

RCN Policy Unit

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The Regulation of Healthcare Support Workers

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Executive Summary

There has been an unprecedented increase in the number of health care support workers (HCWSs) in the health care workforce over recent years, numbers having more than doubled since 1997 in England¹. However policy makers have paid relatively little attention to how HCSWs should or could contribute to health care and how these roles impact and connect with a range of stakeholders, including patients. Consequently there has been wide spread variation in titles, roles and functions, education and training (or lack of), and associated competencies across the HCSW workforce.

Although there have been calls to regulate the HCSW workforce as far back as 1999, no decision or firm proposal has yet been taken and this workforce remains unregulated. There are a number of practical complexities that surround any implementation of HCSW regulation. These include:

- Identification of HCSWs since they are a mobile workforce, have a range of different employers within and outside the NHS, and unlike health professionals do not have a mandatory and accredited qualification to mark entry to regulation
- The cost of HCSW regulation – how it is funded and by whom

However HCSWs who work in nursing teams alongside registered nurses are fully engaged in the delivery of essential nursing care which brings them into intimate contact with vulnerable patients. This raises significant issues for patient safety and public protection.

In addition there are a range of policy initiatives to increase the numbers of HCSWs at the assistant practitioner level which lies at Agenda for Change band 4. This role is deemed able to independently undertake protocol based care under the supervision of a registered practitioner, and to have attained or be studying for a diploma in higher education². It also sits immediately below the threshold for registered practitioners and will have a supervisory role for HCSWs at bands 3, 2 and 1. The assistant practitioner role is an emergent part of the HCSW workforce and will gain significant expertise and qualification with increased responsibility for delivering patient care yet without to date any form of regulation. The patient safety aspect of this needs urgent policy attention.

¹ Buchan, J. and Seecombe, I. (2006) *From Boom to Bust? The UK Nursing Labour Market Review 2005 to 2006* RCN: London

² NHS Knowledge and Skills Framework

The RCN has a clear view that all HCSWs should be regulated in the interests of public protection and patient safety. Further we believe that HCSWs who deliver direct clinical care alongside registered nurses in the nursing team should be regulated by the nursing regulatory body, the NMC³. However we acknowledge the complexities that surround implementation of HCSW regulation. Therefore the RCN believes a pragmatic first step forwards in an evolutionary process towards HCSW regulation is the regulation of assistant practitioners in nursing by the NMC. The RCN recommends:

1. The RCN, NMC and other key stakeholders agree a UK - wide shared understanding about the title assistant practitioner and its related role in nursing as a matter of urgency.
2. The RCN, NMC and other key stakeholders map the current and predicted numbers of assistant practitioners in nursing
3. The NMC to establish a register for assistant practitioners in nursing. This would initially need to be a voluntary register until primary legislation could be enacted to establish a statutory register.
4. The RCN, NMC and other key stakeholders agree the detail for implementation of assistant practitioner regulation, including funding arrangements.

³ RCN (2006) Unpublished Response to the Review of the Regulation of Non – Medical Healthcare Professions

Introduction

There has been an unprecedented increase in the number of health care support workers (HCSWs) in the health care workforce over recent years, numbers having more than doubled since 1997 in England⁴. The impetus behind this increased growth has been attributed to three main factors:

- Changes in the education process for student nurses (Project 2000)
- Increased government investment in the NHS in order to fulfil a policy commitment of greater NHS capacity and reduced waiting times
- Problems in recruitment and retention of registered health professionals

However policy makers have paid relatively little attention to how HCSWs should or could contribute to health care and how these roles impact and connect with a range of stakeholders, including patients. As Kessler et al point out, a range of different policy rationales have been offered for support worker roles:

- “As a *relief* to removing non – core activities from professionals
- As an *apprentice* providing a stepping – stone into qualified work
- As a *substitute* taking on core professional tasks, and
- As a *co – producer* providing complementary and distinctive capabilities”⁵

Consequently there has been wide spread variation in titles, roles and functions, education and training (or lack of), and associated competencies across the HCSW workforce. That said, there *has* been consistency in calls for the regulation of this workforce, predominantly on the grounds of patient safety, from as far back as 1999. Despite this no decision has been taken regarding if, for whom or how such regulation should proceed, with the recent White Paper on professional regulation stating this is still a matter for government consideration⁶.

This policy briefing will consider the rationale for HCSW regulation, the options for implementation of this, the RCN view and recommendations.

⁴Buchan, J. and Seecombe, I *Op Cit*

⁵ Kessler, I. et al (2006) *Strategic Approaches to Support Workers in the NHS: A Shared Interest* Picker Institute Europe and Said Business School

⁶ Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* The Stationary Office : London

Who are Health Care Support Workers? Role and Context

The term HCSW covers a wide range of roles including portering and catering staff, administrative and clerical staff and those in assistant roles to health professionals. In fact the term 'health care support worker' is not universally applied so that people undertaking the same work and role may be known variously as health care assistants, care assistants or support workers, or nursing assistants, physiotherapy assistants, and so on.

In this briefing the term health care support worker will be used but discussion thereof applies *only* to HCSWs who work alongside nurses to provide direct clinical care, within hospitals, community settings and care homes.

There have been significant changes in the type of work such staff undertake. Although there have always been support staff for nursing care – generally formally known as nursing auxiliaries (albeit in fewer numbers) who undertook essential nursing care and sometimes domestic duties - roles have now expanded to include technical clinical work such as recording patient observations, taking blood samples, dressings and wound care^{7,8}. There is some evidence that the type of work HCSWs undertake is setting dependent, both between different care settings and within care settings, for example, different hospital departments and wards⁹. Also limited evidence (as yet) that the relationship between individual registered nurses and HCSWs is key to how far the HCSW role is extended, i.e. personal knowledge and trust of the HCSW is important to determination of what activities the HCSW undertakes, rather than previous education, training or experience¹⁰.

However all HCSWs deliver a substantial proportion of essential nursing care – bathing, helping patients to eat, pressure area care and so on – regardless of setting. Some nurses have expressed concerns that in 'handing over' the bulk of essential nursing care to HCSWs the heart or core of nursing has been lost with registered nurses left to carry out a range of technical or administrative tasks¹¹. This concern was one of the prompts behind an RCN policy statement in 2004 that:

- Recognised HCSWs as part of the nursing family and an acknowledged member of the nursing team

⁷ Thornley, C. (1997) *The Invisible Workers* UNISON: London

⁸ Knibb, W. et al (2006) *The Contribution of Assistants to Nursing* Report for the RCN

⁹ Knibb, W. et al (2006) *Op Cit*

¹⁰ Knibb, W. et al (2006) *Op Cit*

¹¹ Pearce, L (2007) 'Who Does What and When?' *Nursing Standard*, vol 21, no 23, February 14th

- Acknowledged team work as the means to deliver nursing care now and in the future
- Stated that registered nurses were responsible for standards of nursing care regardless of whether it was delivered by a registered nurse or HCSW¹²

The key point in the above for regulation is that the work of HCSWs brings them into intimate contact with patients who are vulnerable and thus raises significant issues for patient safety and public protection.

The Purpose of Regulation

Health care regulation has several different functions and structures that encompass individuals, care settings, organisations, and employment, within which the professional regulation of individuals is one dimension. The functions of regulation (which are not mutually exclusive) can be categorised as follows:

- Professionally – led regulation
- Public protection
- Education
- Safety of individuals
- Competence
- Performance management
- Quality assurance
- Setting standards¹³

The original motivation to establish professionally – led regulation in health care lay in the securement and preservation of the status of individual professions by:

- Protecting professional boundaries with a register that lists those entitled to practise
- Protecting professional title thereof
- Establishing professional standards for practice

¹² RCN (2004) *The Future Nurse: The RCN Vision Explained* RCN : London

¹³ RCN (2004) *The Future Nurse: The Future for Professional Regulation* RCN : London

- Controlling admission and removal from the professional register¹⁴

As such professionally – led regulation also encompassed public protection, education, competence and standard setting. But more recently several high profile cases and Inquiries in which health professionals have harmed those in their care – for example general practitioner Harold Shipman, nurse Beverly Allitt, and medical consultants Neale, Ayling, Haslam and Kerr - have led to greater emphasis on the public protection role of the current eight regulatory bodies for health professions¹⁵. And also led directly to proposals to reform professional regulation and strengthen the public protection element with the publication of the White Paper on professional regulation¹⁶.

It is therefore even more critical that a decision and firm proposal is made regarding the regulation of HCSWs given that they too have the potential for harm and equally pose significant issues for patient safety and public protection.

Policy and Regulation

In 2004 the Department of Health in England carried out a public consultation on extending professional regulation to the wider health care team in England, Northern Ireland and Wales (with the Scottish Executive undertaking a parallel consultation at the same time). The results of these have never been formally published. However a summary appeared in discussion papers preceding publication of the White Paper on professional regulation¹⁷. This stated that:

- The majority of respondents favoured regulation for some – though not necessarily all – support staff
- Patient safety and public protection was put forward as a prime reason for extending regulation
- The complexity of how to regulate this group of staff, by whom, and the implications thereof, needed fuller debate

Currently a pilot study is underway in Scotland (on behalf of the UK) to investigate the feasibility of employer – led registration of *all* HCSWs

¹⁴ RCN (2004) *Op Cit*

¹⁵ These are the: Nursing and Midwifery Council, General Medical Council, Health Professions Council, Royal Pharmaceutical Society of Great Britain, General Dental Council, General Optical Council, General Osteopath Council, General Chiropractic Council

¹⁶ Department of Health (2007) *Op Cit*

¹⁷ Department of Health (2006) *Key Theme Paper Section 3 – Regulation of Support Staff*
Unpublished Paper

employed in the NHS regardless of specific employment role¹⁸. The focus of this pilot is on:

- An employer held non – statutory list of HCSWs
- Standards for safe recruitment and induction
- Standards for HCSWs that relate to general public protection concepts such as confidentiality, dignity and advocacy
- A code of practice for employers

The results of this study will not be known until at least late 2007. The government meanwhile appear undecided on how, or if, to take regulation forward for this group of workers. Although they do comment on assistant practitioners in the White Paper on professional regulation.

“The Government will consider whether there is sufficient demand for the introduction of statutory regulation for any assistant practitioner roles at levels 3 and 4 on the Skills for Health Career Framework. This will be subject to the same mechanisms for determining need, suitability and readiness as for the other emerging professions”¹⁹

Assistant Practitioners

The 2002 Wanless report commissioned by the government recognised the need to maintain and expand the numbers of HCSWs in the NHS in order to meet health service demand²⁰. The more recent UK report *Modernising Nursing Careers: Setting the Direction* also acknowledged the need for large numbers of HCSWs within the nursing team now and in the future, stating nursing needed:

“A career structure with increased number of assistants working as part of multidisciplinary teams”²¹

Moreover both recognised the need for extending and consolidating the skills of HCSWs who are mainly employed at Agenda for Change bands 2 and 3 at present. Agenda for Change band 4 equates to the assistant practitioner role which is deemed to be able to independently undertake protocol based care under the supervision of a registered practitioner, and to have attained or be studying for a diploma in higher education²². This

¹⁸ Scottish Executive Health Department (2006) *Regulation of Healthcare Support Workers: A National Pilot on Behalf of the UK SEHD*

¹⁹ Department of Health (2007) *Op Cit* page 86

²⁰ Wanless, D. (2002) *Securing Our Future Health: Taking a Long Term View*. HM Treasure: HMSO

²¹ Department of Health (2006) *Modernising Nursing Careers : Setting the Direction*

Department of Health : London

²² NHS Knowledge and Skills Framework

level sits immediately below the threshold for registered practitioners and will have a supervisory role for HCSWs at bands 3, 2 and 1.

The policy direction from a range of initiatives is to increase the numbers of HCSWs in the assistant practitioner category (although again the degree to which there is UK - wide shared understanding about the use of this title and its related role is more questionable). Several schemes have begun (in England) which will educate HCSWs who are currently in practice to foundation degree level with the aim of supporting them to become assistant practitioners²³. For example at London South Bank University there are approximately 180 places per annum to educate HCSWs to become assistant practitioners²⁴.

The attraction of this approach for the English Strategic Health Authorities who have the responsibility for workforce planning and commissioning workforce education and training lies in the ability to plug local gaps in staffing within the health care workforce. The downside to this is that it can be argued that assistant practitioners represent a form of cheap labour substitution since they are paid less than registered practitioners and may be cheaper to educate. However, on the other hand, such an approach represents investment in the HCSW workforce with career development for existing HCSWs. Plus, the possibility of recruitment through to registered nursing – it is estimated that around one third of current HCSWs aspire to become registered nurses²⁵.

The assistant practitioner role is an emergent part of the HCSW workforce that will gain significant expertise and qualification with increased responsibility for delivering nursing care but without as yet, any form of regulation. The patient safety aspect of this needs urgent policy attention.

Assistant Practitioners, HCSWs and the Nursing Team

In addition to patient safety and public protection, there is a related issue for regulation and the nursing team: clarification of the areas of responsibility, delegation and accountability. It is known that these areas cause much confusion and concern for both HCSWs and registered nurses and are poorly understood²⁶. In fact they all relate to the responsibility of registered nurses for ascertainment of the competence of the HCSW (or other workers) prior to delegation of the assigned activity.

²³ As assistants within all non – medical health care professions, not only nursing

²⁴ Personal communication

²⁵ Knibb, W. et. al. (2006) *Op Cit*

²⁶ see for example Knibb, W. et. al. (2006) *Op.Cit.*

Yet despite publication of guidance on this issue including that by the RCN²⁷ confusion still remains.

It is suggested that some of this confusion stems from lack of a common code of professional conduct. Registered nurses have – and know they have – a binding professional code of conduct from the Nursing and Midwifery Council (NMC) whereas HCSWs have no such code (although they will have certain standards set out in their employment contract, for example for patient confidentiality). Therefore even though HCSWs and registered nurses will be working together in a nursing team with the same patients, in the same setting and undertake some common patient care activities, because they do not have a common code of conduct they are unsure about their expectations for each other at the outset, and subsequently how they should relate and work together²⁸.

A shared common code of conduct for registered nurses and HCSWs in the nursing team would promote improved team working and understanding but most importantly, explicit team and individual responsibilities for patient safety and welfare. It would also offer protection for HCSWs in circumstances in which they are asked to undertake activities for which they are not competent or are unsure of. The NMC as the regulatory body for nursing could develop a common code of conduct for the nursing team.

Models for HCSW and Assistant Practitioner Regulation

Although the 2004 public consultation on the regulation of HCSWs found broad general agreement on the need for HCSW regulation, there was less consensus on how they should be regulated or by whom²⁹. There are two principal models for the regulation of HCSWs:

- An employer – led model
- A professionally – led model

Employer – Led Model

An employer – led model for HCSWs indicates a list or register of HCSWs who are deemed fit for purpose that is held by employers plus possibly also a set of broad general standards such as the need for patient

²⁷ RCN (2006) *Supervision, Accountability and Delegation of Activities to Support Workers: A Guide for Registered Practitioners and Support Workers* RCN: London

²⁸ This may be reason underpinning evidence in Knibb. W. et. al (2006) that personal knowledge of HCSWs is an important factor in the activities registered nurses delegate to HCSWs rather than HCSW qualification or prior experience.

²⁹ Department of Health (2006) *Op Cit*

confidentiality. There are some advantages to this model in that, in theory, employers can identify individual HCSWs and hold relevant information on them.

Identification of HCSWs is problematic because:

- Unlike health professionals who become identifiable and regulated at the point of a mandatory and accredited educational qualification, there is no such marker or comparator for HCSWs who may, or may not, possess vocational qualifications³⁰
- They are a mobile workforce and move in and out of HCSW employment and also between different health care settings, for example from care homes to the NHS. This is one of the reasons exact numbers of HCSWs are not known
- HCSWs are known by a range of various titles.

However, because HCSWs have multiple employers and can be employed in the NHS, social care or independent sectors, it will be difficult to establish an employer – led model that can cover *all* HCSW employers. Multiplicity of employers also means that even if it were possible to collate data on individual HCSWs from a range of employers in one list, this would necessarily need to hold fairly minimal information, for example listing HCSWs for whom the appropriate police and reference checks had been made. However a single employer held list, as for example in the Scottish pilot study referred to previously which relates only to the NHS, cannot prevent HCSWs whose NHS employment has been terminated because of misconduct being employed as an HCSW in a different sector.

Northern Ireland may have some advantage in this in that it has unitary organisations which carry out both health and social care functions. However the model for HCSW regulation in Northern Ireland is not employer – led but professionally – led in that there is provision for any person engaged in the delivery of personal care to be regulated by the Northern Ireland Social Care Council as social care workers. Consequently some HCSWs in Northern Ireland will be registered by this body.

Although an employer – led model could suggest broad general standards for public protection such as confidentiality, these would be voluntary since there is no suggestion (at this stage) for any compunction on employers and HCSWs to adhere to these. There may well be variation in practice standards between employers that could thus neither be made uniform nor policed to ensure they reach an acceptable level. Such standards would not address the need for consistency and a shared code of conduct for professionals and HCSWs who work together in teams either.

³⁰ There is no compunction for HCSWs to possess qualifications other than the care home sector in England

Professionally – Led Model

The alternative model for HCSW regulation is professionally – led whereby a regulatory body separate and independent from employers holds a list or register of HCSWs and sets standards for practice. This model of regulation is preferred by some because of the independence of regulatory bodies to set and enforce acceptable standards for care outwith that which may be deemed appropriate within the local employment context. There are two options for how this could be implemented for the regulation of HCSWs:

- An umbrella professional regulatory body for all HCSWs
- Uni – professional regulatory bodies that regulate HCSWs who work as assistants to specified health professionals

Responses to the public consultation in 2004 on HCSW regulation found 70% of respondents favoured the Health Professions Council as the home for HCSW regulation whilst 30% favoured single professional regulatory bodies, most notably the NMC, for HCSWs who worked as assistants and support workers to professional groups³¹.

A professional model of regulation that brings together all HCSWs into one regulatory body, most probably the Health Professionals Council, has advantages in that it creates a group identity for HCSWs. On the other hand it does not defacto bring together professionals and those who support them in the health care team in a unified manner with a clear identity for HCSWs in such teams. Nor would it lead to a shared code of conduct and clarification of responsibilities.

Some uni – professional regulatory bodies already regulate support workers allied to health professions. For example the General Dental Council regulates dental nurses and dental hygienists along with dentists whilst the General Optical Council regulates a range of staff employed in optical care.

The choice of regulatory body for future regulation of HCSWs would depend on which currently regulates the specified health professions. For example the Health Professions Council would still be the regulatory body for HCSWs allied to physiotherapists but they fall under the jurisdiction of the specified part of the register for physiotherapists. For HCSWs who work in direct clinical care with nurses in the nursing team, the NMC would be the regulatory body.

This uni – professional model has advantages for team work, HCSW identity and responsibilities within the team and the development of a shared code of conduct. Its drawbacks are in the difficulty in identification

³¹ Department of Health (2006) *Op Cit*

of HCSWs currently in employment and practice. However it will increasingly be possible to identify a group *within* the HCSW category in terms of skills and qualification at the level of the assistant practitioner.

The advantages for regulating HCSWs at the level of assistant practitioner are:

- An identifiable level of entry to regulation, either at qualification or studying for same
- A common code of conduct for HCSWs at this level who work as assistants to health professionals
- A means of ensuring public protection for a specific skilled group of HCSWs who will be undertaking protocol – based patient care independently with supervision from a registered practitioner, and have supervisory responsibilities for other HCSWs

The disadvantage lies in regulation of only a proportion of HCSWs, which will improve public protection and patient safety but not complete or guarantee it for the HCSW workforce.

Cost of Regulation

The cost of regulation is an issue for regulating HCSWs for both employer – led and professionally – led models as even the most minimal form of regulation in terms of provision and maintenance of a list or register requires funding. Health professionals fund their own regulation through payment of a fee but it is not clear whether HCSWs given their lower salaries and employment mobility would wish to assume this. On the other hand, research suggests that HCSWs do want some form of regulation for themselves³² and certainly nurses also want HCSWs in the nursing team to be regulated. Cost of regulation – who funds it and how – is an issue for further debate.

The RCN View

The RCN has a clear view that all HCSWs should be regulated in the interests of public protection and patient safety. Further we believe that HCSWs who deliver direct clinical care alongside registered nurses in the nursing team should be regulated by the nursing regulatory body, the NMC³³. However we acknowledge the complexities that surround implementation of HCSW regulation. Therefore the RCN believes a

³² Johnson, M. et al (2002) *Regulation of Health Care Assistants*, paper presented to the Institute of Public Policy Research seminars on ‘The Future Healthcare Worker’

³³ RCN (2006) Unpublished Response to the Review of the Regulation of Non – Medical Healthcare Professions

pragmatic first step forwards in an evolutionary process towards HCSW regulation is the regulation of assistant practitioners in nursing by the NMC.

Timing is a critical factor because there are real opportunities to influence the future of nursing given the White Paper proposals on professional regulation and publication of *Modernising Nursing Careers*, both of which will cement the development of the nursing profession and nursing practice over the next twenty years at least. The time is right for a concerted lobby to influence the direction of travel of the nursing profession and ensure public protection and patient safety.

RCN Recommendations: The Regulation of Assistant Practitioner Roles in Nursing

The RCN believes that HCSWs should be regulated in the interests of public protection and that regulation of assistant practitioners in nursing by the NMC is a first pragmatic step in this direction.

We therefore recommend that:

1. The RCN, NMC and other key stakeholders agree a UK - wide shared understanding about the title assistant practitioner and its related role in nursing as a matter of urgency.
2. The RCN, NMC and other key stakeholders map the current and predicted numbers of assistant practitioners in nursing
3. The NMC to establish a register for assistant practitioners in nursing. This would initially need to be a voluntary register until primary legislation could be enacted to establish a statutory register.
4. The RCN, NMC and other key stakeholders agree the detail for implementation of assistant practitioner regulation, including funding arrangements.