurse (dark blue top with pale blue lapels)
- Band 5 newly qualified nurse (first six months: white lapel)
- Matron (maroon top)
- HCA (chocolate/coffee top)
- Bank HCA (all white top)
- Student nurse (white top with thin gold and blue stripes on the collar and arms)
- Phlebotomist (white top with maroon piping)
- Pharmacist (white top with grey piping)
- Occupational Therapist (white top with green piping)
- Physiotherapist (white t-shirt)
- Physiotherapist assistant (green t-shirt)
- Domestic (white top with thin vertical blue stripes)
- Ward assistant (pale blue top with white piping)
- Ward clerk (dark blue shirt with a 'spots in squares' pattern)
- Porter (pale blue short sleeved shirt)
- Cardiographer (pale blue top with dark lilac piping)

More specifically, the difficulties patients had in identifying HCAs was reflected in other qualitative data. Patients were quite often observed using the generic term 'nurse' to call to any member of the ward team, a point confirmed in interview with many of the nurses and HCAs:

> *HCA_Midland: A lot of the patients, they're not really sure what we are; because only this morning actually a patient thought I was a student nurse. Most of the patients think that you're the tea lady.*
>
> *HCA_Midland: One woman on the ward the other day called the nurse a pharmacist because… honestly, she said, "Oh there she is, the pharmacist, the one who does the drugs". And it's like, "No, that's your*

[10] A similarly long list could have been compiled from any of the observation wards across each of the hospitals. However, it is interesting to point out that on this ward, although the HCA wore a distinctive coloured top (colour now changed) the bank HCA on the shift performing identical tasks wore a white top– the same colour as a student nurse.

staff nurse, that's not your pharmacist". "Oh she gives out the drugs", I went, "Yes, I know, but that's your staff nurse".

Most tellingly, this was further reflected in a number of patient focus group comments, such as:

Patient_North: Care assistants, they are trained to a different level in different things but there's no way of distinguishing it.

In the context of these findings, it is somewhat surprising that in all Trusts the surveys revealed the majority of patients being able to identify the HCA (see Table 25). At the same time, there were significant differences between the Trusts in this respect, for example, in London, barely half of the surveyed patients could distinguish HCAs, while in Midland this proportion rose to over three quarters.

Table 25. Identifying HCAs (%)

	South	Midland	North	London	p-value
Able to tell the difference between a nurse and a HCA	66	72	69	58	X^2=18.11, p=.000
Of those that could tell the difference, how…? [a]					
Told by a HCA	16	11	17	20	
Told by a nurse	19	23	18	21	
Told by other staff	2	6	4	4	
Told by a patient	2	1	3	1	
Told by relative/friend	3	4	3	5	
By the uniform/name badge	70	76	73	67	
Read info. in the hospital	7	6	5	5	
Pictures on notice board	12	11	18	12	
Already knew	20	20	20	12	
Don't know/can't remember	1	2	1	5	
Other	4	2	1	1	

[a] *This question is a multi-response format, percentages can exceed 100%.*

While Trusts were therefore more or less successful in impressing staff differences on patients, the ways of distinguishing remained fairly standard. Across the four hospitals, uniforms were clearly the most common means of identification: around three quarters of patients who could distinguish did so in this way. Only around a fifth of patients indicated being directly told about differences by a nurse or HCA. The weakness in communication between patients and staff in this respect found some confirmation from other findings. Observation revealed that HCAs (and nurses) often introduced themselves to patients on admission or, if they had been away

for a few days, at the beginning of a new shift. However, this introduction was essentially a matter of politeness. It typically took the form of the staff member informally providing their name and job title with little attempt to explain further the nature of their role or that of other team members.

7.3.2 A distinctive relationship?

Notwithstanding the (in)ability of patients to distinguish HCAs, it still remains pertinent to ask whether patients developed a distinctive relationship with them. Such a relationship might well develop without patients appreciating the difference between roles given the particular tasks performed by HCAs, their specific demeanour and orientation towards the patients. The picture to emerge was nuanced. The HCA and nurse interview data revealed a strong and consistent pattern, suggesting that patients did indeed have a very specific relationship with HCAs. In general, HCAs were seen as being closer to patients, more likely to be viewed as 'friend' or confidant, a position already seen as providing some added value in encouraging patients to open up and reveal useful information. This closer relationship was seen to derive from the tasks performed by HCAs, which, as noted, are often personal and direct care tasks, which in turn involved the HCAs spending sustained periods of time with patients:

> *Nurse_Midland: They can be, appear a little bit closer to the patient; they can get a bit more of a rapport.*
>
> *Matron_Midland: The patients see them [HCAs] as the main people that they see sometimes. You know, it's not very often you'd hear a complaint that's about the healthcare assistants.*
>
> *Ward manager_London: [HCAs] probably develop a more substantial relationship with the patients compared to the staff nurse who I think is quite busy doing lots of different things and who will, but I mean people do develop relationships, don't get me wrong, but I just think because people are giving direct care nursing assistant-wise that the relationships might be a bit sort of more developed.*

There were some differences of view as to whether this distinctive relationship derived from intrinsic features of the HCA role, or whether it was more simply a function of relative work pressures. The latter view was reflected in those who felt that HCAs were able to develop a closer patient relationship simply because they had more time than the nurses to engage with patients: if nurses faced fewer pressures, they would be equally well-equipped to develop such a relationship:

> *Ward manager_Midland: I don't think it's a case that they can offer things that nurses can't, I think they've just got that more time at the bedside than a trained nurse has. So that in itself is fantastic for the patient because they've got somebody there who has maybe got that little bit of extra time to sit and chat about something not necessarily related to why they're in hospital…*

However, others were more inclined to suggest that the HCA role itself – the form it took and the people who filled it – made it easier for patients to engage with it:

> *HCA_North: If [patients are] in pain or they feel this, that, but then there's some that think about how they're feeling so much they might not say to some of the nurses because they might not feel they could approach them.*

> *HCA_London: Sometimes the patients, they find it a bit difficult to talk to the staff nurses. You know, if they use like their lingo like, you know, "You've got to have your TTOs", and they'll say, "Well what does…", wait for us to come along with our brown uniform, "What's a TTO, what's this?", and we can explain to them what that is.*

The latter view finds considerable support from patients. In the focus groups, patients placed emphasis on their greater ease in relating to HCAs:

> *Patient_Midland: You could have a laugh and a joke with those in the brown uniforms [HCAs], but those in the blue uniforms [nurses] you've got to watch your Ps and Qs.*

> *Patient_North: I think they're [HCAs] a godsend sometimes, because they do things that the nurses can't do. I can't specify it, but I know they really are sometimes very helpful… And they were friendly as well.*

> *Patient_Midland: … whereas that's what they see the auxiliaries as, they're one of us. You know, they're just a person like us, you know… I mean they come along and they say, "You're alright?" You know, you're sitting there or, "Are you alright?" You know, "Do you need anything?… They're one of you, you can talk to them.*

> *Patient_South: … A healthcare assistant would have been more helpful. I wasn't sure because it was after my operation I wasn't sure whether I'd actually wet the bed or whether I was actually because I was dopey or whether I was actually sweating a lot. I think actually I was sweating a lot, but it could have been either. And she [the nurse] sort of, she really wasn't particularly nice about it. And I think probably a healthcare assistant would have just taken it as a matter of course and dealt with it. She did, the nurse did, but I just felt that she said, "Oh you stupid woman", you know, that's it, but I don't think a healthcare assistant would have treated me like that.*

This picture was tempered somewhat by data from other sources: the observational material and to greater extent the survey findings. The observations presented a slightly mixed picture on the nature of the HCA-patient relationship. The contact between HCA and patient was often brief, and while HCAs could spend extended periods of time with patients, particularly during washes, these were rarely seen to be occasions when patients opened up and engaged in deep discussions with HCAs. At the same time, if such discussions did take place, and if the patient was seeking a 'friend', this was almost invariably the HCA. This is reflected in extracts from our observational field notes.

Field note_North (Medical): There is one instance where a patient spends a long time explaining her worries and fears in the observee's [HCA] presence. Observee comes across as a good listener.

Field note_North (Surgical): She is one of these 'radar' HCAs who have good peripheral awareness of patients on a bay. There were two main occasions where a very caring side was revealed. The first was at the beginning of the shift where she came onto a bay to find a patient in floods of tears and she sat down and comforted him. It was a young man who had been stabbed some days earlier, had become addicted to the morphine drip and was now in withdrawal. The second was a very frail elderly woman who she spoke to very calmly and at length gently encouraging her through the shift to help her walk to the toilet (amazingly slowly) and to keep up her fluid intake during the day.

Field note_London (Surgical): The observee [an HCA] appeared to be the ward mascot – many patients even those not in his bay knew his name and called his name as he passed by. He was very chatty and did seem to have time to sit and chat, listen with patients. During a long wash a patient was telling him in some detail about her recent bowel movements. He spent time comforting a particularly dependent patient and helping her feed. The observee was valued by patients as a consequence of his happy demeanour, accessibility and willingness to help. So, early in the shift he sorted out the battery of a patient's hearing aid to which she replied 'my hero', and various other comments from patients suggested the observee's value. "He's a very happy lad to have around and he's very competent, nothing is too much trouble for him."

Field note_Midland (Medical): This bank HCA is an example of the bridging link that HCAs have with the community. She found it very easy to talk to patients, find out details about them and to try and make connections with them. One new patient on the ward meeting her for the first time found out that he was born two doors from her husband and was friends with her husband's brother. The entire interaction took less than two minutes but the value to the patient was noticeable, his demeanour changed immediately and each time the bank HCA was back on the bay he was keen to explore further connections and nostalgia. For elderly and scared patients such connections must make a real qualitative difference to their hospital experience.

Table 26. Caring behaviours (mean score)

How difficult or easy do you find it to:	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
…develop a close relationship with a verbally abusive patient	2.72	2.32	2.84	2.52	2.73	2.46	2.76	2.49	*F*=0.516, *p*=.671	*F*=1.76, *p*=.153
…calm a patient who is very stressed about their medical condition	3.36	3.37	3.45	3.41	3.47	3.58	3.29	3.40	*F*=1.30, *p*=.274	*F*=2.08, *p*=.101
…develop a close relationship with a patient whose background is different from your own	3.72	3.67	3.80	3.68	3.93	3.78	3.83	3.80	*F*=2.22, *p*=.085	*F*=1.33, *p*=.264
…cheer up a patient who is deeply upset about an aspect of their stay	3.78	3.54	3.93	3.68	3.94	3.73	3.99	3.71	*F*=2.06, *p*=.105	*F*=2.21, *p*=.086
…develop a close relationship with a confused patient	3.32	2.92	3.46	3.04	3.50	3.21	3.22	3.02	*F*=2.73, *p*=.043	*F*=2.48, *p*=.060
SCALE: Caring behaviours[a]	**3.38**	**3.16**	**3.50**	**3.26**	**3.51**	**3.35**	**3.42**	**3.28**	***F*=1.72, *p*=.161**	***F*=2.72, *p*=.044**

[a] *Two-way ANOVA main effects: Role, F=27.49, p=.000; Trust, F=4.03, p=.007*

Observational data also suggested that HCAs were often effectively able to deal with difficult patients:

> *Field note_North (Medical): A patient came onto the ward during the night and [during observation] had three major episodes of bewilderment, anxiety and raw emotion. Both of the latter times saw the observee [HCA] crouch down on her knees to maintain eye level whilst holding his hands as she listened and tried to centre the patient. The second time took six minutes, which was a considerable period of time. The latter episode was also noteworthy as the observee joined a Band 5 after she had been largely ineffective in her attempt and stayed sitting down during this period almost entirely redundant as the observee took over.*

There are aspects of the HCA and nurse survey data related to what we labelled caring behaviours which lend considerable support to distinctive contribution of HCAs to patient care. Asked whether they find it difficult or easy to deal with various sort of patients, HCAs in three of the Trusts found it easier to enact caring behaviours than nurses (see Table 26). In particular, they found it easier than nurses to deal with:

- deeply upset;
- verbally abusive; and
- confused patients.

This was confirmed during research observation on a shift at North:

> *Field note_North (Medical): During general banter it emerges that [the observee] has been having a hard time with verbal abuse from a patient. This was not raised [during her] interview, suggesting perhaps that HCAs downplay this aspect in an interview situation with us.*

Although survey findings are self-report, coupled with our other data, they suggest that HCAs have a major and distinctive contribution to make in dealing with certain types patients.

However, HCAs and nurses when asked about their contribution to certain forms of patient care consistently rated themselves higher relative to one another. This is indicated in Table 27 which shows that across all Trusts there was a significant divergence of opinion between HCAs and nurses. Tasks which in interview nurses conceded were performed by HCAs, in the survey were now claimed for themselves. In short, nurses were less generous in their acceptance of the HCAs' co-production value. This is further illustrated in Figure 13 which notes that while almost three quarters of HCAs agree or strongly agree that compared to nurses they 'take time to listen to patients when they need to talk', barely a quarter of nurses concurred with this view.

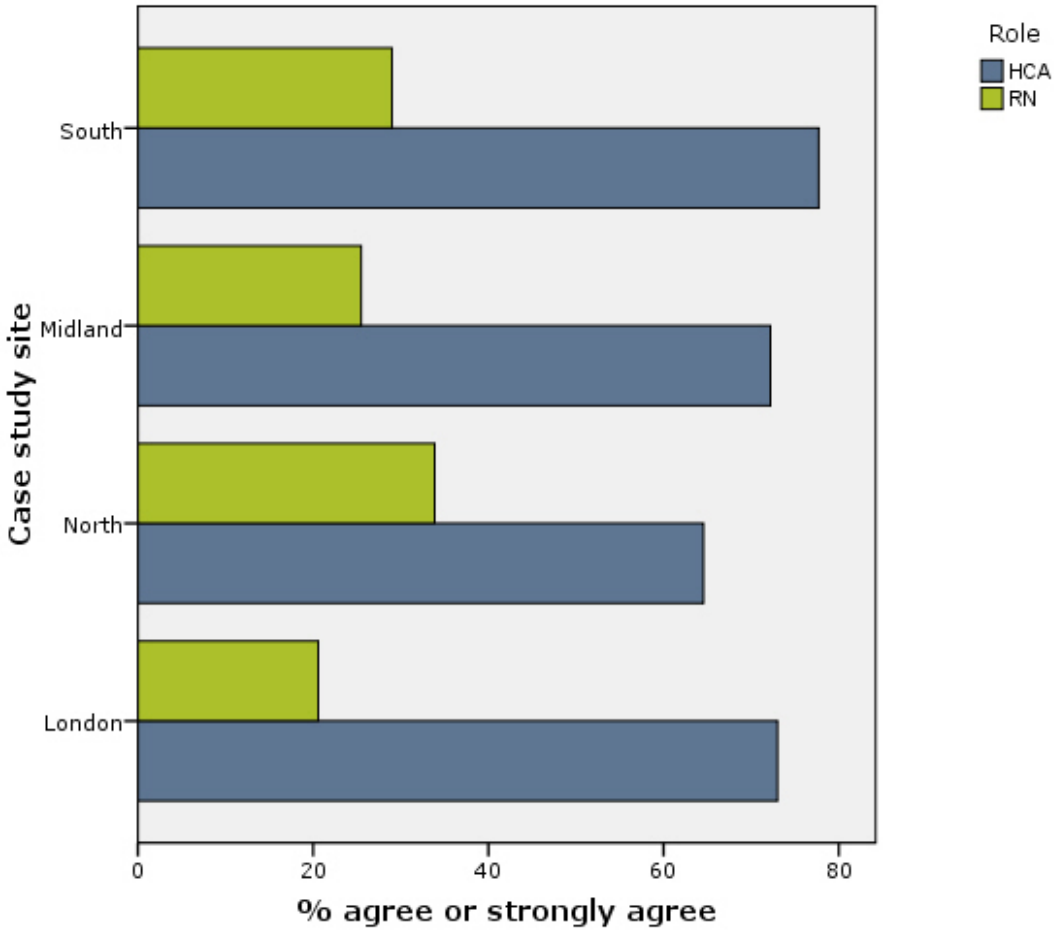
Table 27. Co-production value (mean score)

Compared to nurses, HCAs are more likely to: [a]	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
… notice when patients are in discomfort	3.54	2.51	3.67	2.62	3.34	2.86	3.93	2.54	*F*=7.20, *p*=.000	*F*=3.45, *p*=.016
… show concern when patients complain	3.63	2.50	3.66	2.57	3.34	2.75	3.97	2.45	*F*=8.22, *p*=.000	*F*=2.22, *p*=.085
… talk to patients in a warm friendly manner	3.81	2.85	3.65	2.87	3.35	3.16	3.91	2.70	*F*=7.90, *p*=.000	*F*=4.27, *p*=.005
… be told by patients about their worries and concerns	3.83	2.71	3.81	2.58	3.64	2.98	4.08	2.54	*F*=4.37, *p*=.005	*F*=5.06, *p*=.002
… explain what they are doing when working with patients	3.67	2.49	3.67	2.45	3.45	2.64	3.80	2.34	*F*=2.74, *p*=.043	*F*=1.89, *p*=.130
… take time to listen to patients when they need to talk	4.02	2.78	3.94	2.74	3.69	3.01	3.95	2.61	*F*=3.34, *p*=.019	*F*=3.00, *p*=.030
SCALE: Co-production value [b]	**3.75**	**2.64**	**3.73**	**2.64**	**3.47**	**2.90**	**3.94**	**2.53**	***F*=7.18, *p*=.000**	***F*=4.20, *p*=.006**

[a] *For nurses the original wording and scoring have been reversed so that all results are from the point of view of HCAs to ease interpretation of the data.*

[b] *Two-way ANOVA main effects: Role, F=428.28, p=.000; Trust, F=0.18, p=.911*

Figure 13. HCAs are more likely to listen to patients[a] by role (%)[b]



[a] *For nurses the original wording and scoring have been reversed to aid interpretation.*

[b] *% is those who agreed or strongly agreed with the statement.*

The patient survey findings also encouraged a more qualified view of the HCA-patient relationship than apparent from the focus groups. Table 28 indicates that patients rated the care received both from HCAs and nurses extremely highly; however, across all Trusts the mean scores are significantly higher for nurses than HCAs. Looking at the specific items on this scale, it is particularly apparent that when it came to answering questions about care and when seeking out someone to confide in, the nurse scores were significantly higher than for HCAs. As already implied, these results, especially the latter point on who to confide in, are somewhat at odds with the qualitative data, and suggest that on certain matters patients still prefer to deal with nurses rather than HCAs.

Table 28. Difference between care given by HCAs versus nurses (mean score)

Statements: [a]	South		Midland		North		London		p-value	
	HCAs	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**	**HCAs**	**Nurses**
[…] were willing to listen to what I had to say	4.01	4.21	4.11	4.33	4.03	4.04	3.99	4.01	*F*=0.55, *p*=.651	*F*=4.85, *p*=.002
When […] answered questions about my care I was able to understand them	3.91	4.21	4.01	4.21	3.91	4.11	3.96	4.13	*F*=0.56, *p*=.644	*F*=0.86, *p*=.460
I was able to confide in […]	3.62	3.93	3.90	4.19	3.61	3.99	3.61	3.92	*F*=3.21, *p*=.023	*F*=3.12, *p*=.025
I was treated with respect and dignity by […]	4.24	4.28	4.36	4.43	4.21	4.23	4.14	4.18	*F*=2.72, *p*=.044	*F*=2.51, *p*=.058
SCALE: Patient reported care [b]	**3.96**	**4.15**	**4.11**	**4.30**	**3.96**	**4.09**	**3.95**	**4.09**	***F*=2.00, *p*=.113**	***F*=2.93, *p*=.033**

[a] *[…] are used to indicate where the term 'Healthcare assistants' or 'Nurses' was used in the statement. Patient respondents who had previously stated that they could tell the difference between HCAs and nurses rated each statement for both staff groups.*

[b] *Repeated measures ANOVA: F=37.77, p=.000*

7.3.3 Does it matter?

In assessing 'bottom line' outcomes, the study sought to explore the link between the patients' ability to identify HCAs and the quality of their care experience. Our qualitative data suggested the plausibility of such an association: general uncertainty about what is happening is likely to contribute to a feeling of confusion and disorientation, while more tangibly, given some ongoing demarcations on who does what on the ward, knowing precisely who to approach with certain questions and requests is likely to have a profound impact on physical and mental well-being. Indeed, the importance of being to able to identify the right member of staff was reflected in a number of patient comments:

Patient_London: I was in a lot of pain and I would often ask for pain relief and it would be a HCA and she, "You'll have to wait a minute because I have to go and ask sister… and get it signed off"… And I didn't feel frustrated, I felt frustrated with the system.

Patient_South: Part of my [hospital] experience and the bad part of the experience I had now I can see because I was asking the wrong questions to the wrong people, because I didn't understand the difference. So I was probably asking a healthcare assistant something that he or she wasn't qualified really to deal with, and done their best to accommodate me but didn't deliver my expectation and made me more frustrated. So I think this comes around that the communication of really understanding who's doing what roles and where their roles stops in turns of qualification and the next role starts, because that awareness I think helps the patient as much as it does help the system.

Table 29. Overall rating of care by knowledge of staff role differences (mean score)

	South	Midland	North	London	p-value
Patient could tell the difference between HCAs and nurses:					F=52.20, p=.000
Yes	3.83	4.03	3.60	3.71	
No	3.59	3.50	3.15	3.35	

The patient survey findings strongly endorse the relationship between HCA identification and care quality. As Table 29 indicates, across each Trust the result is the same: patients who can tell the difference between HCAs and nurses report a significantly more positive hospital experience. Even when controlling for the impact of other survey variables that may impact on the relationship – patient age, gender, ethnicity, length of stay, frequency of visit or number of wards stayed on – there remained an additional positive

and significant relationship between patients' knowledge about staff role differences and their reported assessment of care.[11]

The messages are clear: Trusts are at best only moderately successful in helping patients distinguish between HCAs and nurses, and there are benefits to be made from making sure that patients are not left to deduce differences by uniforms alone, but are actively informed by the staff themselves and through other additional means.

7.4 Issues for reflection

The findings in this part of the report suggest the need for Trusts to consider the following in respect to consequences for HCAs, nurses and patients.

For HCAs:

- The greater use of induction to better prepare HCAs for different aspects of their role and to more effectively manage and shape their expectations about the role and their futures.
- The development of a more effective collective voice for HCAs.
- The consequences of a misalignment between pay band, NVQ qualifications and tasks performed: for example, whether HCA with NVQ 3 on pay Band 2 are withholding capabilities or underpaid for their delivery.
- The residual dissatisfactions with pay amongst HCAs.
- The lack of recognition and respect perceived by some HCAs.
- The comprehensive completion of PDRs for HCAs as a means of developing HCA futures in a more transparent, structured and disciplined way.
- The emotional intensity of the HCA role and ways HCAs might be better supported in this respect.

For nurses:

- Fostering a greater mutual recognition between nurses and HCAs on their respective contributions of the patient care and functioning of the ward.
- Greater clarity on the tasks which might legitimately be delegated to HCAs so reducing nurse concern about their accountability for HCA performance.
- Some ongoing sensitivity amongst nurses about role boundaries.

[11] Change in R^2 = .04, change in F = 59.88, p < .000

For patients:

- Ensuring that patients can distinguish between HCAs and other members of the ward team: in particular explaining to patients the contribution made by different ward roles, so allowing them to know who to approach for what.
- Acknowledging and leveraging the distinctive relationship HCAs are able to develop with patients: this includes HCAs finding it easier to deal with certain difficult types of patient than nurses; being able to get closer to patients; and patients finding it easier to relate to HCAs.
- The ongoing preference of patients to deal with nurses rather than HCAs on some issues.

8 Summary and conclusions

The primary purpose of this project was to provide a stronger evidence base for the assumptions underpinning the increasingly important and wide ranging public policy goals held for support workers in secondary healthcare. While a nursing support role was seen as a long established presence in the secondary healthcare workforce, the modernisation of the NHS over recent years had propelled the role to the fore in public policy terms. Unregulated, and with the potential to provide hands-on care, it was a role, particularly in the guise of the healthcare assistant, which raised some dilemmas for policy makers and practitioners, not least in relation to the balance to be struck between workforce flexibility and care quality. Nonetheless, with varying degrees of explicitness, it was seen as a role which could act 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 assistant practitioners and nurses; and as a co-producer – enhancing care quality by bringing distinctive capabilities to bear on the care process.

These public policy goals were based on assumptions related to the strategic orientation of Trusts to the HCA role; to the background of those taking-up the role; to the shape and structure of the job; and to its consequences for key stakeholders: the post holders themselves, the nurses they worked with and the patients they cared for. The research literature on the HCA had provided important insights into many of these issues: on the personal characteristics of HCAs; on the malleability of the role; on its degraded nature for some post holders; and on the ambiguity of nurses towards it. This literature was, however, presented as somewhat fractured, focusing on discrete issues and lacking an integrated analytical framework, as well as being uneven, both in terms of the issues covered and in the forms of investigation.

Our project sought to address the four questions which clearly emerged from the policy assumptions: Are HCAs considered as a strategic resource by Trusts? Who are HCAs? What do they do? What impact do they have on post holders, nurses and patients? An analytical framework was adopted which sought to explore whether the answers to these questions were sensitive:

- to local labour markets as well as Trust policy and practice, with four case study Trusts drawn from different regions of the country being investigated (following a wider range of regional Trust interviews);
- to clinical division, with consideration being given to the role in general medical and general surgical wards within each Trust;
- to individual agency, with a concomitant attempt to examine the relationship between HCA backgrounds, action and the shape as well as the consequences of the role;

- to data source, with qualitative and quantitative research methods being adopted in the form of interviews, observation, focus groups and surveys; and
- to stakeholder perspectives, with material collected from HCAs, nurses and patients.

This final part of the report is divided into two parts: the first summarises the findings as they relate to the four core questions; the second concludes by returning to the policy goals and assumptions, assessing the evidence base for them.

In broad terms, the picture presented in this report has highlighted the standardising influence of the NHS on the HCA role: important similarities can be found across the Trusts in who fills the role, its shape and consequences. However, against this backdrop, contingent influences were found to produce variation along these dimensions. While clinical division failed to emerge as a major influence, important differences were revealed between Trusts, suggesting the effect of local labour markets as well as of corporate policies and practices on the role. The scope for individual agency in shaping the role within the context of these structural constraints remained muted, but still present, with personal background linked to job crafting at the margins. Different data sources often aligned with one another, confirming the validity of findings, yet there were disconnects, for example between the quantitative and qualitative data on how nurses and patients viewed the HCA. Moreover, a shared view on aspects of the HCA role could not detract from differences of opinion on others, such as between HCAs and nurses on who performs certain care tasks. Such differences suggest some contradictions in the nature and consequences of the HCA role and the need for some care in the role's use by policy makers and practitioners at different levels of secondary healthcare.

8.1 An overview of findings

8.1.1 Strategic orientations

While Trust executive directors and senior managers routinely expressed the organisational value of the HCA, there was little to suggest a strong strategic orientation to the role in terms of a planned and considered approach linking its use to the pursuit of corporate objectives. This is not to detract from the standard statements often appearing in Trust nursing strategies proclaiming the search for new and more flexible ways of working, from consideration given to developing Band 4 posts, or more tangibly from the occasional but isolated initiative to develop the role, as with the EDT at London. But the main findings suggested that the role rarely figured on the corporate or even the divisional agenda in proactive terms.

This situation was apparent partly in the fact that any consideration of the HCA role at corporate level was usually within the context of a skill mix review. While such reviews could be linked to broader, forward looking Trust

goals related to the (more) even and patient-sensitive distribution of staff resources and improvement in care quality, they were typically guided by more pressing issues associated with cost efficiency. This was reflected not least in the fact that the most recent thorough skill mix review, accompanied by a workforce reduction programme, had been completed in Midland, the Trust facing the most pressing financial pressures. It was also apparent in the compression of the HCA workforce into Band 2, a pattern hardly suggestive of a careful consideration of how Band 2 and Band 3 roles might be used to deliver care. Indeed this compression within Band 2 was perhaps a further indicator of the HCA role being driven by cost efficiency concerns. It was a finding reinforced by the disordered alignment of pay band, qualification and tasks across the Trusts.

This cost efficient approach to the HCA workforce might well have reflected the ease with which Band 2 HCAs could be recruited across Trusts: as a ready source of cheap labour there was little incentive for Trusts to consider more imaginative ways of attracting individuals to the role or innovating on its use. However, this approach might also be seen to reflect a more general weakness in workforce planning across the Trusts: the HCA role was not alone in being considered in an ad hoc and opportunistic way; this characterised the broader approach to workforce issues. There was little evidence of what might be labelled a strategic human management approach in Trusts, linking the development of work roles and other HR practices to corporate goals. The HR agenda at this level was rather driven by a monitoring of selective workforce targets, for instance related to level of staff absence, turnover, the use of agency staff and completion of PDRs.

8.1.2 Backgrounds

Demand for HCAs, crudely driven by skill mix ratios, was formulated in broadly drawn job descriptions and founded upon low entry requirements, loosely interpreted by those recruiting at ward level. A plentiful supply of applicants, albeit of uneven quality, was elicited in this way. The result was HCA workforces across the four case study Trusts which shared a number of qualities related to their personal features, career histories, motivation, working and employment patterns. In short, an unregulated care support role positioned within the secondary healthcare sector of the NHS attracted those with similar background characteristics regardless of Trust or location.

In terms of shared personal features, HCAs tended to be middle-aged women with children and partners, well embedded in the local community. Moreover they were distinguished from nurses in being much less likely to have an ethnic background and more likely to have roots in the local community. Career histories were typically diverse, with work experience in a range of sectors across heath, social care, education, retail and manufacturing as well as in a non-paid domestic setting. Gateways into the HCA role were limited: the last job before assuming the role was mainly in the social or health care sector. There were also a number of common narratives rationalising the decision to become an HCA: re-connecting to a disrupted nurse career; building on a personal care experience; and

becoming a registered nurse. The survey data suggested that ambition to become a nurse was a particularly strong narrative. In terms of working patterns, part-time working was not particularly frequent amongst HCAs, but they were more likely to work part-time than nurses. As already noted, HCAs were principally in Band 2, while union density was generally lower amongst HCAs than nurses.

The background of HCAs did, however, vary, especially by Trust, in part reflecting local labour conditions, and the associated industrial structure of the catchment area, but also differences in corporate cultures, policies and practices. For example, the Trust located in the most ethnically diverse area had a significantly higher proportion of HCAs with a BME background than other Trusts; in addition some Trusts had been better able than others at recruiting HCAs deeply embedded in the community. It was apparent that the tightness of the labour market created some HCA recruitment difficulties on one site in one Trust, while the looseness of that market provided greater choice in the selection of candidates in another Trust, reflected in the higher proportion of HCAs with a social care background. Moreover, the significantly higher HCA union density in one Trust likely reflected a more entrenched tradition of trade union membership; with the regularisation of shift working in another Trust directly related to the introduction of an e-rostering system. However, the most striking example of differences between Trusts lay in the proportion of the workforce with NVQ levels 2 and 3: variation in Trust approach to the delivery NVQ training had produced workforces with highly contrasting levels of formal accreditation.

8.1.3 The shape of the HCA role

In exploring the shape of the HCA role, consideration was given to the often overlooked question of who the HCA is actually assisting or supporting. There were different emphases placed on whether the HCA supported the nurse, the team or the patient by different actors: the nurse was more likely to view the HCA as a nurse support, the ward manager as a team support and the HCA as a patient support. These differences of emphases spilled over into perceptions of the 'good' HCA: thus, while 'caring' was seen by all actors as the most important characteristic, HCAs were more inclined to stress the importance of patience and empathy with the patient, while nurses stressed the significance of HCA initiative.

Central to this chapter, however, were attempts to characterise and then explain the various forms assumed by the HCA role. The characterisation of the HCA role revolved around notions of core and extension. Public policy developments suggested the role's general direction of development lay in a movement away from traditional nurse auxiliary activities, typically revolving around routine ward maintenance tasks. The more recent focus was on direct and indirect patient care, overlapping and perhaps even replacing the registered nurse as the lead care provider, with further scope to take on more technical and specialist tasks. Our observation data provided some support for these developments, suggesting that HCAs certainly were spending much more of their time on the provision of direct

and indirect care than nurses. At the same time, it was noted that a more refined shaping of the role was linked to four sets of factors: three already considered at length – the Trust, the division and the individual – with the fourth, the ward, highlighting the influence of the shift, the composition of the ward team and ward manager style.

The survey data provided a much sharper picture of the different forms assumed by the HCA role. Five HCA types were distinguished, varying in the diversity and complexity of tasks performed:

- the Bedside Technician (medium complexity/medium diversity)
- the Ancillary (low complexity/low diversity)
- the Citizen (medium complexity/high diversity)
- the All-rounder (high complexity/high diversity)
- the Expert (high complexity/low diversity)

With the Ancillary seen perhaps as the remnants of the traditional nursing auxiliary, the Bedside Technician emerged as the new standard model. The Bedside Technician remained distinct from the registered nurse in not carrying out the full array of technical tasks, but as the new standard model, it was a role which undertook routine technical tasks such as BMs and observations as well the regular direct and indirect care work. The All Rounder and the Expert HCAs were noteworthy in scoring high on complexity, indicative of some role extension, although the numbers in these roles were limited, suggesting some constraint on the scope of this extension.

The distribution of these HCA role types was related to Trust, with a significant proportion of HCAs in two hospitals found to be Bedside Technicians, while another had a relatively high proportion of Ancillary HCAs. Unpacking the reasons for these patterns was far from straightforward: in the latter case it might have been related to the collapse of NVQ accreditation creating problems in signalling advanced skills, but elsewhere latent elements in terms of path-dependent values, practices and routines might be well have been at work.

Other patterns were more transparent. The influence of structure was revealed in the greater concentration of the Bedside Technician in medical than in the surgical wards: the higher dependency and need for direct care of patients on these ward lending some plausibility to this finding. Clinical area was also important in accounting for the emergence of the Expert and the Citizen; while these types were not linked to broad clinical division, the make-up of these types was found to be heavily concentrated in certain areas. The exercise of agency was more apparent in the case of the All Rounder. Breaking through structural constraints was not easy: there were few All Rounders. However, the dispersion of those in this role across many clinical areas, allied to the fact that they were not performing in line with others on their ward, and the link between this type and personal aspiration

suggested that the All Rounder was very much the product of individual job crafting.

8.1.4 Consequences

For each of the main actors with a stake in the HCA role – the post holders themselves, the nurses and the patients – the consequences were originally presented in terms of positive and negative scenarios. Across the three stakeholders there was often a disconnect between the qualitative and quantitative data on these outcomes: in the main the qualitative material supported positive scenario, while the quantitative findings typically presented a more qualified picture. It remains open to some debate as to why this was the case. It might well be that the specific methods used encouraged particular responses, for example, a facilitated focus group might well have been more conducive to producing a positive patient view of the HCA than a questionnaire received unsolicited and completed by the respondent alone. On the other hand, this disconnect may well reflect a genuine ambiguity amongst actors about the role. In the case of nurses, for example, this ambiguity seems highly plausible: perhaps a reflection of contradictory elements within the nurse professionalisation project.

HCA outcomes

For the HCAs alone of the three actors, it was the qualitative data which gave a slightly stronger hint of negative outcomes than the quantitative. The interview material suggested that the management of HCAs was problematic in a number of respects. The collective voice of the HCA was weak in the absence of safe Trust spaces or opportunities for them to aggregate and express shared interests, and in the context of fragile workplace trade union organisation. Moreover, the misalignment of task, pay banding and NVQ qualification, driven by the concentration of the HCA workforce in pay Band 2, had distorted the effort – reward bargain for some, especially those with an NVQ3, and others, in Band 2 performing extended roles. Selective HCAs raised some concerns about their role and their treatment – a lack of respect and of recognition, a sense that they were sometimes ‘dumped-on’. More generally, the HCA role emerged as emotionally intense, although the impact of such intensity on the quality of working life was heavily contingent on the circumstances of the emotional experience and the individual HCA’s coping strategy. Indeed, depending on interpretive responses from HCAs, emotional labour could emerge as contributing considerably to job enrichment.

Certainly in interview, many of the HCAs did stress the enjoyment they gained from their work, the source of such enjoyment often lying in the contact with patients. This positive view of their role was confirmed in the survey data, which revealed HCA job satisfaction across the Trusts, and few signs of intention to leave. This data also suggested that while in most Trusts a majority of HCAs saw themselves as remaining and developing in the HCA role, the role allowed a considerable minority of HCAs to hold out the hope of becoming a registered nurse. Indeed the HCA role did not appear to ‘squeeze out’ this ambition; with perhaps some poignancy HCAs

held on to this aspiration for many years. This should not, however, detract from the major institutional and personal barriers which HCAs faced in moving on to nurse training.

Nurse outcomes

The qualitative data indicated that nurses viewed HCAs in an extremely positive way across all Trusts: in interview, nurses stressed the value of the HCA contribution to the ward team, often suggesting that the ward could not function without them. It was a picture confirmed in observation, which revealed few workplace problems between HCA and nurses, and workplace routines which reflected smooth and co-operative forms of working. Certainly nurses perceived some tensions: nurses were 'niggled' at what they felt were misconceptions amongst some HCAs of their laziness; a 'them' and 'us' divide was occasionally noted which could reflect and spill over into the odd dispute about role boundaries. The most tangible nurse concern, however, related to accountability. There was some nervousness around nurse responsibility for the HCA, not least in the context of vagaries around Trust policies on the delegation of tasks to HCAs and around the absence of statutory regulation of the role. At the same time it was clear from the nurse perspective that the HCA was valued by the nurse not only as a relief but as a mentor, an 'extra pair of eyes' and a partner.

The nurse survey data presented a more nuanced picture. In general nurses were more grudging in the value they placed on the HCA as a relief, and more especially as mentor and an 'extra pair of eyes'. More striking were differences in nurse and HCA views on who performed certain routine direct and indirect care tasks. Whilst in general HCAs felt that they mainly performed these tasks, nurses resolutely adhered to the view that they continued to deliver them.

Patient outcomes

The qualitative data from all stakeholders provided strong support for the positive scenario of the HCA as patient friend and confidant. Certainly, there were suggestions that patients had difficulty distinguishing HCAs from other members of the ward team, but there was a strong consensus that HCAs developed a closer relationship with patients than nurses, a relationship patients often felt more comfortable with. Views on the reasons for this distinctive relationship varied. Clearly HCAs spent more time with patients than nurses and this time was often spent providing personal care. For some, there was nothing intrinsic to the HCA role which allowed them to get closer to the patient; nurses with the same time on their hand would have been able to get just as close. For others, patients did find it easier to relate to those who carried out a support role, and the kind of people who performed it. This was a view which strongly emerged from the patients themselves, as apparent in the focus group discussions.

The survey data again presented a more complex picture. There was strong evidence to suggest that HCAs contributed in a distinctive way to patient care: it was apparent from these data that HCAs across all Trusts found it easier to deal with certain types of difficult patient than nurses. However

nurses were again more reluctant to stress the co-producing value of the HCAs than they had been in interview: when it came to specifying a number of ways in which HCAs and nurses might be more sensitive to patient needs and better able to develop a close relationship with them, in all Trusts nurses continued to score themselves quite highly on their performance of them.

Surveyed patients also presented a more qualified view of their relations with HCAs. A noteworthy majority of patients claimed to be able to distinguish between HCAs and nurses. This proportion did vary by Trust, suggesting the importance of local practice, although the main source of identification across all hospitals remained the uniforms. Despite suggestions in the focus groups of a close relationship with HCAs, patients indicated in the survey that they preferred to deal with nurses than HCAs, particularly on questions related to their condition. Equally significant was the finding that across all Trusts those patients who could distinguish between HCAs and nurses had a better care experience. Our qualitative data indicated that this was a highly plausible finding: for example, knowing who to approach with a question or a form of care is likely to improve the quality of care and reduce frustration. It is also a finding which had significant policy implications. The final section of this report returns to public policy and, in particular, the extent to which the findings presented in this report support those policy assumptions related to the HCA role.

8.2 Public policy goals and assumptions

The initial rationale for this project was the growing importance attached by public policy makers to the support worker role in secondary healthcare against the backdrop of public services reform and modernisation. Articulated with varying degrees of explicitness, and not without a degree of ambiguity, the role was seen as a vehicle for pursuing a number of policy goals: the HCA, in particular, was seen as a relief, substitute, apprentice and a co-producer. The evidence base for the viable use of the HCA role in these ways, crucially related to who HCAs were, what they did and how they impacted on various stakeholders, is presented below. Prior to considering each of the goals in turn, the cross-cutting and founding assumption that Trusts adopt a strategic approach to the HCA role is briefly reviewed.

8.2.1 A strategic resource?

Drawing on a strong definition of ‘the strategic’ as a forward looking approach which explicitly relates policy and practice to medium and longer term organisational objectives, it is difficult to conclude that the Trusts viewed and used HCAs in a strategic manner. In general, Trusts were driven by pressing targets linked to patient access, finance and other outcome measures, which senior managers were unable in any considered way to relate to workforce reform or planning, and certainly not to the support worker role. This was, for example, reflected in the concentration of HCAs in pay Band 2 and in the disordered relationship between pay Band,

qualification and tasks performed. This is, however, a picture which needs to be qualified in a number of ways.

- The scope to develop the support role on general medical and surgical divisions might have been less obvious than in other, more specialist clinical areas. In some Trusts there were initiatives, but they tended to be in such areas as emergency care and theatres.
- There were differences in Trust approaches to managing HCAs, apparent in contrasting policy and practices. For example, different local labour market conditions generated HCAs with different work experience; level of NVQ accreditation varied markedly; some Trusts were more successful than others in aligning Band 3s with NVQ3s; while there was some unevenness between Trusts in how easy it was for patients to identify HCAs. These are variations which imply an opportunity for Trusts to address the HCA role in a more considered way: this might not be a 'grand strategy' as defined above, but senior management could plan and more explicitly acknowledge the HCA's contribution to patient care. Most obviously, it is clear from our research that a Trust-wide approach which facilitated patient identification of HCAs would likely improve patient perceptions of their care experience.
- Closely related, the research has revealed different patterns in the distribution of various types of HCA between Trusts. Uncovering the reasons for these differences was not easy; these may well lay in 'deep' and path-dependent structures, systems and values. Nonetheless, in revealing these differences, our research encourages Trusts more explicitly to build upon the forms assumed by the HCA role and their particular contribution to patient care.

8.2.2 A relief?

The research provided some support for the development of the HCA role as a relief for nurses, taking some of the more 'routine' tasks from them and freeing them up to concentrate on more technical, specialist clinical tasks. Both the qualitative and quantitative data suggested that the HCA is the primary provider of direct and indirect care, nurses being distinguished from the standard HCA in carrying out a greater range of more complex tasks. Equally noteworthy was the fact that the new standard HCA, the Bedside Technician, was not only undertaking such direct and indirect care tasks but also performing routine technical tasks such as observations and BMs; in short the HCA had not only relieved nurses of basic care tasks but was now also a partner in the delivery of some technical ones.

This had bred some discontent amongst HCAs, occasionally viewing themselves as the 'work horses' of the ward and as being 'dumped on'. But more generally it was not reflected in low levels of job satisfaction; indeed many HCAs suggested that their enjoyment from the job resided in this more direct patient care. Moreover, nurses also seemed to value the HCA greatly in helping in these respects, although there was some residual nurse

ambiguity about the implications of these developments for their claims to the provision of holistic care.

8.2.3 A substitute

A more qualified picture emerges as to whether and how effectively the HCA was being used as a substitute for the nurse. It might well be argued that in taking on routine technical tasks on a partnership basis with nurses, HCAs were increasingly substituting for nurses in these spheres of activity. Moreover, the boundaries between the HCA and nurse were fairly broadly drawn, with the limits of the HCA role lying in the dispensing of medication and patient assessment, allowing considerable scope for HCA role extension. However our data suggested that while some HCAs were performing more extended roles, the number should not be overstated: the HCA All Rounder and the Expert, those role types at the high complexity end of the scale, were fairly limited in numbers.

Caution about the claims that HCAs were being used as substitutes in this sense should not, however, detract from the misalignment between pay Band, formal qualification and tasks performed. The concentration of the HCA workforce in pay Band 2 had resulted in a distortion in the effort-reward bargain for some, particularly those with advanced capabilities, typically but not invariably signalled by NVQ 3. It was where the HCA was in pay Band 2, performing an extended role with or without an NVQ 3, that the issue of fairness and notions of 'cheap labour' most obviously emerged.

8.2.4 An apprentice?

The research provided considerable support for the HCA as an apprentice, both in terms of the individual post holder developing within the role to become 'high performing HCAs' and as a potential source for future registered nurses. Most HCAs saw their future as HCAs, with many of these keen to develop within the role. The uneven approach to training within Trusts, the patchiness of completion of PDRs and the general absence of workplace planning at any level raised some doubt about the efficiently and effectiveness with which Trusts were addressing these enthusiastic HCAs keen to develop within the role.

More striking was the significant stock of HCAs willing to become registered nurses. This was often a rationale for becoming an HCA, with many individuals holding nurse aspirations on taking up the role. Moreover, it was a remarkably durable aspiration, which only faded after a number of years in the HCA role. Indeed it was the very durability of this aspiration, allied to continuing and significant barriers faced by HCAs in becoming registered nurses, which suggests the need for a more considered approach to this issue amongst policy makers at different levels. There are grounds for seeking a balance which retains the enthusiasm of those HCAs who wish to become a nurse, continues to seek ways of reducing the barriers they face in pursuing this goal but at the same time shapes HCA expectations to ensure their sensitivity to the difficulties faced in pursuing this aspiration.

8.2.5 A co-producer?

The research lent strong support to the suggestion that HCAs brought distinctive capabilities to the provision of healthcare. This support took a number of forms.

- HCAs did have different backgrounds to nurses, most significantly being more deeply rooted in the local community. They also had a breadth and richness of work experience which suggested they brought with them a range of tacit skills and capabilities.
- Much of the evidence suggested that HCAs were able to develop a much closer relationship with patients than nurses, a closeness which patients themselves put down to being able to relate much more easily to HCAs than nurses.
- There was also firm data to indicate that HCAs 'add value' by being able to deal with certain types of difficult patient more easily than nurses. More specifically HCAs found it easier to deal with verbally abusive patients and deeply upset patients than nurses.

The value of HCAs as co-producers in these terms should not detract from the apparent preference of patients to deal with nurses rather than HCAs on some issues. However, this only strengthens the suggestion that the quality of care experience is likely to be improved if patients are more clearly informed about the differences between the roles of respective ward team members.

References

(1) Department of Health. *Regulation of heath care staff in England and Wales*: *a consultation document*. London: Department of Health; 2004

(2) Saks M, Allsop J. Social Policy, Professional Regulation and Health Support Work in the UK. *Social Policy and Society* 2007;6(2): pp. 165-77.

(3) NMC. *The Regulation of Health Care Support Workers: A Scoping Paper*. London: NMC; 2006.

(4) NHS Information for Health and Social Care. *NHS Hospitals and Community Services, Non Medical Staff, England 1999-2008*. Leeds: NHSIHSC; 2009.

(5) Stokes J, Warden A. The changing role of the healthcare assistant. *Nursing Standard* 2004;18(51): pp. 33-7.

(6) Webb B. Enrolled nurse conversion: A review of the literature. *Journal of Nursing Management* 2000;8: pp. 115-20.

(7) Buchan J, Claman L. *Skill Mix and Policy Change in the Health workforce*, OECD Working Papers, 17. Paris: OECD; 2005.

(8) RCN. *Maxi Nurses: Advanced and Specialist Nursing Roles*. London: RCN; 2005.

(9) Hansard. *HC deb 24 Feb*. 1999: cc 364-71.

(10) Wanless D. *Securing Our Future Health Taking a Long Term View*. London: HM Treasury; 2002.

(11) Department of Health. *High Quality Workforce*. London: Department of Health; 2009.

(12) Thornley C. *The Invisible Workers: Health Care Assistants and Support Workers*. London: UNISON; 1997.

(13) Buchan J, Seccombe I. *Behind the headlines*. London: RCN; 2002.

(14) Kessler I, Bach S, Heron P. *The Role of the Public Service Support Workers*. Invited plenary session a paper presented to Employment Research Unit Conference, Cardiff University; 2005.

(15) Department of Health. *Delivering the HR in the NHS plan*. London: Department of Health; 2003.

(16) Grimshaw D. Changes in the skill mix and pay determination amongst the nursing workforce in the UK. *Work, Employment and Society* 1999;13(2): pp. 295-328.

(17) Langlands A. *Gateways to the Professions Report*. London: DfES; 2005.

(18) Skills for Health. *Thames Gateway Project: Final Report*. London: SfC; 2009.

(19) Department of Health. *Introduction to the Skills Escalator*. http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelcareer/index.htm [accessed 3rd February 2010]

(20) Department of Health. *High Quality Care for Next Stage Review*. London: Department of Health; 2008.

(21) Buchan J. *Nurse Workforce Planning in the UK: A Report for the RCN*. London: RCN; 2007.

(22) House of Commons Heath Common Committee. *Workforce Planning: Fourth report of session 2006*-7. London: HMSO; 2007.

(23) Imison C, Buchan J, Xavier S. *NHS Workforce Planning: Limitations and Possibilities*. London: King's Fund; 2009.

(24) Roberts I. The healthcare assistant: Professional supported or budget necessity. *Health Manpower Management* 1995;21(5): pp. 25-37.

(25) UNISON. *Just a Little Respect*. London: UNISON; 2008.

(26) Knibb W, Smith P, Magnusson C, Bryan K. *The Contribution of Assistants to Nursing: Report for the RCN*. Guildford: University of Surrey; 2006.

(27) Health Commission. *Acute Hospital Portfolio Review, Ward Staffing 2005*. London: Health Commission; 2005.

(28) Elliot B, Skatun D, Farrar S, Napper M. *The impact of local labour factors on the organisation and delivery of health services*. Final report. NCCSDO; 2003.

(29) Hardie M, Hockey L. (eds.) *Nursing Auxiliaries in Health Care*. London: Croom Helm; 1978.

(30) Bosley S, Dale J. Healthcare assistants in general practice: practical and conceptual issues of skill mix change. *British Journal of General Practice* 2008;58: pp.118-24.

(31) Hogan J, Playle J. The utilisation of the healthcare assistant role in intensive care. *British Journal of Nursing* 2000;9(12): pp. 794-801.

(32) Meek R. Evaluation of the role of the healthcare assistant within a community mental health intensive care team. *Journal of Nursing Management* 1998;6(1): pp. 11-19.

(33) Spilsbury K. *Who Cares? A case study to explore HCAs' Jurisdiction in a hospital setting*. PhD thesis. City University London; 2004.

(34) Spilsbury K, Meyer J. Use, misuse and non use of healthcare assistant: understanding the work of HCAs in a hospital setting. *Journal of Nursing Management* 2004;12: pp. 411-18.

(35) Thornley, C. A question of competence? Re-evaluating the roles of the nursing auxiliary and health care assistant in the NHS. *Journal of Clinical Nursing* 2000;9: pp. 451-8.

(36) Jack B, Brown J, Chapman T. Ward managers' perceptions of the role of HCAs, *British Journal of Nursing* 2004;13(5): pp. 270-5.

(37) Ford P. The role of support workers in the department of diagnostic imaging: service managers' perspectives. *Radiography* 2004;10: pp. 259-67.

(38) Thornley C. Segmentation and Inequality in the Nursing Workforce. In: Crompton R, Gallie D, Purcell K. (eds.) *Changing Forms of Employment*. London: Routledge; 1996.

(39) Thornley C. Double Jeopardy: Non Registered Nurses in the NHS. *Gender Research Forum*. 8 November 2002.

(40) Workman B. An Investigation into how the health care assistants perceive their role as 'support workers' to qualified staff. *Journal of Advanced Nursing* 1996;23: 612-9.

(41) Gould D, Carr G, Kelly D. Seconding healthcare assistants to a pre-registration nursing course. *Journal of Research in Nursing* 2006;11(6): pp. 561-72.

(42) Cox A, Grimshaw D, Carroll M, McBride A. Reshaping internal labour markets in the NHS: New Prospect for pay and training for lower skilled serve workers? *Human Resource Management Journal* 2008;18(4): pp. 347-65.

(43) Hochschild A. *The Managed Heart*. Berkeley: University of California Press; 1983.

(44) Theodosius C. *Emotional Labour in Health Care: The Unmanaged Heart of Nursing*. Abingdon: Routledge; 2008.

(45) Abbott A. *The system of Professions: An Essay on the Division of Expert Labour*. Chicago: University; 1988.

(46) Hughes EC. *The Sociological Eye*. London: Transaction; 1993.

(47) Rye D. Nursing Auxiliaries: A Professional Perspective. In: Hardie M, Hockey L. (eds.) *Nursing Auxiliaries in Health Care*. London: Croom Helm; 1978.

(48) Doherty C. *The Effect of Jurisdictional Change on the Professionalisation of Nursing*. DPhil Thesis. King's College London; 2007.

(49) Chief Nursing Officer. *Keynote Address*. CNO Conference 14 January 2007.

(50) http://news.bbc.co.uk/1/hi/health/3701855.stm [Accessed 3rd February 2010]

(51) Power P, Dickey C, Ford A. Evaluating an RN/Co-worker model. *Journal of Nursing Administration* 1990;20: pp.15-25.

(52) Reeve J. Nurses' attitudes towards healthcare assistants. *Nursing Times* 1994;90: pp. 43-6.

(53) McKenna H, Hasson F, Keeney S. Patient safety of care: the role of HCAs. *Journal of Nursing Management* 2004;12: pp. 452-9.

(54) McLaughlin FE, Barter M, Thomas SA, Rix G, Coulter M, Chadderton H. Perceptions of registered nurses working with assistive personnel in the UK and the US. *International Journal of Nursing Practice* 2000;6: pp. 46-57.

(55) Dingwell R. Atrocity stories and professional relationships. *Sociology of Work and Occupations* 1977;4: pp. 317-96.

(56) Bach S, Kessler I, Heron P. Role Redesign in a Modernised NHS: The Case of HCAs. *Human Resource Management Journal* 2008;58(2): pp. 171-87.

(57) Allen D. *The Changing Shape of Nursing Practice*. London: Routledge; 2001.

(58) Daykin N, Clarke B. 'They'll still get bodily care'. Discourses of care and relationships between nurses and HCAs in the NHS. *Sociology of Health and Illness* 2000;22(3): pp. 349-63.

(59) Carr-Hill R, Dixon P, Gibbs I, Griffiths M, Higgins M, McMaughan D, Wright K. *Skill mix and effectiveness of nursing care*. Centre for Health Economics, University of York; 1992.

(60) McKenna H. Nursing Skills mix substitutions and quality of care: exploration of assumptions from the research literature. *Journal of Advanced Nursing* 1995;21: pp. 452-9.

(61) Spilsbury K, Meyer J. Defining the nursing contribution to patient outcomes: lessons form a review of the literature examining nursing outcomes, skill mix and changing roles. *Journal of Clinical Nursing* 2001;10: pp. 3-14.

(62) James N. Care = organisation + physical labour + emotional labour. *Sociology of Health and Illness* 1992;14(4): pp. 488-509.

(63) Barley S, Kunda G. Bringing Work Back In. *Organizational Science* 2001;12(1): pp. 76-95.

Appendix 1 The ward housekeeper role

Alongside the HCA, the ward housekeeper has also attracted considerable attention from policy makers and practitioners in recent years. As a dedicated role, the ward housekeeper has more recently emerged, being explicitly linked in the NHS Plan (DH, 2000)[12] to develop services more sensitive to patient needs (May and Smith, 2003)[13]. More specifically, the role has been related to the pursuit of eleven patient-focused standards covering such aspects of care as cleanliness, catering, and infection control. In 2001, NHS Estates (2001) published the 'First Guide' to the role.[14] This provided a greater insight into the public policy goals underpinning its use. Thus, emphasis was placed on its contribution to improving the patient experience: 'Patients want to feel hospital staff are attentive to their individual needs, that the ward environment is clean and that the food is good.' (NHS Estates, 2001:1). But considerable weight was also placed on the role's scope to act as a relief in relation to nurses: 'Ward housekeepers are being introduced across the NHS to release nurses form non-clinical tasks, such as chasing maintenance requests, and to allow them to concentrate on nursing duties.' (Ibid). A target was set to introduce the role into at least 50% of Trusts by 2004. Certainly this target had been breached by 2007, the DH website noting that 'more than 53% of NHS hospitals currently offer a ward housekeeping service.'

The NHS Estate (2001:5) First Guide asserted that the ward housekeeper service 'will focus on cleanliness, food and maintain the environment'. It also established common, core principles related to the organisation of the role (Ibid): that ward sisters/managers will have responsibility for the ward environment, supported by the ward housekeeper; that the ward sister will be responsible for the day to day supervision of the ward housekeepers; that the ward housekeeper will be ward-based and part of the ward team. At the same time it was acknowledged that the organisational model underpinning the role – for example the precise line management responsibilities between ward manager, matron and facilities manager and housekeeper – might vary.

The role has added interest in the context of this study given the likely overlap between its activities and those of the HCA. At the same time it is noteworthy that the First Guide completely fails to acknowledge this fact. As it notes, 'This Guidance is aimed at ***everyone*** involved in ward housekeeper

---

[12] Department of Health. *The NHS Plan: A plan for investment, a plan for reform*. London: The Stationary Office; 2000.

[13] May D, Smith L. Evaluation of the new ward housekeeper role in UK NHS Trusts. *Facilities* 2003;21(7/8):pp. 168-174.

[14] NHS Estates. *Housekeeping: A first guide to new, modern and dependable ward housekeeping services in the NHS*. London: The Stationery Office; 2001.

services: ward nurse; facilities managers; ward housekeepers; patients, their relatives and carers' [emphasis added]. The exclusion of the HCA from this list seems strange, but as implied, the shape and nature of the housekeeper role might be expected to have consequences for the HCA.

The housekeeper role was explored in all case studies on the basis of the same themes used to consider the HCA role: the background of those taking up the role; the nature of the work in terms of the tasks performed; how the role was perceived; and its impact on relationships with various stakeholders. As noted below, in the account of the fieldwork undertaken, we did not study this role in the detail we did the HCA role, nor did we consider the ward housekeeper role in our survey data; we are therefore deliberately cautious in drawing conclusions from this data.

The structure, management and nature of the role was found to vary between Trusts. Indeed in London a dedicated role did not exist; this section as a consequence focuses on a housekeeper role in South, Midland and the North. A broad overview of the data collected across the cases is set out below, followed by a discussion of the role in relation to the analytical framework adopted in the main study.

Fieldwork undertaken

Senior management interviews at all Trusts sought to explore the nature of the housekeeper role: its structure and how it was perceived in terms of its purpose and impact. This exploration process was followed in the nurse and HCA interviews we conducted. The core data on this role was collected as follows:

- **South**: eight senior ward housekeepers were interviewed and three observation sessions of shifts (7am to 1pm) were conducted.
- **Midland**: one focus group with five ward housekeepers and two observation sessions of the shift (7am to 1pm) were conducted.
- **North**: four ward housekeepers were interviewed and two observation sessions of housekeeper shifts (7am to 1pm) were conducted.

Contextual influences impacting on the role

South

Had recently introduced a senior ward housekeeper role (SHK) at Band 3. Catering and cleaning are outsourced in the teaching hospital site we studied. Cleaners have their own managers despite SHKs being responsible for overall cleanliness of the ward. SHKs reported into the ward manager and tend to work the morning shift only on weekdays. In the District General Hospital site in South the catering is done in-house.

Midland

An in-house catering and cleaning system operates. There were multiple Band 1 ward housekeeper roles in operation. The hostess 'who does the food and keeps the kitchen clean'. The ward assistant who plays a role in the delivery and distribution of food as well as cleaning and the housekeeper auxiliary who has additional duties of ordering in medical equipment. Housekeepers in this case report into the ward manager.

North

The housekeeping role is performed in-house and falls within the Facilities Directorate. Team leaders from this directorate manage this Band 1 role. Three recent policy decisions have impacted on the organisation and functioning of the role within the Trust: the introduction of a 'credits for cleaning system' allowing central planning of staffing; the establishment of 'rapid' response cleaning teams and the splitting of cleaning and food duties on the wards to guard against cross-contamination. An outsourced cook-chill food distribution system is in operation.

Who the housekeeper reported to and the nature of the meals system proved to be significant mediating factors in the shaping of the role.

Background of ward housekeepers

As with the HCA interviews we asked the housekeepers we interviewed about their careers and background since they had left school. Across all the cases, interviewees had all left school at 16.

In Midland and North, housekeepers tended to have worked in retail, office work, catering, and in the NHS (usually as domestics), before taking on the role.

In South, five of our interviewees were previously HCAs, two cleaned in the hospital, one worked on the hospital switchboard and one was a former nurse.

We asked this group of interviewees what motivated them to take up this role. Midland and North interviewees consistently spoke of the role being attractive to them because of enabling them flexibility to meet their home and work commitments. Only one of this group saw the role as a stepping-stone for another role in the NHS.

Amongst our SHKs in South, it was flexibility and improved pay that were consistently given as reasons for applying for the role.

As with the HCAs in our sample, we found housekeepers less likely to have an ethnic background and they were well-embedded in the local community. There were common narratives across this small sample rationalising the decision to become a housekeeper as re-connecting to a disrupted career and building on care experience. This group were, however, different from our HCAs in that the majority of those we interviewed did not express a strong desire to move on to other caring roles within the NHS.

In Midland, for example, it was noticeable that housekeepers were not keen to move into Band 2 roles because they had seen how hard HCAs had to work and believed the increased salary was not a big enough incentive to take on the demands of the job:

HK_Midland: ... I did not realise the job they did until I worked here and I've seen it for myself. Because I thought I'd like to be an auxiliary [HCA] – I'm like no, I don't any more. I'm quite happy where I am.

The work of the housekeeper and shape of the role

Core aspects of the role across the sites:

- Food distribution
    - Assisting with the completion of the menus and collection of menus.
    - Ensuring drinking water is clean. Collection of jugs.
    - Assisting in the distribution of meals.[15]
    - Ensuring the tea trolley is stocked with beverages.
    - Checking meals ordered for the ward are distributed correctly and monitoring special dietary needs/nil by mouth.
    - Offering tea and coffee to patients with meals and between meals.
    - Preparing snacks for patients.
    - Collecting trays and items associated with meals and ensuring they are returned to where they will be washed or ensuring these are washed and cleared away personally.
- Cleaning
    - Keeping the 'kitchen' clean and tidy.
    - Ensuring 'clutter' is removed from patient tables.
    - Taking the dirty laundry to a collection area.
    - Cleaning ward floors and more general ward cleaning.
    - General monitoring of the ward environment to ensure it is clean and tidy.
- Keeping alcohol gels topped up
- Ensuring adequate supplies of toilet paper and paper towels
- Food ordering

[15] There are variations in how this aspect of the work is carried out and this is reported in detail in the main cases.

- Usually beverages, biscuits.

Whilst these activities were the core of the role, we observed housekeepers innovating around the core. For example:

- Helping on reception and taking calls
- Photocopying
- Collection from pharmacy
- Collecting equipment from around the hospital
- Helping make beds
- Commode work
- Weighing of patients
- Giving a patient a tablet during meals (one occasion)
- Dealing with lost property
- Helping with feeding.

It is interesting to note that in South, the SHK undertook the same range of duties as the Band 1 roles in the other two sites. The only significant differences that emerged from our interviews and our observation work related to specific responsibilities for infection control and stock ordering. They were accountable for providing the 'terminal' cleaning teams with relevant information and played a key part in any infection outbreak incidents. They were also responsible and accountable for reporting equipment failure and stock maintenance. This involved them interacting with Estates, Facilities and Central Sterile Supply Department (CSSD). This direct contact was not a feature of the role studied in Midland and North. SHKs in the district general hospital (DGH) site differed from those in the teaching hospital site in South in that they had a more active role in the food distribution as the catering was in-house. The fact that the SHK was both responsible and accountable for these two areas of infection control and stock ordering was appreciated by other interviewees in South, in particular, nurses commented that it relieved them of these tasks, allowing them to focus on other work.

Stepping back from our data on this role, the overwhelming observation is that across all our sites this role is very routinised.

> *HK_North: I suppose it's very regimented because we come in at half past seven and say I'm doing water jugs, I will do them and I know they have to be taken back out by ten past eight because the nurses are taking the tablets around. And then I'd come back, restock the trolley for teas and breakfast because I know that has to be out by twenty past eight, so we can collect it in, wash it up and do the menus before we go for our break. And I'll come back from the break, probably do the teas, then start me cleaning and I know that has to be done before half past eleven so I can hand out the trays for lunch, then go probe the meal and*

serve the meal for twelve o'clock, make sure everyone's fed before one o'clock to collect it all back then go home.

That said, as we commented earlier, certain individuals did innovate in the tasks that they chose to do and the timing of these tasks, thus breaking through the structural constraints associated with the role. We comment below on some of the variation in the role that emerged from the data and seek to trace the source of this variation.

Variations in tasks associated with the role

The more subtle variation in the work undertaken by this support worker role related to the following factors:

- Who manages the role?

  In North, housekeepers were managed by Estates and Facilities rather than the ward manager as in South and Midland. There were many difficulties reported by the ward managers in North about this arrangement:

  Ward manager_North: I think that, if you, she does her job, you know, "Let's look at this bit, let's take a look at thi"s… But I've got to go back to her manager and say, "She's done that room but I've asked her to go back and do a little more" and it's, "No I've done that room. I'm doing that." And if you point out errors, so I've got to go back and that's the frustrating part of doing that.

  The relationship with the manager and the extent to which the manager monitors and motivates the housekeeper is a source of the variation in housekeeper work practices that we found.

- The nature of meal provision.

  In North, HKs collected frozen meals from a central point and a key aspect of their work was checking the meals were thoroughly cooked by testing the temperature of the food.

  In South (the teaching hospital), catering and cleaning are outsourced and meals come to the ward plated up on hot trolleys. The SHKs oversee the distribution of meals that are taken to patients by employees of the outsourced company. SHKs in the DGH site in this case had a more active role in the food distribution as the catering was in-house. Indeed, the move to dishing up from pre-plated has allowed the SHKs to improve the presentation of the food and made it easier to control portions.

  The food distribution system is therefore another explanation for the variation in the role work practices.

- Policy and practice relating to housekeepers feeding of patients.

In Midland, policy with respect to the feeding of patients was confused. None of our housekeeper interviewees had been trained to feed however:

HK_Midland: The situation is if there's no auxiliary and there's a patient that needs feeding you will do it.

HK_Midland: Hostesses don't have hands; they do not have patient contact.

Yet we saw examples of HKs feeding patients at this site.

In North, housekeepers were advised not to have physical contact with the patients and this proved to be a source of frustration to HCAs and HKs:

HCA_North: Even if a person can feed themselves and they just need pushing up, they won't even push them up. They'll just put it on the table and leave it.

HK_North: Its frustrating when patients ask you to get involved with things that you can't get involved in… it seems stupid that a patient has to wait until you can find a nurse.. .their dinne'rs nice and hot then gets cold.

The tolerance of the ward team towards the housekeepers helping out with feeding, (despite ambiguity in policies in this area), is another explanation for the variation in role practices we found.

- The policy with respect to splitting the cleaning and catering responsibilities associated with the role.

  In North, the housekeeper role we studied recently split the duties in relation to cleaning and food. This change was driven by the desire to reduce cross-contamination of food and cross-infection. In our observation work on this site we observed differences in how the two housekeepers that worked together split their tasks for serving food and drink and cleaning i.e., specialisation in the cleaning or catering aspect of the job; alternating the cleaning and catering aspect of the job on a weekly basis; working separately or as a team. In South and Midland, such a regimented split was not in operation.

- Individual agency.

  In Midland we witnessed several differences in the catering practice of housekeepers. In one ward the housekeeper provided a hot drink with breakfast, in another ward, the drink was prepared as a separate activity after the serving of food. In one ward the housekeeper checked patients' preferences for further meals before giving out breakfast, in another ward, they did not check for preferences and left the patient to sort meal choice out alone. Finally, some housekeepers took clutter away from the patients' table, in contrast to another ward where the HCA did this. Had we been able to do more observation, it is probable that more examples of individual agency impacting on practices would have been found.

- The creation in the Trust of dedicated discharge clean service.

  In North, a separate in-house team is called upon to carry out discharge cleans and this impacts on the type of cleaning required by the housekeepers. In South, SHKs provide outsourced (terminal cleaning

team) with information. The existence of such a service changes the rhythm and pattern of the housekeepers' cleaning duties.

- Banding of the role.

  As discussed earlier, the Band 3 SHK role was more of an overseeing role and had specific responsibilities for ordering of equipment and stock and terminal cleaning. This added more variety to the role and impacted on its shape. These additional responsibilities involved new relationships being formed with other work groups in the NHS beyond the ward.

The housekeeper view of the role

Our sample of housekeepers regarded their role as providing relief for HCAs and nurses; a common comment is echoed in the quote below:

> *HK_Midland: It releases time for others [especially for HCAs and nurses] to carry out their work.*

Many of our sample also spoke of the role providing value to patients.

> *HK_Midland: Well we offer them [the patients] a lot of emotional support, some of the patients you know, I mean I've had quite a few tearful patients that you can go and sit with them hold their hand and comfort them.*

Housekeepers also saw themselves as providing useful information on patient well-being for the nurses and HCAs.

> *SHK_South: It is a source of information about the patient well-being – another pair of eyes.*

> *HK_Midland: When I first started the nurses told me that I was probably the most important person there because the patients don't, you know they haven't got to pretend they're better to go home.*

HKs reported that patients would often tell them things they would not tell the nurses.

> *HK_North: They tell us their life stories… we probably know more about them than some of the nursing staff.*

> *HK_Midland: Well we go around and we feed them and give them something nice to eat and drink. We are not the vampires who take blood.*

Common responses about what housekeepers most enjoyed about the job included:

- Patient contact
- Feeling valued and helping
- Keeping the ward clean and helping keep down infections
- Flexibility.

Common responses for least enjoyed included:

- Being a ‘gofer’ and not valued
- Dealing with bodily fluids
- Being short-staffed
- Aggressive patients
- Dealing with the outsourced catering and cleaning company in South
- Lack of clear guidance and communication from ‘management’.

What housekeepers would like changed about their role

Most of the housekeeper interviewees loved their job:

SHK_South: I love my job and I would not go back into nursing because I feel I’m more involved in patients doing what I’m doing.

There were some suggestions for how the job could be improved:

- More cleaning staff
- Ensure the board is accurately updated for patient information especially relating to feeding.
- Sort out the frustrating things associated with the catering arrangements
- The possibility of doing overtime
- Being able to manage housekeepers (cleaners) more directly
- Clarifying the job description:

  SHK_South: I think this is where the problem comes. Just the words ‘ensure that the housekeeping is done’ can be read in two different ways. Its being read by matron as saying ensures that it’s done, so delegate, and facilities think it’s done so get on and do it.

- To assist with the feeding of patients.

Management of housekeepers

Most interviewees across the cases spoke of induction not equipping them for work on the ward. Appraisals were rare for this group and were not reported as regular.

There did not appear to be a systematic approach to training. Notably SHKs in South were ‘noticeably’ more satisfied with the training they received. SHKs appeared to have a stronger group identity than HKs studied in the other two cases, reporting regular meetings occurring with other SHKs.

Consequences

We explored the consequences of the housekeeper role for HCAs and nurses in our interviews. Across all the cases, the role appeared isolated and very separate from HCAs and nurses. The main area of overlap was the passing

on of patient information particularly with respect to patients' feeding requirements or changes in their feeding status. Other areas of overlap were associated with helping out HCAs with bed making and feeding duties.

In South, SHKs spoke of overlap with HCA work in relation to stocking up, trolley cleaning, bed making and, if the ward was really busy, feeding of patients. SHKs in South who were previously HCAs reported finding it difficult not to help as a HCA would. Two spoke of trying to convince their sisters to help out with HCA work:

> *SHK_South: This is my argument at the moment, say I come in the morning and say a couple of nurses have phoned in sick and you've got five patients to get in. I've done my immediate job, and then surely it's better for me to admit a couple of patients, which then releases the nurses to do the clinical jobs. Or say at lunchtime someone venflons tissued so they need a new one putting in. Instead of bleeping a doctor and waiting 40 minutes why can't I slip one in but because of my job role and insurance I can't do it.*

In South, there were mixed views on the value of the Band 3 role for HCAs and nurses. For some interviewees, the role was 'irreplaceable'; for others its value was questionable.

> *Ward manager_South: I think it's overpaid. It depends on who does the role. A lot of people think her job is to clean. Her role is not to clean. The cleaners are here to clean. Her role is to ensure the ward is clean.*

Resentment tended to stem from the role being a more 'facilitative' than 'doing role'.

In Midland, HCAs who commented saw housekeepers as a great help allowing them to focus on patient care tasks. Ward manager interviewees confirmed the role took pressure off the HCA role and many believed the role could be extended.

North interviewees were also positive about the role:

> *HCA_North: If we did not have them we would have to do it all as well as your normal duties and it does make life easier with them there.*

In Midland and North, many interviewees commented that the housekeeper role appeared to be an increasingly pressured job.

Summing Up

Given our limited data base on this role we are cautious about drawing conclusions about the role. We can say with confidence that the role appears to be significantly shaped by a number of structural factors:

- The nature of the ward and the type of patients and their feeding requirements.
- The staffing on the ward and team arrangements across housekeepers.
- The shift patterns.

- Banding of the role.
- The organisational arrangements for catering and cleaning.
- The food distribution system in operation.

A number of process factors also shape the role:

- The management style and aspirations of the ward manager.

  HK_Midland: So your job starts off as one thing and when you change managers your job changes.

- The quality of the cleaning staff.
- The performance management and training process in existence.
- The ward manager's perception of the role.

  SHK_South: I think it's a good role, depending on the senior ward sister, and I think that's a big thing also depending on the sister's perception of the role. Because on my ward I'm short of a housekeeper I'll pull my sleeves up, I'll do the rubbish, I'll do hot drinks, I'll do dinner. I'll get the mop stuff ready for them and I get stuck in, but that's the way I have always been told. If you work as a team you get more out of them when you need a bit of an extra push. You can go on another ward and their ward sister would say you can't do this, you can't do that and all you get is the housekeeper bitching behind their back saying [the ward manager] never bothered helping us, why should we do extras.

- The understanding of and attitude to the role of other actors.

Finally there are agency factors at work that shape the role. As with our HCAs, qualifications, self-esteem, pre-role expectations and the capacity and desire to innovate, all play a part.

Issues for reflection

The senior ward housekeeper is a Band 3 role. There is mixed evidence about the extent to which this role was valued, although we have highlighted that nurses did value being relieved of the responsibility for reporting and sorting equipment failure. A number of questions are raised from the research with respect to this role.

- What is the distinctive contribution made by the SHK role?
- What work is taken away as a result of this role, from whom, and what are the consequences of this?
- What would be the actual consequences if the role was eliminated?

A second area for reflection lies in the extent to which the role is of relief to HCAs and nurses. We found that generally the role was valued by both groups, and therefore the role did indeed have consequences for the HCA. We therefore draw attention again to the absence of the HCA role in the NHS First Guide (Ibid).

A third area of reflection relates to the consequences for housekeepers, HCAs and nurses if the reporting arrangements with the cleaning staff were altered so that the housekeeper/ward manager were more formally involved in directing this service. It appears from our data that the ward managers who did not have responsibility for housekeepers as part of the delivery team were frustrated and believed that performance in this area would be improved if they had more direct control.

A final reflection concerns the possibility of extending the role:

- Could the role be usefully extended and training be provided to include involvement in feeding and bed making? These were the areas where further relief could be given to the ward team.
- The data suggests that very few housekeepers in our sample saw the role as an apprentice role, nor wanted to move into an HCA role because of the increased workload and a belief that the extra pay for carrying out such tasks was not a sufficient incentive.

Appendix 2 Locus of support and the 'good' HCA

General perceptions: the locus of support

Asked in general terms to describe the role of the HCA, interviewees unsurprisingly responded in a variety of different ways. For example, some went straight into the detailed tasks performed by the HCA. However, most of the respondents offered a summary definition in terms of the core purpose of or rationale for the HCA. The HCA was presented in one or more of the following ways:

- a nurse support;
- a patient support;
- a team support.

The emphasis placed on these options varied somewhat by actor: nurses were more inclined to view the HCA as a nurse support; HCAs were more likely to place weight on their role in supporting the patient; and ward managers often stressed the HCA's role as a team member.

The selection of quotes below indicates how HCAs, nurses and ward managers placed differing degrees of emphasis on the HCA as a nurse, patient and team support.

- Nurse Support:

  Matron_North: I'd say that basically it's about supporting the registered nurse; it's about delivering direct care. It's about, you're delivering the care that the registered nurse has, that that's what should happen. You know, so if the registered nurse would give an assessment and giving some direction about what it is that we need to do while that person's in, plan the care, and the Band 2 role is about delivering that. So if a patient's got a problem with maintaining hygiene needs, then the nursing assistant's role is around supporting that nurse to make sure that that person's hygiene needs are met.

  Nurse_London: To assist the trained nurses in all aspects of things we do. Our girls are very good so, you know, if they get, they will get on with their work, you know, they need, I would say minimal supervision, our Band 3s. They're very, very good.

- Patient support:

  HCA_South: Making people comfortable, fresh, feeding them, you know, and healthcare assistance, health caring really for their health and their care… Well I might be called a healthcare assistant but really, truly I do it all on my own. You know, so I don't really assist, they assist me in a way because I do, it's my job to clean and freshen up patients.

HCA_Midland: It's frontline patient care. You are helping people to do things they can't initially do for themselves.

- Team support:

  Ward manager_North: I think they're, I think they're an important part of the team. They might not think they are sometimes but I think they're what you like to think of as, that they're the ones that are going to stay long-term and in a way we should be maybe investing more in to them.

  Ward manager_London: They're a fairly valuable member of our team actually are healthcare assistants, because… patients being quite depending but also can be very sick as well, you know, they're very, oh how can I put them into words really?

The 'good' HCA

In exploring the nature of the HCA role, HCAs, nurses and ward manager interviewees were asked an open question about the qualities they felt a 'good' HCA needed. This question was also raised in the patient focus groups.

Table 30. The 'good' HCA (%)

	HCA (n=72)	Nurse (n=49)	Ward mgr (n=27)	Total (n=148)	Patient focus groups
Caring/compassion	58	35	37	47	✓
Communication	26	31	30	28	
Team orientated/flexible	24	20	44	26	
Enjoys/ motivation/committed	24	18	44	26	
Friendly/ approachable/listens	21	18	33	22	✓
Patience/ tolerance/empathy	26	16	4	19	✓
Knows limits/follows instructions	10	20	22	16	✓
Initiative	8	22	11	14	
Sense of humour	14	8	19	13	✓

Table 30 sets out a summary of responses by stakeholder group and highlights a number of points:

- Caring and compassion was the most frequently mentioned features of the 'good' HCA. They were cited by patients and by well over half of the HCAs; they were also the most commonly mentioned features amongst nurses. They were frequently referred to by ward managers, although, interestingly, other features were rated more highly (see below).

- Communication was also rated highly, particularly amongst nurses and ward managers.
- Ward managers placed particular emphasis on HCA commitment and flexibility.
- Some features highlighted by HCAs were seen as much less important by other stakeholders: for example, while HCAs placed some weight on patience, tolerance and empathy, these were less likely to be mentioned by nurses and hardly at all by ward managers.
- Finally, nurses were more likely to cite the importance of HCAs knowing their limits, following instructions and using their initiative. These are qualities significantly influencing how nurses related to HCAs but reveal an interesting tension between the nurse seeking HCAs who remain focused, and the nurse wanting HCAs who can work with greater discretion.

Appendix 3 Interview schedules

Support worker

General background

Can you tell me about what has happened to you since you left school?

[Educational/career/domestic history, check details on pro forma/press on firm dates/nature of past work]

How long have you been a HCA? How long have you worked at this Trust & on this ward?

What hours do you work as a HCA? What is the pattern of your shift working & do you work overtime?

[Ask for an explanation of their working pattern especially of part-time]

Getting into the job

Why did you become a HCA, what attracted you to the job?

How did you become a HCA?

[How did you hear about the job, how did you apply, were you interviewed & by whom?]

What training courses have you been on in connection with your job?

[Induction? What courses, when & usefulness? NVQs?]

How well prepared were you to do your job? What else would have helped when you started your job, and since then?

Carrying out the job

Have you seen a full copy of your formal job description?

What do you see as the purpose or role of the HCA?

[Has it changed since you've been here?]

How is work organised on a shift and what do you think of the way work is organised

[Could it be done better? Does it cause you any problems?]

What tasks and activities are you involved in as a HCA?

[Weighting of activities in typical week, do they specialise?]

What would be the current balance between these three aspects of your role: direct care, technical & admin?

Have your tasks and activities changed since you've been in post?

[If so, how and why?]

How does your role differ to that of a nurse?

[Are there tasks that only a nurse could do?]

Are there tasks you could do but aren't given/allowed to?

Are there tasks that you do but don't feel properly equipped to do? What do you do/would you do in these circumstances?

What do you think makes a good HCA?

What aspects of your job do you enjoy most and least enjoy?

Are there any unpleasant aspects of your work?

[If yes, how do you feel about having to deal with these unpleasant aspects and how do you cope in dealing with these aspects?]

Of all the bodily fluids you have to deal with which one causes you the most problem?

Have you ever hand to deal with a dead body? Does it cause you any problems?

Have there been any aspects of the job you didn't expect when you started?

[Has it been better or worse that you expected?]

Relationships

Do you feel yourself to be a full member of the ward team?

[If not, why not? Do you have a voice in the running of the ward? (Check here whether they always attend handover meetings, team meetings and MDT meetings)]

Have there ever been any instances when you've felt excluded from what is going on in the ward?

Relationships – with nurses:

What kind of working relationship do you have with the nurses?

[Changes? Frequency/nature of contact? Plan together?]

What do you think makes a good nurse?

Do different nurses use and treat HCAs in different ways?

Are there any difficulties in your relationship with the nurses?

[If yes, what would those be, ask for examples?]

Relationships –managers:

What do you think makes a good ward sister?

What kind of relationship do you have with your ward manager?

[Frequency of contact and for what purpose?]

Is your performance formally appraised?

[If so by whom, when, what purpose, how useful? If no, what feedback do you get?]

If you had a work-related problem, who would you talk to about it? Has this ever happened?

Are you fairly paid?

[If not why?]

Relationships – other HCAs:

How do you get on with other HCAs on your ward?

[How do you get on with bank/agency staff?]

Do the HCAs on your ward work in similar or different ways?

Do HCAs ever meet as a group, on the ward or elsewhere?

[If NO, would you like to? Would it be useful? What would you discuss?]

Are you a union member?

[If yes, what union and why did you join? If NO, have you ever been asked?]

Do you know who your steward is? Have you ever gone to the union with any issue?

Relationships – with ward housekeepers:

How would you describe the role? How useful is this role for you? Are there any problems/issues associated with the role?

Relationships – with doctors:

Do you have much direct contact with junior doctors? With senior doctors?

[If yes, give details on frequency/purpose]

How would you describe the quality of your relationship with doctors?

[Levels of doctors, frequency and purpose]

Relationships – with patients:

Do you think patients know whether they are being treated by a nurse or a HCA?

Do you think patients view you differently to the nurses?

[If yes, how and why?]

How personally and emotionally involved do you become with the patient and their condition?

[Do you have to deal with a patient's worries/fears? If yes, how do you deal with them?]

Do you have an example of a patient you became particularly close to?

[When, what condition and why the involvement?]

Who, if anybody, would you go to if you did become upset on a patient-related issue?

What kind of contact do you have with relatives?

[Do you regularly have contact and about what?]

How easy or difficult is it for you to switch off at the end of a day's work?

Do patients or relatives ever directly complain to you about the quality of the care they are receiving?

[If YES] What kind of complaints do they make and have such complaints increased or decreased in volume and/or have they changed in character since you have been on this ward?

In general do you feel patients have become more or less demanding?

Overview

How important is your job to you (i.e. relative to what else is going on in your life)?

Are there any changes/improvements you'd make to your working life given the chance?

[Training, different type of working relationships & activities, personal development, pay?]

What would make you leave your current job?

What are your plans for the future?

[Intention to stay or move on from post, consider nursing, more training?]

Registered nurse

General background & nursing role

When did you join this trust and how long have you been working on this ward?

What are the positives and negatives of working as a nurse in this hospital? And as a nurse on this ward?

Nurses role

Have you seen a full copy of your formal job description?

How would you define the role of the nurse?

How has the nurse role changed in recent years?

Have you found yourself taking on more doctors' tasks and or specialising in recent years?

[Interface between levels of doctor?]

How do you spend your time regarding the balance between different types of activities (i.e. direct care, technical & admin)?

How do you view this current balance?

[Views on any drift away from holistic care]

What do you think makes a good nurse?

How are staff organised in teams for each shift?

[Number of patients per team, would you work within one team or across teams?]

If you had a work related problem who would you go to to talk about it? Has this ever happened?

What makes a 'good' ward sister?

Do patients or relatives ever directly complain to you about the quality of the care they are receiving?

[If YES] What kind of complaints do they make and have such complaints increased or decreased in volume and/or have they changed in character since you have been on this ward?

In general do you feel patients have become more or less demanding?

The HCA role

What do you see as the purpose or role of the HCA?

[Has it changed, and if so how and why?]

Can you provide details of the kinds of tasks/activities the HCA will undertake?

[Have these changed?]

Are there tasks/activities you wouldn't give to a HCA?

[If yes, is the HCA not allowed or unable to do them?]

What do you think makes a good HCA?

How well prepared/able are HCAs to carry out their roles?

If you've worked in another ward, did the number and use of HCAs differ from here?

How does the HCA role differ to that of the nurse?

Your job

What impact does the presence of a HCA have on the way you do your job?

[Are consequences seen as positive or negative – does it make it easier/more difficult?]

Could the HCA be used differently to make your job easier?

[Taking on more HCAs, new or wider tasks?]

Are there activities you'd like to give them but are unwilling/unable to give them currently?

[What and why?]

The relationship

How well do you think the relationship between nurses and HCAs works?

[Are there ways you think it might be improved?]

How do you organise your relationship with HCAs, particularly those you're working directly with?

[Probe on allocation of work, division of labour]

How do you know whether or not to trust an HCA to a do a job for you?

How would you define or characterise a good relationship between an HCA and a nurse?

Does your relationship vary between HCAs?

[Explore why and ask for examples]

What relationship do you have with bank or agency HCAs?

[Is there any difference in the way you work?]

Is it a burden to be responsible for HCA supervision?

Are there any risks associated with the use of HCAs?

[If so, how do you manage those risks?]

Do you have any input into the appraisal (formal or informal) of a HCA?

Are there ever tensions in your relationship with HCAs?

[If yes, explore details]

Other relationships

Do you feel other nurses in the team use HCAs in a similar/different way to yourself?

Is the HCA treated or accepted as a full member of the team?

What kind of relationship do HCAs have with patients?

[Is it different from the one you have with them?]

What, if any, is the distinctive contribution made by the HCA to a patient?

[What is there added value?]

Do you think patients know whether they are being treated by a nurse or a HCA?

How personally and emotionally involved do you become with the patient and their condition?

[Do you have to deal with a patient's worries/fears? If yes, how do you deal with them?]

Do you have an example of a patient you became particularly close to?

[When, what was their condition and why the involvement?]

Who, if anybody, would you go to if you did become upset on a patient-related issue?

Do HCAs talk to patients' relatives?

[What would they talk about, what would you talk about?]

What things shouldn't a HCA talk about to patients' relatives?

[Would they ever talk about a patient's condition?]

Is there anything you think a patient would ask a HCA rather than yourself?

Is there a ward housekeeper role?

If yes, how would you describe their role? How useful is this role for you? Are there any problems/issues associated with the role?

Future developments

How easy or difficult is it for you to switch off at the end of a day's work?

Are there any changes/improvements you'd make to the HCA role given the chance?

[Training, different type of working relationships, different activities, personal development, pay?]

Ward manager

General background

How long have you been in this role – how long at the Trust?

Can you describe for me what your role involves in terms of responsibilities?

How many beds are on the ward?

What are the nature/conditions of the patients?

Has the patient base changed over recent years?

[Details and reasons]

Can you give me a breakdown of the skill mix on the ward?

How is the skill mix determined?

Have skill mix/staffing patterns changed recently?

[Including vacancy and use of bank/agency staff]

What is the composition of the care team in terms of different occupations and roles? How many WTE and actual HCAs are in post?

[Composition changed, if so, how and why?]

What is the size of your budget?

[What is the level of discretion and control over the budget?]

Do you have a distinctive management style? How would you characterise it?

What do you think it takes to be a good ward sister?

Do patients or relatives ever directly complain to you about the quality of the care they are receiving?

[If YES] What kind of complaints do they make and have such complaints increased or decreased in volume and/or have they changed in character since you have been on this ward?

In general do you feel patients have become more or less demanding?

The HCA role

How do you view the role of the HCA?

[What do they contribute?]

How, if at all, and why has the HCA role changed in recent years?

What do you think makes a 'good' HCA?

In general, what activities are they involved in?

[Could they do other activities?]

How is work organised on the ward?

Who decides what the HCA does and how? How do you keep in touch with what HCAs do?

Do HCAs contribute something distinctive to the team, or are they simply another pair of hands?

Where does the boundary between the HCA/nurse lie?

Has the boundary beyond HCA/nurse roles shifted in recent years and where does it now lie?

[Explain any shift in boundaries]

To what extent have nurses/HCAs taken on doctors' roles in your ward?

[Effect on medical hierarchy]

Managing the HCA

How are HCAs recruited?

[Adverts, internally, interviews?]

How easy is it to recruit HCAs?

[Numbers of applicants for posts & their quality, public perception of job]

Do new support workers undergo any induction?

[What does it cover, responsibility for carrying it out, how long does it take?]

How well does induction prepare HCAs for their job?

What is the type of person who becomes a HCA?

[Qualifications, gender, age etc.]

What motivates HCAs?

[A career move into nursing or a manageable/convenient job?]

Who decides the pay and grading?

What are the typical hours of work?

[Level of overtime, unsocial hours, weekend working – at premia rates?]

How many HCAs work part-time?

Who is the HCAs' line manager and who supervises their activity?

Is the performance of HCAs evaluated or appraised?

[Details of procedure and substance]

What is the level of sickness, turnover and absence of HCAs? Is it any different from nurses?

How many HCA vacancies do you currently have?

What is your policy on covering for vacancies & absence?

[Overtime or the use of bank/agency staff]

How do you cope with HCA staff shortage?

[Use of overtime or agency HCAs?]

What is the level of union membership in the team and amongst HCAs?

How do you view the role and influence of the unions at trust and ward level?

Are HCAs fully integrated into the ward?

[Do they attend ward meetings?]

Do HCAs have an effective voice in the running of the ward?

[Any examples?]

Are there any meetings that HCAs are typically excluded from?

What training is made available to HCAs?

[Typically, what training do they commonly undertake? Is it NVQ accredited?]

What factors will determine if training is made available to HCAs?

Is training for HCAs ever restricted?

[Are HCA training requests ever turned down?]

How well prepared/able are HCAs to carry out their roles?

Is there anything else that could be done to prepare HCAs for their roles?

Do wards vary in the numbers and use of HCAs?

[What explains the variation?]

HCAs' relations with others

Do nurses value the HCA role, and if so why?

What do you thing makes a 'good' nurse?

Who is responsible for supervising the HCA?

[How is that supervision organised?]

Are there any tensions between HCAs and nurses?

What are the features/characteristics of a good nurse-HCA relationship?

How do you think patients view the HCA?

[Regarding being treated by a HCA versus a professional?]

How do HCAs affect the nature/quality of the service provided?

Are there risks or dangers associated with the use of HCAs?

[If so, how are they managed?]

If there is anything you could change about SWs what would it be?

[Who they are, what they do, how they interact with others]

How do you see the HCA role developing in the future?

Ward housekeepers

Is there a ward housekeeper role?

How would you describe their role?

How useful is this role for you? Are there any problems or issues associated with the role?

Matron

Personal background

How long have you worked at the Trust?

[How long in post?]

Where did you work before?

Background on clinical area

What are the number of wards in their area and the beds per ward?

What is the staffing per ward:

Staff per shift;

HCA/nurse numbers;

Number of bank/agency staff;

Number of ward housekeepers (if any).

Have there been any noticeable changes in these figures over the last five years (or since in post)?

Who do you report to, and who reports to you?

[Explore reporting relationships]

Do you hold a budget for your area?

[Explore financial management, how much and what is the budget for?]

What influence do you have over skill mix/staff numbers?

Working at the Trust

What is it like working at this Trust?

[Explore good and bad aspects]

Is there a particular Trust culture, if so can you characterise it?

What changes have there been in the general running of the Trust over recent years?

[Explore good and bad changes]

Acquiring HCAs

How are HCAs (SWHKs) recruited?

How easy or difficult is it to recruit HCAs?

What type of person becomes an HCA?

[Qualifications, gender, age, etc.]

What are people coming to this role looking for?

[Career, interesting work, just an income, fit in around kids?]

Have there been any noticeable changes regarding the recruitment and profile of HCAs in recent years?

The HCA role

How would you define the role of the HCA?

[What do they contribute?]

How, if at all, and why has the HCA role changed in recent years?

In general, what activities are they involved in?

[Could they do other activities?]

Who, or what, decides what the HCA does and how?

Who are HCAs supporting: the patient, the nurses, the team?

Do HCAs contribute something distinctive to the team, or are they simply another pair of hands?

What can't HCAs do?

[Not allowed or not able to do]

What distinguishes what HCAs and nurses can do?

Are there protocols which regulate what HCAs can do and how they do it?

Do HCAs work to/for particular nurses/patients?

Has the boundary between HCA/nurse roles shifted in recent years and where does it now lie?

[Explain any shift in boundaries]

What are HCAs good at and what are they less good at?

Are HCAs used differently in different wards or parts of the Trust?

Managing HCAs

Who is the HCAs' line manager, and who supervises HCAs?

What pay bands are HCAs on?

Is the performance of the HCA appraised?

[By who, when and how]

Is there an induction programme for HCAs?

Do HCAs have training/development plans?

[How are they determined?]

What training have HCAs in your wards had?

Are there team meetings at ward level?

[How often and do HCAs attend?]

Impact on HCAs

Are HCAs looking to move into nursing?

[If yes, are they managing to succeed?]

Are HCAs seeking to develop in the HCA role?

What are the levels of turnover and absenteeism of HCAs on your wards?

[Is this higher or lower than for nurses?]

Impact of HCAs on nurses (& doctors)

How do nurses view HCAs?

What are relationships like between HCAs and nurses?

Are there any tensions between them?

Could the relationship be improved, and if so how?

To what extent have HCAs relieved nurses of burdens?

To what extent have they presented nurses with new responsibilities?

To what extent does the use of HCAs undermine the notion of holistic care?

How do doctors view HCAs?

Would doctors deal directly with HCAs?

[When, why, how often]

Impact of HCAs on patients

Are there any risks associated with the use of HCAs?

[If so, how are these minimised?]

How do patients view HCAs?

[Do patients view HCAs any differently to nurses and if so, in what way?]

Are there things that patients are more likely to go to HCAs with than nurses?

[Explore what these might be]

What contribution do HCAs make to the patient's experience?

Is there anything you would change in how HCAs are used, managed or perceived?

Managers

Personal background

Name & position.

How long have you worked at the Trust?

Trust background

Brief history of the Trust

[When was it formed etc.]

What is its current size?

[By workforce, beds and budget]

How has the Trust changed in the last five years?

[Financial wellbeing, workforce, beds etc.]

Where is the Trust located?

[Number of sites and geographical distribution]

How is the Trust structured?

[Number and names of clinical directorates]

What is the Mgmt structure?

[Number and type of directors, board level directors, management committees etc.]

Detailed workforce breakdown

[Numbers in clinical, nurse and support grades]

What are the pressures/factors driving Trust performance/activity?

Does the Trust have a business plan/strategy?

Can you summarise the key goals/objectives of the Trust?

[Impact of performance targets, which ones are driving activity]

Does the Trust have an HR plan/strategy?

[What are the key HR goals/objectives]

Does the Trust have a workforce planning process?

[If yes, how does it relate to regional/national workforce planning? If no, does the Trust come under a regional/national process?]

Is it possible to characterise the Trust's culture?

[What is it like to work here?]

What are the Trust's organisational strengths and weaknesses?

Explore issues of skill mix

[Registered/non registered ratios, where/how these are set, whether they vary by clinical area]

What role, if any, do trade unions play in the Trust?

[Explore relations with unions, joint machinery, quality of relations]

Division & directorate background

Outline the key features of the division and directorate

[Number of beds, workforce size, skill mix ratios, number of clinicians, number of HCAs and Housekeepers]

Is there a distinctive culture at this level?

[i.e. different from the Trust-wide culture?]

Explore general ways of working

[patient journey, protocols]

Who is responsible for: setting skill mix at this level; setting rotas; setting staff levels; recruiting, appraising, training staff?

Explore the use of bank/agency staff

[How many, types of workers, when used, who decides, changes in their use over time]

Are there staff meetings at Division/Directorate/Ward levels?

[How often, who attends, for what purpose?]

Support staff

How do you think support roles fit into the government's agenda for modernising/reforming the NHS?

What kind of people become support workers and how easy is it to get them?

Are they different in any way from other staff, say in terms of links to community, absence and turnover rates?

How does the Trust/Division/Directorate view such roles in terms of the general contribution they make towards achieving the Trust objectives?

What functions do you feel these roles are fulfilling in your Trust/Division/Directorate?

How do you think support workers are viewed by nurses, doctors, patients?

Can support workers relieve professionals of burdens? [If so, what burdens and how]

Is the support worker role the basis for career progression/stepping stone?

Can, or do, support workers substitute for professionals?

Can, or do, support workers 'add value' over and above the professionals' contribution? [What form does this take?]

What, if anything, is new about how support worker roles are being used?

[Has the boundary shifted over recent years?]

Who determines what support workers can do?

Are there things that a nurse cannot/must not delegate to a support worker?

Who are support workers responsible to and who is responsible for what support workers do?

What are the potential dangers and benefits associated with the use of support workers?

[Dangers and benefits for: NHS in general, NHS workforce structure and development, patients, professionals, support workers]

What, if any, systems are in place to manager any danger?

What are your views on the regulation of support worker roles?

[The current situation, pros and cons of regulation, government's agenda on regulation]

How well are support workers treated and prepared for their roles?

[Pay and other terms (pay rates, hours et.), training (what's available including induction), performance appraisal]

What has been the impact of Agenda for Change on support workers?

[Might they be viewed as cheap labour?]

What are the immediate and longer term issues which need to be addressed by the Trust, the government and other Trusts in the management and deployment of support workers.

Any other comments?

Appendix 4 Observation task categories

Definitions

Direct patient care

Tasks that address the patient's basic needs on the ward and involve direct physical contact of a non-technical or specialist nature.

For example:

- Bed bath
- Feeding
- Toileting
- Shaving.

Indirect patient care

Direct patient care that is not of a technical or specialist nature and does not involve physical contact.

For example:

- Making beds
- Serving meals/drinks
- Assisting with discharge/admissions/theatre check lists
- Cleaning around bedside.

Pastoral care

Providing general support to the patient or relative that is unrelated to their physical condition.

For example:

- Reassuring patients/relatives
- Helping confused patients
- Dealing with patients' non-medical queries.

Ward/Team-centred

Tasks that are one step removed from direct patient care, usually occurring away from the bedside and in communal areas.

For example:

- Clerical

- Answering the phone
- Keeping stores stocked
- Handover and updating members of staff.

Technical/specialist care

Clinical/medical tasks and procedures that require training to perform.

For example:

- Monitor/record patient observations
- Blood glucose monitoring
- Dressings and wound care
- ECGs.

Appendix 5 Focus group topic guide

Patient focus group

The support worker (SW) role

Did you come into contact with any SWs while on the ward?

(Probe: who were they, in what capacity)

Did anyone on the ward explain to you the difference between SWs and nurses?

(Probe: who told you, at what stage in your stay, how did they explain the difference?)

Were you able to spot who were SWs and who were nurses?

(Probe: how? different uniforms, different jobs, different shifts?)

How do you see the role of SWs?

(Probe: How would you distinguish it from that of the nurse?)

What has been your experience of SWs?

(Have they been helpful/unhelpful; efficient/inefficient?)

If you've been in hospital before, has their role changed in recent years?

(Probe: how?)

What are the +ves & -ves of being cared for by SWs in this hospital?

(Probe: Are they easier/less easy to talk to than nurses? Are they more accessible/less accessible than nurses? Do they have more time/less time than nurses?)

Can you provide details of the kinds of tasks/activities that were provided to you by SWs?

(Probe: bathing, feeding etc)

Were there tasks/activities provided by a SW that you were unhappy about?

(Probe: why? Did they do them badly? Did you think they should have been done by someone else?)

What makes a good SW?

(Probe: How is it different from what makes a good nurse?)

Are there tasks that SWs do particularly well and tasks they do less well?

(Probe: why? Are there tasks/activities you'd have liked SWs to carry out – what, why?)

If you've had a stay in another hospital, did your experience of SWs differ?

(Probe: in what way?)

What kind of qualifications and training would you expect a SW to have?

Your care

Were you cared for by hospital staff in the way you expected?

(Probe: better or worse)

How confident were you in the doctor/nurse/SW that cared for you?

(If not, then why not?)

Did the doctors/nurses/SWs ever talk in front of you as if you weren't there?

In your opinion, were there enough nurses on duty to care for you in hospital?

Did you ever get contradictory information about your treatment or care from nurses and SWs?

What difference do you think it made to your care having SWs on the ward?

(Probe: can you illustrate?)

Support workers on the ward

How would you describe the relationship between nurses and SWs on your ward?

(Probe: equal, hierarchical, friendly, difficult?)

Do you think the SW is treated or accepted as a full member of the care team?

Did you view being treated by a SW as any different to being treated by a nurse?

Generally, how well do you think SWs are treated?

(Probe: by doctors, nurses, patients?)

Future developments

Is the ratio of nurses and SWs on the ward right?

(Probe: If not how should it be changed?)

Could SWs be used differently to improve quality of care in your hospital?

Are there any changes/improvements you'd make to the way SWs are used given the chance?

Any other comments you'd like to make about the role of the SW?

Appendix 6 Action research

Our approach

Following the collection of data by the research team, participants at three of the case study sites (South, Midland and London) were invited to take part in an action research project. The principle behind this action research element was to offer each case site an opportunity to work with a range of stakeholders including patients and staff from a variety of roles. By building on the evidence gathered in the research, it was anticipated that case sites would focus on an issue for improvement relating to the role of support workers. The hope was that it would be possible to work with each of the sites to make a measurable difference.

Discussions were held at each of the three case study sites, either directly after, or towards the end of the research gathering process to highlight the key issues arising from the study and other relevant evidence that the Trust had previously gathered.

Staff at each case site were give the final decision relating to the focus for the action research, the only requirement the research team had was that the work had to involve and centre on the role of the support worker.

Members of the research team then worked in partnership with Trust staff to scope and implement each of the projects. An overview of each project is highlighted in Table 31.

Overview of action research projects

Each of the action research projects centred on the evaluation of a training intervention for support workers although the purpose, nature and duration of the training varied between the different case study sites. A training intervention emerged as the best means of exploring the 'before' and 'after' effect of an HCA-related initiative given the time and resource available.

Lessons learnt

It can be seen from the Table that all of the action research projects related to the implementation of training courses for hospital support workers, delivered in slightly different ways: in South a workshop; in Midland a residential away day and in London an extended modular programme. The training programmes in Midland and London were successfully evaluated and highlighted key areas for the Trusts to focus on to improve and spread learning for the future. In Midland these areas related to HCA communication and to constructively challenge. In London they were linked to the development of an EDT role, a broadening of the HCA role in A&E to take on more advanced tasks *inter alia* to improve patient access and

throughput. The training session in South resulted in the development of ward-based customer care standards.

Table 31. Action research projects

Trust	Focus	Approach	Outcome
South	- Audit of communication and customer service - Training to improve communication and customer service	- Focus group with patient panel - Baseline audit of communication and customer service- ward based observation and patient survey - Support in delivery of half day customer care training workshop	- Half day training delivered to group of staff - Feedback from action research incorporated into training - Training session used by hospital staff to develop set of customer care training standards
Midland	- Evaluating impact of residential training course for HCAs- focusing on communication and constructive challenge skills	- Two day residential course - Pre and post course surveys - Follow up focus group	- Training course evaluated positively by participants - Improved levels of confidence reported - Examples of successful constructive challenge reported - Progress with personal objectives set at training - Some examples of new ways of working implemented - Recommendations for future networking opportunities and future training for other staff
London	- Evaluation of Emergency Department Technician Training Programme	- Eight month training programme - Pre course survey - Focus groups throughout course of training with participants - Survey of A&E staff to assess impact	- Ongoing

The action research projects were originally intended to provide an opportunity for the Trusts to build upon evidence from the case study research undertaken. The hope was that participants would use the findings as a basis for a service improvement or a redesign project in collaboration with staff and patients. In practice the case sites preferred to use the action

research component of the project as a vehicle to help solve outstanding problems and facilitate pre-determined projects which were already under consideration. It may have been helpful to be more prescriptive from the start about what was expected from the action research, in particular the requirement for collaborative working with patients and staff and the need to focus on projects with a service development angle.

Given the overall timetable, there was a limit on the time available between the delivery of research findings and the need for the sites to make a decision on the focus for action research projects. Providing a longer lead-in time may well have helped them to fully digest and discuss the implications of the research data in collaboration with a range of stakeholders from across the trust before deciding how to proceed. Requesting an opportunity to share the details of the research with a wide cross-section of staff may well have helped to generate more creative discussions on the choice of topic.[16]

Each of the projects outlined above had resource implications for the Trusts. Inevitably this has an impact on the ability to effectively embed and sustain the intervention more widely within the organisations. Service redesign projects may well have offered an opportunity to implement cost-neutral or cost-saving interventions rather than those that require ongoing or long-term investment.

We know from existing work on the challenges of getting research into practice in complex organisations like the NHS that a number of factors make this difficult, notably the fact that different professional groups have very different views of what constitutes robust evidence for change, and professional groups find knowledge-sharing difficult because they often learn as uni-professional groups. If action research interventions are to increase their impact, then a major analysis is needed of the context in which the intervention is occurring in order to tailor the intervention appropriately. Such an analysis needs to include: the strength of senior management support; identification of the key opinion leaders who can drive the change; available resources; the incentives and disincentives for the people involved to make the change happen; and finally, who has the power to convene relevant conversations amongst the stakeholders. In future, the SDO's initiative on translational research led by Huw Davies will yield additional knowledge that will be useful for action research efforts such as the one we undertook.

[16] Note the research findings were shared with the sponsors of the research in each site.

Recommendations

The lessons learnt highlight a number of recommendations for any future projects of a similar nature. These include:

- Manage expectations effectively. Be clear from the beginning that the action research is about designing, implementing and evaluating an intervention in collaboration with key stakeholders.
- When introducing the concept of action research, carefully articulate the anticipated process and the need to draw upon the earlier research findings as a basis for the project.
- Ensure that Trust-based teams engage a cross-section of staff in the design and implementation of the action research project.
- There is clear value in linking action research to broader research findings. However, allow sufficient time for Trusts to receive and absorb research findings before choosing an area for the action research and ensure that the action research element is sufficiently resourced
- Be more explicit about the opportunity to broaden the focus of the action research beyond just the support worker role.
- Support Trust teams in the ability to differentiate between the research and action research elements of the study.
- Clarification that this opportunity is to help facilitate a service development/redesign project and not just to carry out more research.
- Encourage Trusts to think creatively about project focus and to consider approaches that may not have a large resource requirement thereby increasing the likelihood of long term sustainability.

Appendix 7 Survey method and administration

Questionnaire design

Drawing upon our extensive fieldwork from our case study Trusts, three questionnaires were developed. The key themes and issues that emerged from our qualitative work were used to develop a core of questions that related to the role of HCAs.

Drafts of all three surveys were sent to our advisory panel and to senior managers at the Trusts themselves. Detailed and useful comments were received from unions, professional bodies, academics and NHS managers. Revised surveys were piloted amongst target groups at two of our Trusts.

A model that guided development of the questionnaires is available in Appendix 8, copies of the questionnaires can be found in Appendices 9-11. The model sets out which HCA and nurse questions relate to the three primary questions the surveys were designed to address: who takes up the HCA role; what do HCAs do in their role; and what is the impact of the role. Ambitions for the patient survey were scaled back after focus groups revealed fundamental issues with recognising and understanding the role of HCAs on the wards. With patients reporting difficulties in appreciating the difference between HCAs and registered nurses, it was decided that this issue of recognition had to be the central issue addressed in the patient survey. It was judged that a more detailed and wide ranging patient questionnaire on the HCA role could have resulted in a reduction in the quality of data due to these issues of (mis-) identification. In contrast to the HCA survey (12 pages) and the nurse survey (eight pages) the patient survey was designed as a four page instrument tackling background information, assessing whether patients could identify HCAs, and if so how. For those who reported care by HCAs during their stay, a suite of questions on the care they received was also included.

Sampling

Sampling for the patient survey was informed by the Care Quality Commission's (CQC) process set out for use in the National Inpatient Survey Programme: so in each of our four Trusts we sought a sample of 850 patients with at least one overnight stay and selected retrospectively from a set discharge date. To achieve the 850 sample a two stage procedure was operationalised. The first stage involved setting an agreed discharge date with the Trusts and working back no further than two months from this date. In this stage all patients were included who had been discharged from our general medicine/surgery case study wards where fieldwork had been carried out. To complete the sample of 850 the second stage involved taking a random selection of patients from wards within the same clinical divisions. Once complete the sample was sent to the NHS Strategic Tracing Service to ensure no recently deceased patients were

included. For all subsequent mailings the sample was also checked against Trust records to further remove any newly deceased patients.

Again following the CQC's approach to survey sampling, we sought a combined sample of 850 staff for the HCA and nurse surveys in each of our Trusts. Variation existed between our Trusts due to the different workforce sizes. In all Trusts a census of HCAs and registered nurses on our case study wards were included in the sample. Where the size of the workforce allowed, the remainder of the sample entailed a random selection of HCAs and registered nurses from the case study hospital sites.

Survey administration

Questionnaires were distributed during the late spring and early summer of 2009.

Each mailing of the HCA and registered nurse staff survey consisted of a copy of the survey, a signed cover letter introducing the research and a reply-paid envelope. The survey packs were sent to the Trust post rooms for internal distribution. Two further mailings at three weeks apart were sent to those who had not responded.

As with the staff surveys, the mailing for the patient survey also consisted of a copy of the survey, a signed cover letter and a reply-paid envelope introducing the research. Additionally a language sheet for those respondents who wished to answer the survey in their native tongue was also included. The cover letter reassured patients that the survey was anonymous, entirely voluntary and that individual results were confidential.

All potential respondents were provided with a freephone telephone number to discuss any concerns or requests for further information that they may have had.

The first of three mailings of all questionnaires was distributed on 20th April, 2009, with the exception of one Trust where the construction of the patient sample frame was delayed and subsequently only two mailings were distributed. There was one further administration issue that negatively impacted the response rate at one of our case study Trusts where the first mailing of the HCA and nurse surveys was only distributed to one of the two hospital sites and the third mailing failed to be delivered at all.

Survey response

Full details of the survey response are given in Table 32. The combined overall response from Trusts was positive: 51% of HCAs, 41% of nurses and 51% of patients chose to respond. This represents a very good engagement with an independent research survey programme that had limited promotional opportunities.

Table 32. Survey response by case study Trust

Trust	Survey	Sample	Ineligible[a]	Opted out	Returned	Response[b]
Trust 1	HCA	381	9	9	198	53.2%
	Nurse	469	13	5	227	49.8%
	Patient	836	18	32	379	46.3%
Trust 2	HCA	443	0	24	235	53.0%
	Nurse	384	0	8	156	40.6%
	Patient	850	52	25	449	56.3%
Trust 3	HCA	391	0	6	163	41.7% [c]
	Nurse	459	0	3	130	28.3% [c]
	Patient	850	32	41	415	50.7%
Trust 4	HCA	253	4	8	149	59.8%
	Nurse	400	5	8	175	44.3%
	Patient	850	23	34	408	49.3%
All Trusts	HCA	1468	13	47	746 [d]	51.3%
	Nurse	1712	18	24	689 [d]	40.7%
	Patient	3386	125	132	1651	50.6%

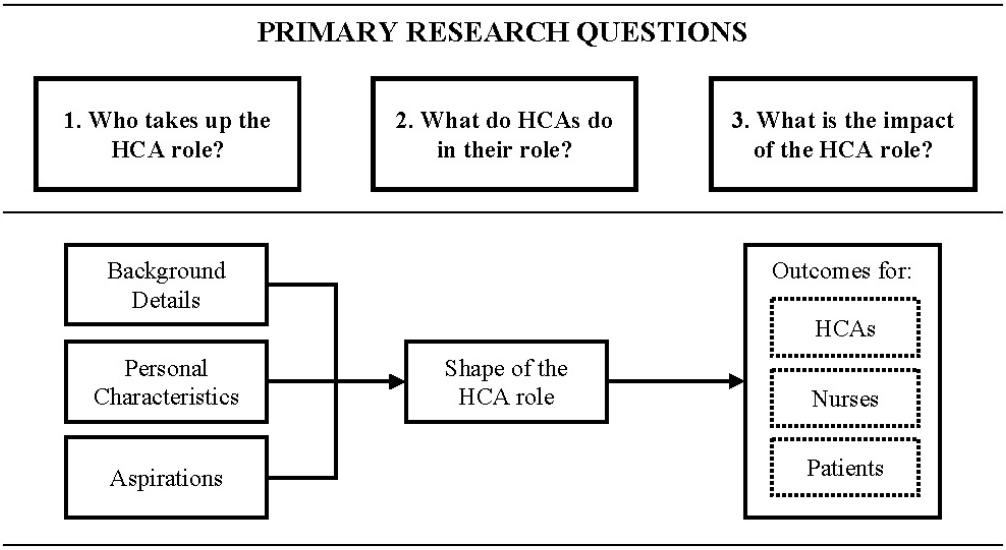
[a] i.e. questionnaires returned as undeliverable, patient deceased or staff member on maternity leave.

[b] Response rate is calculated as: Response = completed questionnaires / (sample - ineligibles).

[c] The first mailing for one hospital site and the third mailing for both sites were delivered to the Trust but not distributed, resulting in a lower response compared to other Trusts.

[d] Includes a respondent who removed the barcode from their questionnaire and cannot be linked to their Trust.

Appendix 8 Survey model



Research Question	Survey Measures	HCA Survey Questions	RN Survey Questions
1. Who takes up the HCA role?	***Background details***		
	Career history	1-3, 13-16, 18, 20	11-14
	Age, gender and domestic circumstances	24-27	18-21
	Community and cultural background	29, 33	23-24
	Education & training	7, 30-32	16-17
	Economic position	19, 28	15, 22
	Personal characteristics		
	Self-esteem	23	10
	Propensity to extend the role	8	-
	Caring behaviours	11	8
	Aspirations		
	Pre-role aspirations	17	-
	Future aspirations	21	-
2. What do HCAs do in their role?	***Shape of the HCA role***		
	Tasks carried out by HCAs	4-6	5-6
	Tasks carried out by registered nurses		4
3. What is the impact of the role on HCAs, nurses & patients?	***Outcomes***		
	Job satisfaction	12	-
	Role value	10	7, 9
	Co-production value for patients	10	9
	Role boundary & tensions	9	7
	Intention to leave	22	1
	Managing HCAs	-	1, 2-3

Appendix 9 HCA questionnaire

oxford
SAID BUSINESS SCHOOL

The Working Lives of Healthcare Assistants

What is this survey and why are we asking you to complete it?

This is an independent survey of your experience working on a hospital ward. The healthcare assistant (sometimes called clinical support worker or nursing auxiliary) is a vital role in the NHS. The survey is designed to help understand who becomes a healthcare assistant, what work they do and how the role impacts upon the healthcare assistants themselves, the professionals they work with and the patients they care for.

Why should I complete the survey?

This is your opportunity to express your views in **confidence**. Your opinions are very important. The anonymous research results will be made available to your trust management, policy makers and government so allowing your views to inform how the role develops in the future.

Who is carrying out the survey?

The survey is being carried out by researchers at the University of Oxford, as part of a research project funded by the NHS Service Delivery and Organisation R&D Programme (SDO). Further information about the research is available on the project website:
http://www.sbs.ox.ac.uk/research/supportworkers/

How to complete this survey?

Please answer the questions as fully as you are able by placing a tick in a box, circling a number, or writing in the spaces provided. There are no right or wrong answers.

Who will see my answers?

Your answers will be treated in complete confidence. The survey findings will be presented in a summary report in which no individual, or their responses, can be identified. The bar code/number below is only used by the researchers to identify which staff should be sent a reminder and will not be available to staff at your Trust.

Questions or help?

If you have any queries about the questionnaire or need any help to complete it, please call Paul Heron on FREEPHONE 0800 9150509. The line is open between 10am and 4pm Monday to Friday.

Please return this questionnaire, in the FREEPOST envelope provided, to:

FREEPOST
Oxford Support Worker Research
Wembley
HA0 4PE

BARCODE

The NHS uses many job titles to refer to the role of a support worker who, as part of the ward team, works alongside a nurse in providing patient care: e.g. clinical support worker, auxiliary nurse and nursing assistant.

Questions in this survey use the title **HEALTHCARE ASSISTANT** or **HCA** to refer to this support worker role.

YOUR WORK HISTORY

Please remember that this information is confidential and no one in your organisation will see your individual results.

1. Since leaving school, and before working in this hospital, where else have you worked on a permanent basis (either full or part time)?

Please tick all that apply

A. Health care (e.g. GP practice, community hospital)..... 1 ☐ Yes 2 ☐ No

B. Social care (e.g. residential care home, home help)..... 1 ☐ Yes 2 ☐ No

C. Education and child care (e.g. a school, nursery, childminding)..... 1 ☐ Yes 2 ☐ No

D. Voluntary or unpaid charity work..... 1 ☐ Yes 2 ☐ No

E. Retail (e.g. shop work, hairdressing)..... 1 ☐ Yes 2 ☐ No

F. Manufacturing (e.g. factory work, assembly line)..... 1 ☐ Yes 2 ☐ No

G. Leisure (e.g. pub, restaurant, leisure centre)..... 1 ☐ Yes 2 ☐ No

H. Finance (e.g. a bank, insurance)..... 1 ☐ Yes 2 ☐ No

I. Utilities (e.g. gas, electricity, water)..... 1 ☐ Yes 2 ☐ No

J. Full time carer at home (e.g. looking after own children or relatives)..... 1 ☐ Yes 2 ☐ No

K. Other: **please specify** ..... 1 ☐ Yes 2 ☐ No

.....

2. Before working as a healthcare assistant at this hospital, which of the above was your last job?

Please put the corresponding letter to your last job in the box below. For example, if your last job was working in a school you would put the letter 'C' in the box.

☐

3. Approximately, how many jobs have you held since leaving school and before becoming a healthcare assistant at this Trust?

☐

Project 08/1619/155

YOUR TASKS AND RESPONSIBILITIES

4. Below is a list of some of the tasks and responsibilities that a healthcare assistant can do on a ward. On average, how often do you carry out the following in your current role?

Please circle one number 1 – 5 for each task and responsibility

Never	A few times a **year**	A few times a **month**	A few times a **week**	Every **day**
1	2	3	4	5

A.	Bathe a patient	1	2	3	4	5
B.	Feed a patient	1	2	3	4	5
C.	Make a bed	1	2	3	4	5
D.	Distribute meals	1	2	3	4	5
E.	Collect medicine from the pharmacy (TTO)	1	2	3	4	5
F.	Escort a patient to another ward or theatre	1	2	3	4	5
G.	Keep stores stocked	1	2	3	4	5
H.	Monitor/record a patient's observations	1	2	3	4	5
I.	Monitoring a patient's blood glucose (i.e. 'BM' or blood sugars)	1	2	3	4	5
J.	Carry out a simple dressing	1	2	3	4	5
K.	Take a blood sample from a patient	1	2	3	4	5
L.	Carry out female catheterisation (i.e. insertion)	1	2	3	4	5
M.	Carry out a complex dressing (i.e. involves 'packing')	1	2	3	4	5
N.	Carry out an ECG	1	2	3	4	5
O.	Carry out a cannulation	1	2	3	4	5

5. Which of the above tasks and responsibilities do you **enjoy** carrying out the most?

Please put the corresponding letter for each task and responsibility in the boxes below

Most enjoy ☐ 2nd most enjoy ☐ 3rd most enjoy ☐

Project 08/1619/155

6. In general, do healthcare assistants on your ward carry out the same range of tasks to yourself?

1 ☐ Yes 2 ☐ No

7. Have you been trained to do more complex tasks (e.g. taking blood, cannulation, ECG)?

1 ☐ Yes 2 ☐ No

If YES, please answer the following; If NO go to Question 8

a. Since your training, have you had the chance to carry out any of these more complex tasks?

1 ☐ Yes, most days 2 ☐ Yes, a few times a month

3 ☐ Yes, a few times since training 4 ☐ No

8. To what extent do you **agree or disagree** with the following statements? Where reference is made to complex tasks these include activities that require training, for example taking blood, cannulation or ECG.

Please circle one number 1 – 5 for each statement

	Strongly disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly agree 5
There are career opportunities for me at this Trust	1	2	3	4	5
My potential is not fully realised in my current role	1	2	3	4	5
There are healthcare assistants on my ward who routinely carry out more complex tasks than me	1	2	3	4	5
I would only be happy to take on more complex tasks if I was on a higher pay band	1	2	3	4	5
There are some complex tasks I see other healthcare assistants doing on my ward that I believe I could be trained to do	1	2	3	4	5
I have enough to do in my current role without taking on more complex tasks	1	2	3	4	5
I believe that I have the ability to successfully carry out more complex tasks than I am currently doing	1	2	3	4	5
I am always looking for ways to extend my role	1	2	3	4	5

WORKING RELATIONS

9. To what extent do you **agree or disagree** with the following statements about your ward?

Please circle one number 1 – 5 for each statement

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

A registered nurse will usually answer a patient buzzer before I do	1	2	3	4	5
Newly qualified nurses are often intimidated by me	1	2	3	4	5
It is usually a registered nurse that will empty a patient's commode	1	2	3	4	5
Washing a patient is an important part of my job	1	2	3	4	5
Registered nurses rely on HCAs to do all the 'heavy' work	1	2	3	4	5

10. Below are some statements asking you to compare how you feel registered nurses treat patients on your ward compared to HCAs.

Please circle one number 1 – 5 for each statement

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Compared to registered nurses, HCAs are more likely to:

... notice when patients are in discomfort	1	2	3	4	5
... show concern when patients complain	1	2	3	4	5
... talk to patients in a warm friendly manner	1	2	3	4	5
... be told by patients about their worries and concerns	1	2	3	4	5
... explain what they are doing when working with patients	1	2	3	4	5
... take time to listen to patients when they need to talk	1	2	3	4	5

WORKING WITH PATIENTS

11. Below are some statements asking you how difficult or easy you find it to deal with different aspects of a patient's care. Please be as **honest** as possible remembering that no one in your organisation will see your completed questionnaire.

Please circle one number 1 – 5 for each statement

Very difficult	Difficult	Neither easy or difficult	Easy	Very easy
1	2	3	4	5

How difficult or easy do you find it to:

... develop a close relationship with a verbally abusive patient.....	1	2	3	4	5
... calm a patient who is very stressed about their medical condition .	1	2	3	4	5
... develop a close relationship with a patient whose background is different from your own	1	2	3	4	5
... cheer up a patient who is deeply upset about an aspect of their stay	1	2	3	4	5
... develop a close relationship with a confused patient.....	1	2	3	4	5
... ease any conflict between patients on the ward	1	2	3	4	5
... listen closely to a patient's concerns.....	1	2	3	4	5
... always explain to a patient what you are doing	1	2	3	4	5
... reassure a very anxious patient.....	1	2	3	4	5
... reduce any tension between a patient and a member of staff	1	2	3	4	5

YOUR JOB

12. How satisfied are you with each of the following aspects of your job?

Please circle one number 1 – 5 for each statement

	Very dissatisfied 1	Dissatisfied 2	Neither satisfied nor dissatisfied 3	Satisfied 4	Very satisfied 5
The recognition I get for good work	1	2	3	4	5
The support I get from my immediate manager	1	2	3	4	5
The freedom I have to choose my own method of working	1	2	3	4	5
The support I get from my work colleagues	1	2	3	4	5
The amount of responsibility I am given	1	2	3	4	5
The opportunities I have to use my skills	1	2	3	4	5
The extent to which the Trust values my work	1	2	3	4	5
My level of pay	1	2	3	4	5

13. How did you hear about your current job?

1 ☐ A friend or relative
2 ☐ Local press
3 ☐ Trust or NHS website
4 ☐ Job centre
5 ☐ Other: **please specify** .....

14. Approximately, how long have you worked for this **Trust**?

☐ **years** ☐ **months**

15. Approximately, how long have you worked on your current **ward**?

☐ **years** ☐ **months**

16. How many hours a week are you contracted to work?

1 ☐ Up to 29 hours
2 ☐ 30 or more hours a week

Project 08/1619/155

17. When you started work as a healthcare assistant did you have an ambition to become a registered nurse?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know / can't remember
4 ☐ Already qualified as a registered nurse

18. Which shifts have you worked in the last month?

Please tick all that apply

1 ☐ Early
2 ☐ Late
3 ☐ Night
4 ☐ Other: **please specify** .....

19. What pay band are you currently on?

1 ☐ Band 1
2 ☐ Band 2
3 ☐ Band 3
4 ☐ Band 4
5 ☐ Other: **please specify** .....

20. Are you a member of a union?

1 ☐ Yes
2 ☐ No

21. In terms of the future, which of the following do you **most** want to do?

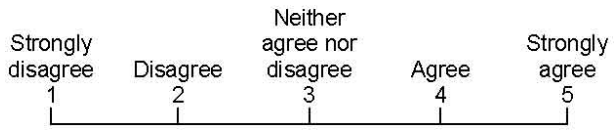
Please tick <u>one</u> box only

1 ☐ Continue in your current job
2 ☐ Train to be a registered nurse
3 ☐ Train to be an allied health or social care professional (e.g. physiotherapist, social worker)
4 ☐ Leave for a job outside of health or social care
5 ☐ Other: **please specify** .....

.....

22. To what extent do you **agree or disagree** with the following statements?

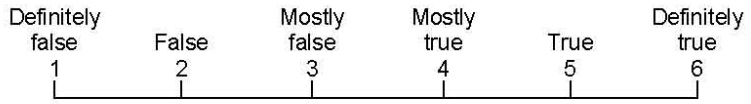
Please circle one number 1 – 5 for each statement



I often think about leaving this Trust	1	2	3	4	5
I will probably look for a job at a new organisation in the next 12 months	1	2	3	4	5
As soon as I can find another job, I will leave this Trust	1	2	3	4	5

23. To what extent do you feel that each of the following statements is a more or less true description of you? Respond to the items as you now feel even if you felt differently at some other time in your life.

Please circle one number 1 – 6 for each statement



I am able to do things as well as most other people	1	2	3	4	5	6
I feel that I'm a person of worth, at least on an equal basis with others	1	2	3	4	5	6
I feel that my life is not very useful	1	2	3	4	5	6
I feel that I have a number of good qualities	1	2	3	4	5	6
I feel that I do not have much to be proud of	1	2	3	4	5	6
I take a positive attitude towards myself	1	2	3	4	5	6
I think I am no good at all	1	2	3	4	5	6
I am a useful person to have around	1	2	3	4	5	6
I feel I can't do anything right	1	2	3	4	5	6
When I do a job, I do it well	1	2	3	4	5	6

YOUR BACKGROUND

Please remember that this information is confidential and no one in your organisation will see your individual results.

24. Are you male or female?

1 ☐ Male 2 ☐ Female

25. What was your age last birthday?

Please put the number of years in the box below

☐ **years**

26. Are you married or in a long term relationship?

1 ☐ Yes 2 ☐ No

27. Do you have any children?

1 ☐ Yes 2 ☐ No

If YES, please answer the following; If NO go to Question 28

a. Are any of your children still at primary or secondary school?

1 ☐ Yes 2 ☐ No

28. Are you the sole or main income earner in your household?

1 ☐ Yes 2 ☐ No

29. Did you attend a local primary school (i.e. within 20 miles of this hospital)?

1 ☐ Yes 2 ☐ No

30. At what age did you leave secondary school?

☐ **years**

31. Did you leave school with any qualifications?

1 ☐ Yes 2 ☐ No

32. Have you attained a National Vocational Qualification (NVQ)?

Please tick all that apply

1 ☐ Yes, NVQ Level 1 2 ☐ Yes, NVQ Level 2

3 ☐ Yes, NVQ Level 3 4 ☐ I have **not** attained an NVQ

If YES, please answer the following; If NO go to Question 33

a. Have you attained an NVQ whilst working at this Trust?

1 ☐ Yes 2 ☐ No

33. Which **one** of these ethnic groups would you say you belong to?

1 ☐ Asian or Asian British (Bangladeshi, Indian, Pakistani, or other Asian background)

2 ☐ Black or Black British (African, Caribbean, or other Black background)

3 ☐ Chinese

4 ☐ Mixed

5 ☐ White (British, Irish, or other White background)

6 ☐ Other: **please specify** .....

THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS QUESTIONNAIRE

If you have any additional comments that you would like to make, please use the space below.

Please continue on a separate sheet of paper if necessary

Appendix 10 Registered nurse questionnaire

oxford
SAID BUSINESS SCHOOL

Working with Healthcare Assistants

What is this survey and why are we asking you to complete it?

This is an independent survey about your experience as a registered nurse working with healthcare assistants. We are interested in your views about the role of the healthcare assistant, particularly about how this role impacts on you and the patients you care for.

Why should I complete the survey?

This is your opportunity to express your views in **confidence** about working with healthcare assistants. Your opinions are very important to the future development of the role. The anonymised research results will be made available to your trust management, policy makers and government so allowing your views to inform how the role develops in the future.

Who is carrying out the survey?

The survey is being carried out by researchers at the University of Oxford, as part of a research project funded by the NHS Service Delivery and Organisation R&D Programme (SDO). Further information about the research is available on the project website:

http://www.sbs.ox.ac.uk/research/supportworkers/

How to complete this survey?

Please answer the questions as fully as you are able by placing a tick in a box, circling a number, or writing in the spaces provided. There are no right or wrong answers.

Who will see my answers?

Your answers will be treated in complete confidence. The survey findings will be presented in a summary report in which no individual, or their responses, can be identified. The bar code/number below is only used by the researchers to identify which staff should be sent a reminder and will not be available to staff at your Trust.

Questions or help?

If you have any queries about the questionnaire or need any help to complete it, please call Paul Heron on FREEPHONE 0800 9150509. The line is open between 10am and 4pm Monday to Friday.

Please return this questionnaire, in the FREEPOST envelope provided, to:

FREEPOST
Oxford Support Worker Research
Wembley
HA0 4PE

BARCODE

A Healthcare Assistant (HCA) works alongside a registered nurse providing patient care. On some wards this role is referred to as a clinical support worker, auxiliary nurse or nursing assistant.

YOUR JOB

1. To what extent do you **agree or disagree** with the following statements?

Please circle one number 1 – 5 for each statement

	Strongly disagree		Neither agree nor disagree		Strongly agree
	1	2	3	4	5
Nurse training gave me the skills to use HCAs effectively	1	2	3	4	5
I often think about leaving this Trust	1	2	3	4	5
Before qualifying as a registered nurse I had very little contact with HCAs	1	2	3	4	5
I will probably look for a job at a new organisation in the next 12 months	1	2	3	4	5
Nurse training did not adequately prepare me to manage HCAs	1	2	3	4	5
On qualifying as a registered nurse I had very little understanding about the role of an HCA	1	2	3	4	5
As soon as I can find another job, I will leave this Trust	1	2	3	4	5

2. At present, approximately how many HCAs are actually **in post** on your ward?

☐

3. Has a bank or agency HCA worked a shift on your ward in the last month?

1 ☐ Yes 2 ☐ No 3 ☐ Don't know / can't remember

Project 08/1619/155

TASKS AND RESPONSIBILITIES

4. On average, how often do **you** carry out the following tasks and responsibilities in your current role?

Please circle one number 1 – 5 for each task and responsibility

Never	A few times a **year**	A few times a **month**	A few times a **week**	Every **day**
1	2	3	4	5

A.	Bathe a patient	1	2	3	4	5
B.	Feed a patient	1	2	3	4	5
C.	Make a bed	1	2	3	4	5
D.	Distribute meals	1	2	3	4	5
E.	Collect medicine from the pharmacy (TTO)	1	2	3	4	5
F.	Escort a patient to another ward or theatre	1	2	3	4	5
G.	Keep stores stocked	1	2	3	4	5
H.	Monitor/record a patient's observations	1	2	3	4	5
I.	Monitoring a patient's blood glucose (i.e. 'BM' or blood sugars)	1	2	3	4	5
J.	Carry out a simple dressing	1	2	3	4	5
K.	Take a blood sample from a patient	1	2	3	4	5
L.	Carry out female catheterisation (i.e. insertion)	1	2	3	4	5
M.	Carry out a complex dressing (i.e. involves 'packing')	1	2	3	4	5
N.	Carry out an ECG	1	2	3	4	5
O.	Carry out a cannulation	1	2	3	4	5

5. Which three of the above tasks and responsibilities do you think are the most important for **Healthcare Assistants** (HCAs) to carry out?

Please put the corresponding letter for each task and responsibility in the boxes below

Most important ☐ 2nd most important ☐ 3rd most important ☐

6. Which three of the above tasks and responsibilities do you think are the **least** important for HCAs to carry out?

Please put the corresponding letter for each task and responsibility in the boxes below

Least important ☐ 2nd least important ☐ 3rd least important ☐

Project 08/1619/155

WORKING WITH HCAs

7. To what extent do you **agree or disagree** with the following statements about your ward?

Please circle one number 1 – 5 for each statement

	Strongly disagree		Neither agree nor disagree		Strongly agree
	1	2	3	4	5

Managing a HCA on a shift is a burden	1	2	3	4	5
Most of my tasks could be carried out by a HCA	1	2	3	4	5
Washing a patient is an important part of my job	1	2	3	4	5
HCAs will often be the first to show student nurses how to do things on the ward	1	2	3	4	5
I regard HCAs as another pair of eyes on the ward	1	2	3	4	5
HCAs carrying out direct care tasks has made my life easier	1	2	3	4	5
Being accountable for the delegation of tasks to HCAs is a constant worry for me	1	2	3	4	5
On my ward, there is a clear distinction between the work I do and the work a HCA does	1	2	3	4	5
A HCA will usually answer a patient buzzer before I do	1	2	3	4	5
Newly qualified nurses will often look to HCAs for advice	1	2	3	4	5
It is easier for me to get essential paperwork done with a HCA on the ward	1	2	3	4	5
It is usually a HCA that will empty a patient's commode	1	2	3	4	5
I am not always confident that HCAs fully understand what they are doing on the ward	1	2	3	4	5
Newly qualified nurses are often intimidated by HCAs	1	2	3	4	5
I can rely on HCAs to let me know when there is something wrong with a patient	1	2	3	4	5
I have a greater understanding of the tasks I carry out than a HCA	1	2	3	4	5
Newly qualified nurses will often pick up bad working habits from HCAs	1	2	3	4	5
Being able to delegate tasks to a HCA makes a positive difference to my workload	1	2	3	4	5
I rely on HCAs to do all the 'heavy' work	1	2	3	4	5
HCAs often help newly qualified nurses 'find their feet' on the ward	1	2	3	4	5
A HCA will sometimes spot something that I have missed	1	2	3	4	5

Project 08/1619/155

WORKING WITH PATIENTS

8. Below are some statements asking you how difficult or easy you find it to deal with different aspects of a patient's care. Please be as **honest** as possible remembering that no one in your organisation will see your completed questionnaire.

Please circle one number 1 – 5 for each statement

Very difficult	Difficult	Neither easy or difficult	Easy	Very easy
1	2	3	4	5

How difficult or easy do you find it to:

... develop a close relationship with a verbally abusive patient.....	1	2	3	4	5
... calm a patient who is very stressed about their medical condition .	1	2	3	4	5
... develop a close relationship with a patient whose background is different from your own	1	2	3	4	5
... cheer up a patient who is deeply upset about an aspect of their stay	1	2	3	4	5
... develop a close relationship with a confused patient.....	1	2	3	4	5
... ease any conflict between patients on the ward	1	2	3	4	5
... listen closely to a patient's concerns.....	1	2	3	4	5
... always explain to a patient what your are doing	1	2	3	4	5
... reassure a very anxious patient.....	1	2	3	4	5
... reduce any tension between a patient and a member of staff	1	2	3	4	5

Project 08/1619/155

9. Below are some statements asking you to compare how you feel registered nurses treat patients on your ward compared to HCAs.

Please circle one number 1 – 5 for each statement

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Compared to HCAs, registered nurses are more likely to:

... notice when patients are in discomfort	1	2	3	4	5
... show concern when patients complain	1	2	3	4	5
... talk to patients in a warm friendly manner	1	2	3	4	5
... be told by patients about their worries and concerns	1	2	3	4	5
... explain what they are doing when working with patients	1	2	3	4	5
... take time to listen to patients when they need to talk	1	2	3	4	5

ABOUT YOU AND YOUR BACKGROUND

Please remember that this information is confidential and no one in your organisation will see your individual results.

10. To what extent do you feel that each of the following statements is a more or less true description of you? Respond to the items as you now feel even if you felt differently at some other time in your life.

Please circle one number 1 – 6 for each statement

Definitely false	False	Mostly false	Mostly true	True	Definitely true
1	2	3	4	5	6

I am able to do things as well as most other people	1	2	3	4	5	6
I feel that I'm a person of worth, at least on an equal basis with others	1	2	3	4	5	6
I feel that my life is not very useful	1	2	3	4	5	6
I feel that I have a number of good qualities	1	2	3	4	5	6
I feel that I do not have much to be proud of	1	2	3	4	5	6
I take a positive attitude towards myself	1	2	3	4	5	6
I think I am no good at all	1	2	3	4	5	6
I am a useful person to have around	1	2	3	4	5	6
I feel I can't do anything right	1	2	3	4	5	6
When I do a job, I do it well	1	2	3	4	5	6

Project 08/1619/155

11. Approximately, how long have you worked for this **Trust**?

☐ **years** ☐ **months**

12. Approximately, how long have you worked on your current **ward**?

☐ **years** ☐ **months**

13. How many hours a week are you contracted to work?

1 ☐ Up to 29 hours 2 ☐ 30 or more hours a week

14. Which shifts have you worked in the last month?

Please tick all that apply

1 ☐ Early 2 ☐ Late 3 ☐ Night

4 ☐ Other: **please specify** .....

15. What pay band are you currently on?

1 ☐ Band 5 2 ☐ Band 6

3 ☐ Band 7 4 ☐ Band 8

5 ☐ Other: **please specify** .....

16. How many years ago did you qualify as a registered nurse?

☐ **years**

17. Did you train as a nurse in the UK?

1 ☐ Yes 2 ☐ No

18. Are you male or female?

1 ☐ Male 2 ☐ Female

19. What was your age last birthday?

Please put the number of years in the box below

☐ **years**

20. Are you married or in a long term relationship?

1 ☐ Yes 2 ☐ No

Project 08/1619/155

21. Do you have any children?

1 ☐ Yes 2 ☐ No

If YES, please answer the following; If NO go to Question 22

a. Are any of your children still at primary or secondary school?

1 ☐ Yes 2 ☐ No

22. Are you the sole or main income earner in your household?

1 ☐ Yes 2 ☐ No

23. Did you attend a local primary school (i.e. within 20 miles of this hospital)?

1 ☐ Yes 2 ☐ No

24. Which **one** of these ethnic groups would you say you belong to?

1 ☐ Asian or Asian British (Bangladeshi, Indian, Pakistani, or other Asian background)

2 ☐ Black or Black British (African, Caribbean, or other Black background)

3 ☐ Chinese

4 ☐ Mixed

5 ☐ White (British, Irish, or other White background)

6 ☐ Other: **please specify** .....

THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS QUESTIONNAIRE

If you have any additional comments that you would like to make, please use the space below.

Please continue on a separate sheet of paper if necessary

Project 08/1619/155

Appendix 11 Patient questionnaire

oxford
SAID BUSINESS SCHOOL

Patient Survey: Your Recent Hospital Experience

What is this survey about?

This survey is about your **most recent** experience as an inpatient at the National Health Service hospital named in the letter enclosed with this questionnaire.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his/her point of view – not the point of view of the person who is helping.

Who is carrying out the survey?

The survey is being carried out by researchers at the Said Business School, University of Oxford, as part of a long term research project funded by the NHS Service Delivery and Organisation R&D Programme (SDO). Further information about the research is available on the project website:
http://www.sbs.ox.ac.uk/research/supportworkers/

How to complete this survey?

Please answer the questions as fully as you are able by placing a tick in a box, circling a number, or writing in the spaces provided. When asked your opinions please remember there are no right or wrong answers.

Who will see my answers?

Please **do not** write your name or address anywhere on the questionnaire.

Taking part in this survey is voluntary. **Your answers will be treated in absolute confidence and will not affect your NHS care in any way.** No one at the hospital will be able to identify individual responses. The bar code/number below is only used by the researchers to identify which patients should be sent a reminder and will not be available to hospital staff.

Questions or help?

If you have any queries about the questionnaire or need any help to complete it, please call Paul Heron on FREEPHONE 0800 9150509. The line is open between 10am and 4pm Monday to Friday.

Please return this questionnaire, in the FREEPOST envelope provided, to:

FREEPOST
Oxford Support Worker Research
Wembley
HA0 4PE

BARCODE

ABOUT YOUR HOSPITAL STAY

1. How many times have you been an inpatient at this hospital in the last 12 months?

1 ☐ 1 2 ☐ 2

3 ☐ 3 or more 4 ☐ Don't know / can't remember

2. Thinking about your **most recent** hospital visit as an inpatient, how many nights did you stay at this hospital?

☐

3. During your **most recent** hospital visit, how many wards did you stay in?

1 ☐ 1 2 ☐ 2

3 ☐ 3 or more 4 ☐ Don't know / can't remember

4. Overall, how would you rate the care you received at the hospital?

1 ☐ Poor 2 ☐ Fair 3 ☐ Good 4 ☐ Very good 5 ☐ Excellent

You will now be asked a number of questions about HEALTHCARE ASSISTANTS.

Healthcare assistants work alongside registered nurses providing patient care, but healthcare assistants are not qualified nurses. On some wards this role is referred to as a clinical support worker, auxiliary nurse or nursing assistant, but they all do a similar job.

5. Thinking about the **last ward** you stayed on, were you able to tell who was a nurse and who was a healthcare assistant?

1 ☐ Yes → **Go to Question 6**

2 ☐ No → **Go to Question 10**

6. How were you able to tell the difference between nurses and healthcare assistants?

Please tick all that apply

1 ☐ I was told by a healthcare assistant

2 ☐ I was told by a nurse

3 ☐ I was told by another member of hospital staff

4 ☐ I was told by a patient

5 ☐ I was told by a relative or friend

6 ☐ I could tell by the uniform and/or name badge

7 ☐ I read information provided by the hospital

8 ☐ I saw pictures of the staff on a ward notice board

9 ☐ I already knew how to tell the difference

10 ☐ Don't know / Can't remember

11 ☐ Other: **please specify** .....

Project 08/1619/155

7. While on the ward, did you receive any of your care from a healthcare assistant?

1 ☐ Yes → **Go to Question 8**

2 ☐ No → **Go to Question 10**

3 ☐ Don't know / Can't remember → **Go to Question 10**

8. To what extent do you agree or disagree with the following statements about **healthcare assistants** on your ward?

Please circle one number 1 – 5 for each statement or N/A if you don't know or the statement is not applicable to you

	Strongly disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly agree 5	N/A
Healthcare assistants were willing to listen to what I had to say	1	2	3	4	5	N/A
I wasn't comfortable talking to healthcare assistants about my worries and fears	1	2	3	4	5	N/A
When healthcare assistants answered questions about my care I was able to understand them	1	2	3	4	5	N/A
Healthcare assistants would often talk in front of me as if I wasn't there	1	2	3	4	5	N/A
I was able to confide in a healthcare assistant	1	2	3	4	5	N/A
I was treated with respect and dignity by healthcare assistants	1	2	3	4	5	N/A
Overall, I received excellent care from healthcare assistants	1	2	3	4	5	N/A

9. To what extent do you agree or disagree with the following statements about **nurses** on your ward?

Please circle one number 1 – 5 for each statement or N/A if you don't know or the statement is not applicable to you

	Strongly disagree 1	Disagree 2	Neither agree nor disagree 3	Agree 4	Strongly agree 5	N/A
Nurses were willing to listen to what I had to say	1	2	3	4	5	N/A
I wasn't comfortable talking to nurses about my worries and fears	1	2	3	4	5	N/A
When nurses answered questions about my care I was able to understand them	1	2	3	4	5	N/A
Nurses would often talk in front of me as if I wasn't there	1	2	3	4	5	N/A
I was able to confide in a nurse	1	2	3	4	5	N/A
I was treated with respect and dignity by nurses	1	2	3	4	5	N/A
Overall, I received excellent care from nurses	1	2	3	4	5	N/A

ABOUT YOU

Please remember that this information is confidential and only the research team will see your individual results.

10. Are you male or female?

1 ☐ Male 2 ☐ Female

11. What was the **year** of your birth?

Please write the year in the box, e.g. 1 9 4 6

☐☐☐☐

12. Did you attend a local primary school (i.e. within 20 miles of this hospital)?

1 ☐ Yes 2 ☐ No

13. Which **one** of these ethnic groups would you say you belong to?

1 ☐ Asian or Asian British (Bangladeshi, Indian, Pakistani, or other Asian background)

2 ☐ Black or Black British (African, Caribbean, or other Black background)

3 ☐ Chinese

4 ☐ Mixed

5 ☐ White (British, Irish, or other White background)

6 ☐ Other: **please specify** .....

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

If you have any additional comments that you would like to make, please use the space below.

Please continue on a separate sheet of paper if necessary

Project 08/1619/155

Appendix 12 Analysis of the 2006 NHS staff survey data: Acute Trusts only

Introduction

This paper presents an analysis of the 2006 NHS staff survey results drawn from the publicly released data provided by the Healthcare Commission.[17] The national survey has been run each year since 2003 and gives detailed results on the attitudes and experiences of NHS staff and their working lives. NHS staff are sampled from all NHS Trusts and the survey regularly achieves a response rate of above 50%.

The rationale guiding this analysis was three-fold. First, given that analysis of this data by these staff groups has not been documented by the Healthcare Commission, the results were designed to provide an important resource in their own right for a range of interested parties. Second, the analysis sought to highlight patterns between registered nurses and support workers prior to and worthy of pursuit during case study fieldwork. Third, the analysis will help determine the substance of our case study surveys being carried out in the autumn of 2008.

The paper sets out a descriptive overview of the similarities and differences between registered nurses and support workers (healthcare & nursing assistants, support to AHPs, support to S&T and maintenance/ancillary) working in acute trusts. Analysis is presented according to the sections of the survey itself and, in the main, reports on the results for registered nurses (adult/general) and healthcare & nursing assistants (all one category).

At the end of the document is a summary table showing the 28 key scores, as defined by the Healthcare Commission, across each of these staff groups.

It is important to point out that because of the large numbers of respondents (approximately 15000 nurses and 5000 HCAs) significant differences can be found between these groups when the difference is as little as 2% or 0.1 for a mean score. With a sample this size judgement needs to be made over 'meaningful' difference rather than purely statistical and, as such, attention has mainly been drawn to where percentage differences are at least 5% or more. Analysis is based on results for acute Trusts only.

Background details

- There is a similar gender divide between nurses and HCAs (91% vs 90%), although there is a lower percentage of women filling other

[17] Now named the Care Quality Commission.

support roles (support to AHPs, 81%; support to S&T, 71%; maintenance and ancillary, 47%).

- On average, nurses are younger than HCAs, with more in the 31-40 age range (32% vs 21%) and fewer in the 51-65 age range (18% vs 30).
- Nurses are from more ethnically diverse backgrounds with 73% reporting White British compared to 80% of HCAs and approximately 84% for other support workers.
- Nurses are more likely to manage others within the trust compared to HCAs (45% vs 6%), although other support workers report higher levels, particularly maintenance & ancillary (25%) and support to S&T (17%).
- On average, nurses have a longer length of service in the trust compared to HCAs with less in the 1-2 year category (13% vs 16%) and more that have served 15 years or more (28% vs 22%).
- There are no differences between nurses and support workers on long-term illness, health problem or disability which limits their work.

Work-life balance

- Nurses are more likely to be contracted to work 30 or more hours a week than HCAs (81% vs 73%).
- However, whilst approximately a third of both groups work additional paid hours, 67% of nurses work additional unpaid hours of which 13% work more than 6 unpaid hours a week compared to 3% of HCAs.
- Looking at the reasons for why they worked additional hours, the most common reasons for nurses were:
    - Because I want to provide the best care I can for patients (84%)
    - Because I don't want to let down the people I work with (72%)
    - To cover for staff shortages at this trust (66%)
    - Because it is impossible to do my job if I don't (62%)
    - Because it is necessary to meet deadlines (57%)
- The most common reasons for HCAs were as follows (note: the first three are the same but whereas the fourth and fifth relate to personal satisfaction reasons, both intrinsic and extrinsic, whereas for nurses they relate directly to work pressure):
    - Because I want to provide the best care I can for patients (75%)
    - Because I don't want to let down the people I work with (69%)
    - To cover for staff shortages at this trust (67%)
    - Because I enjoy my job (55%)

    - Because I want to earn extra money (41%)
- Nurses work greater amounts of flexi-time (24% vs 19%), but HCAs are more likely to work reduced hours (36% vs 30%) and annualised hours (27% vs 20%). Neither group work during school term-time only (1% for both).
- Nurses are more likely to have dependants than HCAs (47% vs 39%), and these are more likely to be children (91% vs 77%) compared to elderly (20% vs 28%).
- However, despite over three quarters of both groups reporting child dependents, nurses report almost twice the level of access to childcare options compared to HCAs:
    - Access to childcare coordinator (33% vs 17%)
    - Provision of subsidised childcare (28% vs 16%)
    - Provision of childcare vouchers (27% vs 15%)
    - Other childcare support (12% vs 7%)
- There were obvious discrepancies across different types of support workers. Maintenance and ancillary workers reported almost identical levels to HCAs across the range of options, however those supporting allied health professionals and those supporting S&T and healthcare scientists reported a higher level of provision of childcare vouchers that was similar to nurses.
- Support for elderly and other types of dependents was low and similar between nurses and HCAs (7% both).

Appraisal, training and teams

- Incidence of appraisals was lower for HCAs than for nurses (52% vs 58%), who were on a par with other health professionals.
- The outcome of appraisals was judged similarly between HCAs and nurses for 'usefulness' (75% vs 77%) and agreeing clear objectives (89% vs 90). However, HCAs reported more positively that their appraisal left them feeling their work was valued by the trust (69% vs 61%).
- Outcomes of personal development plans were also similar between HCAs and nurses, both groups reported that their line manager supported their access to training (67% both) and that they had received the training (57% vs 58%).
- However, the type of training received was qualitatively different with nurses reporting that they were much more likely to attend taught courses (76% vs 56%) and seminars/workshops (83% vs 48%). Both nurses and HCAs had similar levels of on the job training (38% vs 37%), having a mentor (22% vs 21%) and shadowing (19% vs 17%).

Your job

- A high percentage of both nurses and HCAs report having received their new job outline under Agenda for Change (85% vs 84%, when adjusted for the moderate level of don't knows for HCAs).
- However, there is a large significant difference between nurses and HCAs on whether they think the re-banding they received is fair (57% vs 45%, adj for DK). This is a similar view amongst all support workers with all other support groups reporting 48% compared to 60% from other health professionals (adj for DK).
- Ninety-five percent of all nurses and HCAs reported working in a team and 90% of both agreed that they work closely with other team members to achieve team objectives. However, nurses reported meeting more regularly (64% vs 59%).
- Nurses were more likely to agree/strongly agree that they have clear planned goals and objectives for their job (67% vs 58%) and that they are involved in deciding on the changes introduced that effect their work area/team/dept (51% vs 30%).
- Nurses reported higher levels of work pressure with significantly more nurses than HCAs agreeing/strongly agreeing that they cannot meet all the conflicting demands on their time at work (50% vs 32%), that they are asked to work without adequate resources (43% vs 29%) and that they are required to do unimportant tasks preventing them from completing more important ones (40% vs 27%).
- Nurses are significantly more likely to report intending to leave their job (2.79 vs 2.62), but the mean score for both is low and below the midpoint. Approximately a third of both groups agree/strongly agree that they often think about leaving the trust, but more nurses than HCAs report that they will probably look for a new job at a new organisation in the next 12 months (26% vs 20%). Half of both groups report that if they were to leave they would stay in the NHS (49% for both).
- Looking at the reasons for why they would consider leaving, nurses are more likely to leave for career development (16% vs 11%) or because they are unhappy with their current job (18% vs 13%). HCAs are more likely to consider leaving for more pay (17% vs 14%).
- There is no significant difference between nurses and HCAs on overall job satisfaction (3.35 vs 3.36), which is moderately high. Looking at the individual areas nurses are more likely to be satisfied/very satisfied with the opportunities to use their abilities (65% vs 58%) and the amount of responsibility they are given (69% vs 62%).
- Nurses report being under significant more work pressure than HCAs (3.25 vs 2.94) and are more likely to agree/strongly agree that they do not have the time to carry our all their work (53% vs 37%).
- Although there is no significant difference between nurses and HCAs on the overall quality of job design (3.29 vs 3.28), HCAs are more likely to

agree/strongly agree that they are consulted about changes that affect their work/team/dept (55% vs 46%). This is in contrast to the previously reported finding on 'involvement in change' which saw a reversal of this result.

Management and your organisation

- Support from immediate managers is reported as moderately high by both nurses and HCAs (3.29 vs 3.28) and the findings are consistent across the individual items.
- Overall organisational climate can't be measured from publicly accessible HC data. However, individual items do show some differences with HCAs more likely than nurses to agree/strongly agree that communication between management and staff is effective (36% vs 28%), that care of patients is the trust's top priority (55% vs 46%) and that as a patient of the trust they would be happy with the standard of care provided (48% vs 42%).
- A high percentage of both nurses and HCAs report that if they needed to whistle-blow they would know how (85% vs 82%) and this figure is significantly above that for HCAs compared to other support workers (support to AHP, 75%; support to S&T, 65%; maintenance and ancillary, 70%).
- However, the whistle-blowing system in not viewed as entirely confidential (all acute trusts, 57%; nurses, 65%; HCAs, 62%).

Harassment, bullying and violence

- Nurses reported higher levels of absence from work due to work-related stress (36% vs 30%).
- Nurses and HCAs reported similar levels of physical violence from patients (23% vs 25%) and relatives (8% vs 6%). However, nurses are less likely to report it (59% vs 66%).
- Whilst violence levels are similar between the two groups, nurses report the occurrence of far greater levels of harassment, bullying or abuse from patients (38% vs 30%) and relatives (33% vs 20%). Although, again, nurses are less likely to report it (49% vs 54%).
- Perceptions of effective action from the trust towards violence and harassment are moderately high for both nurses and HCAs (3.34 vs 3.50). This is significantly so in the eyes of HCAs who consistently report higher levels of agreement across each of the areas – action on: physical attack, bullying, racial and sexual harassment.

Health and safety risk

- Almost a quarter of HCAs (22%) reported being injured in the last 12 months due to moving or handling compared to 16% of nurses. There

were very similar results between the two groups for needle-stick and sharp injuries, falls and exposure to dangerous substances.

- Nurses are significantly more likely than HCAs to report having seen errors, near misses or incidents that could hurt patients (48% vs 28%) or that could hurt staff (32% vs 26%). Whilst almost all nurses know how to report such incidents (95%) there is not universal understanding across support workers (HCAs, 84%; support to AHPs, 83%; support to S&T, 79%; maintenance and auxiliary, 78%).
- However, where incidents are seen nurses are as likely as HCAs to report them (95% vs 91%, adj for DK).
- Procedures for reporting errors and near misses are seen as moderately fair and effective by both nurses and HCAs (3.46 vs 3.40). Although given that approximately a third of support workers report not having seen such incidents, these results are contaminated by the inclusion of these people's views.

Table 33. 2006 Acute Trust staff survey results: Key scores by staff group

Key scores	Registered nurses (adult / general)	Healthcare assistants	Allied health prof. / S&T	Support to allied health prof.	Support to S&T	Maintenance / ancillary	All acute trust staff
% staff using flexible working options	71	73	64	73	67	63	70
% staff appraised within previous 12 months	58	52	59	55	49	47	57
% staff having well-structured appraisal reviews within previous 12 months	32	31	29	30	21	25	29
% staff appraised with personal development plans within previous 12 months	52	43	49	46	38	30	47
% staff receiving any training, learning or development in previous 12 months	99	95	97	95	93	87	95
% staff receiving job-relevant training, learning or development in previous 12 months	84	73	76	71	63	52	72
% staff working in a well-structured team environment	33	32	45	46	41	27	38
% staff having had health and safety training in previous 12 months	78	78	78	79	74	67	71
% staff reporting errors, near misses and incidents	95	91	94	94	91	85	93
% staff working extra hours	78	54	73	53	57	59	70
% staff working extra hours due to pressure and demands of job	70	42	67	47	49	48	63
% staff suffering work related injury in previous 12 months	22	28	18	29	22	23	18

Key scores	Registered nurses (adult/ general)	Healthcare assistants	Allied health prof./ S&T	Support to allied health prof.	Support to S&T	Maintenance/ ancillary	All acute trust staff
% staff suffering work related stress in previous 12 months	36	30	32	29	33	24	32
% staff witnessing potentially harmful errors, near misses or incidents in previous month	52	34	46	33	34	27	40
% staff experiencing physical violence from patients or their relatives in previous 12 months	24	25	6	13	5	5	11
% staff experiencing physical violence from other staff in previous 12 months	1	2	1	2	2	3	1
% staff experiencing harassment, bullying or abuse from patients or their relatives in previous 12 months	42	32	20	22	14	10	26
% staff experiencing harassment, bullying or abuse from other staff in previous 12 months	20	17	17	15	21	17	18
Quality of work-life balance	3.27	3.33	3.33	3.40	3.34	3.27	3.30
Quality of job design (clear job content, feedback and staff involvement)	3.29	3.28	3.32	3.28	3.27	3.20	3.29
Support from immediate managers	3.45	3.46	3.44	3.46	3.35	3.29	3.42
Extent of positive feeling within organisation (communication, staff involvement, innovation and patient care)	2.89	3.06	2.95	2.99	2.95	2.96	2.93
Fairness and effectiveness of procedures for reporting errors, near misses and	3.46	3.40	3.40	3.35	3.33	3.31	3.39

Key scores	Registered nurses (adult / general)	Healthcare assistants	Allied health prof. / S&T	Support to allied health prof.	Support to S&T	Maintenance / ancillary	All acute trust staff
incidents							
Perceptions of effective action from employer towards violence and harassment	3.34	3.50	3.37	3.42	3.40	3.55	3.40
Availability of hand washing materials	4.61	4.67	4.39	4.53	4.47	4.60	4.51
Staff job satisfaction	3.35	3.36	3.37	3.37	3.26	3.36	3.39
Work pressure felt by staff	3.25	2.94	3.17	2.93	2.90	3.04	3.16
Staff intention to leave jobs	2.79	2.62	2.71	2.68	2.75	2.58	2.72

Appendix 13 Cluster analysis

Rationale

Cluster analysis is a tool used to find natural groupings within a data set. A cluster represents a group of respondents that are relatively homogeneous on a set of observations yet distinct from other respondents within other clusters. This method of grouping individuals rather than the more traditional grouping of variables that occurs in factor analysis is particularly useful to our inquiry. Whilst factor analysis would help us identify any underlying (factor) structure of our task data, it would not help us to describe any meaningful patterns that may exist between HCAs themselves. Instead, cluster analysis aids our inquiry into whether or not there are a discrete number of similar role shapes that exist amongst a broad selection of Trusts. Our primary interest is therefore the shape of the HCA role, whether it varies within and between our Trusts and what is associated with any role variation.

Method

We used the core sample of 582 HCAs, which excluded 164 HCAs that formed part of the extended sample taken up by Trusts. Of these 582 core HCAs, three had not answered any of the 14 task statements and a further four had failed to answer more than half of the statements. These seven were excluded from the core sample, leaving 575. Cluster analysis is a list-wise procedure and so missing data was substituted with the mean of each variable.

The 14 tasks covered a range of activities including core direct care tasks (e.g. washing patients, feeding patients), indirect care tasks (e.g. making beds, collecting TTOs), ward- or team-centred tasks (e.g. keeping stores stocked), routine technical tasks (e.g. monitoring observations, blood glucose monitoring) and finally a range of complex tasks (e.g. cannulation, female catheterisation). Respondents were asked to detail how frequently they performed each task on a five point scale that ranged from ‘never’ through ‘a few times a year’, ‘a few times a month’, ‘a few times a week’ to ‘every day’.

Adopting the approach favoured by Ketchen & Shook (1996)[18], all 575 HCAs were analysed using the hierarchical cluster analysis procedure. Solutions were compared using output derived by the Ward and Baverage distance measures. Following investigation of the dendogram and the agglomeration

[18] Ketchen DJ, Shook CL. The application of cluster analysis in strategic management research: An analysis and critique. *Strategic Management Journal* 1996;17(6): pp. 441-458.

coefficient it was determined that six clusters using the Baverage measure produced the most acceptable solution.

The cluster centroids were then used as seeds for a K-means cluster analysis. While the hierarchical method is helpful in ascertaining the number of clusters, the method of agglomeration means that once clusters have been merged then cases within those clusters cannot be reassigned. K-means allows cases to be added and removed from clusters enabling a tighter solution.

Investigation of the six cluster solution indicated that one of the clusters (n= 44 cases), was differentiated from other clusters by having the significantly lowest mean score on nine of the 14 tasks. There were no tasks in which this cluster was significantly higher than any other cluster. This implied that for the majority of HCAs in this cluster the scope of the 14 tasks had not been wide enough to encompass what it is that they do within their role. Further investigation of the cluster revealed that the majority of HCAs in this cluster worked in A&E, renal units or other non-typical wards or in specialist roles i.e. respiratory nursing. Of the 44 cases, seven HCAs were from case study wards where extensive interview work had been carried out. With the exception of these seven it was decided to re-run the cluster analysis excluding the remaining 37 HCAs.

New cluster centroids were extracted from a hierarchical cluster analysis specifying a five factor solution. These were used to seed a K-means cluster analysis. Investigation of the resulting five cluster solution found that the integrity of the original cluster membership had been maintained. Table 34 shows that the removal of the outlier group (n=37) had not significantly impacted on membership of the remaining clusters.

Table 34. Membership of final five cluster vs prior six cluster solution

	Cluster 1	**Cluster 2**	**Cluster 3**	**Cluster 4**	**Cluster 5**
1	197	4	0	0	0
2	0	92	0	0	0
3	4	1	129	0	0
4	0	0	0	29	0
5	1	0	3	9	62
6	3	3	0	0	1
Total count	205	100	132	38	63

The five cluster solution is displayed in Table 35. Across each of the 14 tasks strongly significant differences exist between the five clusters. The profiles of the clusters are discussed in the main body of the report.

Table 35. Task frequency by HCA cluster grouping

Task	Bedside tech. (n=205) 1	Ancillary (n=100) 2	Citizen (n=132) 3	All rounder (n=38) 4	Expert (n=63) 5	Sig. contrasts[a]
Bathing	4.52	4.15	4.37	4.53	3.95	1>2; 1,4>5
Feeding	4.47	3.93	3.78	4.50	3.43	1>2; 1,4>3; 4,2>5
Bed making	4.95	4.84	4.98	4.97	4.71	1,3,4>5
Collecting TTO	3.04	3.56	4.29	4.00	3.75	2,3,4,5>1; 3>2,5
Escorting a patient	2.72	2.96	4.20	4.00	3.68	3,4,5>1,2; 3>5
Stocking stores	3.37	4.22	4.56	4.16	4.21	2,3,4,5>1
Observations	4.71	3.26	4.86	4.95	4.95	1,3,4,5>2
Blood monitoring	4.69	1.92	4.67	4.95	4.92	1,3,4,5>2
Simple dressing	3.17	1.88	3.27	4.55	3.83	1,3,4,5>2; 4,5>1,3
Taking blood	1.22	1.07	1.11	3.68	4.51	5,4>1,2,3; 5>4
Female catheterisation	1.11	1.08	1.15	3.11	1.09	4>1,2,3,5
Complex dressing	1.17	1.06	1.45	3.18	1.36	3>1,2; 4>3,5
ECG	1.51	1.18	2.93	3.95	4.00	3,4,5>1,2; 4,5>3
Cannulation	1.09	1.07	1.17	2.88	2.16	4,5>1,2,3; 4>5

[a] *Each of the 14 tasks has significant differences between the cluster groups at the level of p < .001*

Appendix 14 Self-esteem

Self-esteem is generally conceptualised as self-regard, an evaluation of our merit or worth. Individuals with a high level of self-esteem feel good about themselves independently of what others think or feel about them. Low self-esteem can impact on workplace performance, reduce the successful achievement of academic goals and restrict aspirations for future development. The survey used a validated academic instrument to measure self-esteem[19], which consisted of 10 items that were measured on a six-point scale from 'definitely false' to 'definitely true'. In line with previous studies factor analysis produced two sub scales 'self-enhancement' (six items, alpha=.83) and 'self-derogation' (four items, alpha=.72), represented by positively and negatively worded statements respectively.

Table 36 shows the results of the self-esteem sub scales for HCAs and nurses across each of the four case study sites. Both groups registered very high self-enhancement scores at each of the Trusts. There were no significant differences between HCAs across the case study Trusts. At one Trust, Midland, HCAs had higher self-enhancement than their nurse colleagues (F=4.16, p < .05).

Self-derogation scores were consistently low for both groups at all Trusts. Again, there were no significant differences between HCAs across the four Trusts. At two Trusts, South and North, HCAs had higher self-derogation than reported by nurses (F=10.73, p < .01 and F=5.29, p < .05 respectively).

Table 36. General self-esteem by role (mean)

	South		Midland		North		London	
	HCA	**Nurse**	**HCA**	**Nurse**	**HCA**	**Nurse**	**HCA**	**Nurse**
Self-enhancement	5.24	5.15	5.23	5.09	5.12	5.07	5.26	5.28
Self-derogation	1.76	1.52	1.75	1.75	1.81	1.59	1.78	1.63

[19] Ranzijn R, Keeves J, Luszcz M, Feather N. The role of perceived usefulness and competence in the self-esteem of elderly adults: Confirmatory factor analyses of the Bachman Revision of Rosenberg's self-esteem scale. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences* 1998;53(2): pp. 96-104.

Table 37 shows the results of self-esteem for each of the five cluster types. There was no significant difference between clusters and scores for self-derogation. For self-enhancement, HCAs categorised as Expert have significantly higher levels of self-esteem than Bedside Technicians ($F=3.65$, $p < .01$).

Table 37. General self-esteem by cluster type (mean score)

	Bedside tech.	Ancillary	Citizen	All rounder	Expert
Self-enhancement	5.11	5.25	5.27	5.32	5.39
Self-derogation	1.83	1.70	1.77	1.85	1.70

Appendix 15 Multiple response survey tables

Table 38. Most enjoyable HCA tasks (HCAs: %)[a]

Task	South	Midland	North	London	Total
Bathing	51	29	52	41	52
Feeding	47	28	29	38	41
Bed making	19	13	27	12	20
Collecting TTO	8	14	10	11	7
Escorting a patient	17	28	19	27	18
Stocking stores	6	17	4	8	6
Observations	40	52	42	52	46
Blood monitoring	27	21	19	23	24
Simple dressing	28	28	30	24	28
Taking blood	10	20	17	14	12
Female catheterisation	5	1	4	7	5
Complex dressing	7	6	8	3	6
ECG	15	22	18	18	17
Cannulation	11	1	9	4	6

[a] *Table figures refer to the percentage of HCAs that selected each task as one of their three choices and therefore figures will not sum to a 100%*

Table 39. Most important tasks for HCAs to carry out (nurses: %)[a]

Task	South	Midland	North	London	Total
Bathing	90	91	79	80	86
Feeding	88	88	78	81	84
Bed making	52	38	27	44	42
Collecting TTO	5	4	3	4	4
Escorting a patient	5	10	2	6	6
Stocking stores	12	12	10	10	11
Observations	18	14	60	45	31
Blood monitoring	4	5	17	11	8
Simple dressing	6	2	3	2	4
Taking blood	2	0	10	2	3
Female catheterisation	0	1	0	0	0
Complex dressing	1	0	0	0	0
ECG	2	1	4	4	3
Cannulation	1	0	4	0	1

[a] *Table figures refer to the percentage of HCAs that selected each task as one of their three choices and therefore figures will not sum to a 100%*

Appendix 15 Dissemination

The project team undertook a variety of dissemination initiatives and drew heavily in the planning of them on the SDO work on mobilisation and capacity building led by Huw Davies. One of our team, Sue Dopson, is a member or the advisory group for this programme and this enabled us access to best practice in this area.

It is important to note that the feedback and dissemination activities allowed us to hone our findings and discuss and refine our conclusions. In addition to the activities listed below, two of our case study Trusts organised internal steering group committees consisting of the study's principal coordinator at the Trust along with nursing executive and R&D managers. These meetings proved invaluable for both parties providing the research team with regular managerial contact to help ease any access issues and requests for further information, whilst providing the Trusts themselves with the opportunity to engage with the topic area and material being generated by the research.

The details of the dissemination activities we undertook included:

(24/01/2008)	Advisory Group Meeting
(20/03/2008)	International Labour Process Conference (ILPC), Dublin
(3/06/2008)	South case study Trust management feedback session
(5/06/2008)	Health Services Research Network conference (HSRN), Manchester
(20/06/2008)	Scottish Government Health Directorate presentation
(26/06/2008)	British Universities Industrial Relations Association conference (BUIRA), Bristol
(22/07/2008)	UNISON national HCA conference, London
(4/09/2008)	European Group of Public Administration conference, Rotterdam
(12/11/2008)	Midlands case study Trust management feedback session
(27/11/2008)	RCN HCA Roadshow presentation, London
(7/04/2009)	International Labour Process Conference (ILPC), Edinburgh
(30/04/2009)	Organisational Behaviour Group, University of Oxford
(17/07/2009)	Society for the Advancement of Socio-Economics, Paris
(22/10/2009)	London case study Trust Nursing Executive feedback session

(15/01/2010)	End of project conference, University of Oxford (see below)
(02/02/2010)	Workforce Planning & Development for Healthcare Support Workers and Assistant Practitioners Conference, Edinburgh
(02/2010)	Journal of Nursing Management article on the Midlands case study action research
(19/02/2010)	London case study feedback to support worker staff

End of project conference

The conference was scheduled for 15th January 2010 but due to adverse weather conditions it has now been rescheduled for the 26th March.

Organisations represented are as follows:

- Department of Health
- Heart of England NHS Trust
- Hillingdon Hospital NHS Trust
- King's College London
- Leeds Teaching Hospitals NHS Trust
- London South Bank University
- Manchester Business School
- NHS Employers
- Norfolk and Norwich University Hospitals NHS Trust
- Open University
- Oxford Radcliffe Hospitals NHS Trust
- Patients Association
- Picker Institute Europe
- RCN
- RCN Scotland
- RCN West Midlands
- Royal United Hospital Bath NHS Trust
- Royal Wolverhampton Hospital NHS Trust
- Salisbury NHS Foundation Trust
- Scottish Centre for Social Research
- Scottish Government Health Directorates
- Skills for Care

- Smart Work Consulting
- The King's Fund
- UNISON
- University Hospitals Birmingham NHS Trust
- University Hospitals Bristol NHS Trust
- University of Greenwich
- University of Oxford
- University of the West of England
- University of York
- Worcestershire Acute Hospitals Trust

Disclaimer:

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health. The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health"

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.