



The Cavendish Review

An Independent Review into Healthcare
Assistants and Support Workers in the NHS
and social care settings

July 2013

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Executive Summary

Background and Approach

In the wake of the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust, and reports of failings in other hospitals and care homes, the Secretary of State for Health asked me to review what can be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion.

There are over 1.3 million frontline staff who are not registered nurses but who now deliver the bulk of hands-on care in hospitals, care homes and the homes of individuals. The Review's terms of reference included recruitment, training, supervision, support and public confidence. It did not include statutory registration, which the Government felt would not add sufficiently to the general assurance provided by the CQC.

My approach, in the 14 short weeks available, has been to spend as much time as possible on the frontline of care. I have visited hospitals and care homes and met nurses, domiciliary care workers, healthcare assistants and care home staff in focus groups around the country. I have also sought out some of the best organisations in health and social care, to see what can be learned from them.

My recommendations have been guided by two principles: to try to reduce complexity and bureaucracy; and to go with the grain of what the best employers are already doing.

A Disconnected Landscape

I have been struck by how disconnected the systems are which care for the public. The NHS operates in silos, and social care is seen as a distant land occupied by a different tribe. Yet when Mrs Jones leaves hospital for a care home, or to recuperate in her own house, she is still the same person. She wants to be treated as the same person, and to be looked after by staff with the same core knowledge and core values.

If we can identify what is common, we can reduce complexity and duplication, and give Mrs Jones a better service. So this Review proposes new common training standards across health and social care, grounded in what the best employers already do. It proposes a "Certificate of Fundamental Care," written in plain English, to make a positive statement about caring. And it asks that the CQC require all workers to have achieved this Certificate before working unsupervised (Recommendation 1, 3).

The Certificate would link healthcare assistant training to nurse training for the first time (Recommendation 4). For it makes no sense to teach nursing students and assistants the practical elements of fundamental care in different languages and separate silos. Airlines learned years ago that the most junior staff are crucial to passenger safety, and adjusted their training accordingly. The same must be done for patient safety. To build the workforce of the future, there is a big opportunity for employers to try and define a golden thread of values and competences that should be common to workers in both health and social care (Recommendation 2).

What We Found in the NHS

Healthcare assistants (HCAs) make up around a third of the caring workforce in hospitals, but research suggests that they now spend more time than nurses at the bedside. If the NHS wants to improve patient care, it should see healthcare assistants as a critical, strategic resource. Yet many HCAs feel undervalued and overlooked.

Unlike the old State Enrolled Nurses who used to support Registered Nurses, healthcare assistants have no compulsory or consistent training, and a profusion of job titles. This confuses patients, who often assume that everyone is a nurse; and it makes life difficult for some nurses, who are not always sure which tasks they can safely delegate.

Some HCAs are now doing jobs that used to be the preserve of nurses, even doctors. The Review met a group of healthcare assistants from a busy A&E who are inserting IV drips, taking blood and plastering. Yet they are paid at three levels below a newly qualified nurse.

The NHS has tended to treat HCAs and the registered nurses who supervise them as separate workforces. A glaring example is the failure to consider how the move to all-degree nursing would affect the career prospects of HCAs. Good hospitals and care homes are now unable to promote some of their best assistants into nursing. This is a waste of talent which must be overcome by urgently developing new bridging programmes (Recommendations 7, 8).

Nurses are often the greatest advocates of HCAs. If the NHS is to operate in the best interest of patients, Trust Boards must empower Directors of Nursing to take full responsibility for the recruitment, training and management of HCAs, (Recommendation 13). The Review also proposes that organisations gradually try to reduce the number of titles, and allow eligible HCAs to call themselves Nursing Assistants or Auxiliaries, as some of the best Trusts already do, to give patients more clarity and HCAs more status (Recommendation 11).

There is now overwhelming evidence that care outcomes improve when all staff feel valued as part of strong, self-reinforcing teams. The Army treats its 200 HCAs as integral to the team, and sets high standards for them. Ward sisters, midwifery and community leads must be appointed with the right characteristics to lead positive, engaged teams. Paperwork has become a major barrier to first line managers doing their jobs, in both health and social care: so regulators, commissioners and employers must collaborate to define a single common data set (Recommendation 12).

A major obstacle to improving care throughout the NHS is the difficulty in removing staff who are not caring or competent. This Review recommends that the Secretary of State for Health commissions the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal of unsatisfactory staff (Recommendation 14). For patients need to know that the NHS will identify and remove any staff who are not caring or competent. And there is nothing more demoralising, for the many excellent nurses and HCAs, than to see poor care go unchallenged.

What We Found in Social Care

The social care support workforce dwarfs that of health. By helping people to live independently, it plays an essential role in supporting the vulnerable and reducing the strain on the NHS. So the high turnover rates – of 19% a year in care homes and up to 30% a year in domiciliary care – are worrying. For workers in this sector, “I’m only a carer” is too common a refrain.

The phrase “basic care” dramatically understates the work of this group. Helping an elderly person to eat and swallow, bathing someone with dignity and without hurting them, communicating with someone with early onset dementia; doing these things with intelligent kindness, dignity, care and respect requires skill. Doing so alone in the home of a stranger, when the district nurse has left no notes, and you are only being paid to be there for 30 minutes, requires considerable maturity and resilience.

Like healthcare assistants, social care support workers are increasingly taking on more challenging tasks, having to look after more frail elderly people. Yet their training is hugely variable. Some employers are not meeting their basic duty to ensure their staff are competent. I have talked to staff who were given a DVD to watch at home before being sent straight out to the frontline. I have talked to others who were asked to pay for mandatory training out of their own pocket. This is why the Review proposes minimum standards of competence before staff can work unsupervised, in the form of the “Certificate of Fundamental Care” – and a code of conduct for employers (Recommendations 3, 15).

Social care employers are striving to train, retain and motivate staff under considerable financial pressure. They find it burdensome to navigate the sea of vocational qualifications and training courses which has developed in response to changing fashions in government funding. Lack of faith in the system has led to costly duplication, as employers develop their own in-house courses, and retrain new staff irrespective of what training they have had elsewhere.

This Review calls for a rigorous quality assurance mechanism for training courses and vocational qualifications (Recommendation 5). It also recommends that the main trade associations and social care employers lead a process to agree on core national competences that go beyond the minimum (Recommendation 2).

Despite the pressures, charities, hospices and other social care organisations are pioneering some of the most innovative approaches to person-centred care. The NHS has a great deal to learn from them about responding to individual needs, and recruiting people with the right values. This Review proposes help, for employers who want it, in testing test values, attitudes and aptitude for caring (Recommendation 6).

Too many workers do not see caring as a career, with opportunities to progress. The fragmented nature of the sector, lack of faith in qualifications and lack of portable skills do not help. The Review recommends that employers be consulted on the possibility of creating a career development framework for health and social care workers (Recommendation 10). It also proposes that Higher Education Institutions give more weight to care experience, so that talented staff can progress into therapy, social work or nursing (Recommendation 9).

Time to Care

An inescapable fact is that good caring takes time. It will not be possible to build a sustainable, caring, integrated health and social care system on the backs of domiciliary care workers who have to travel long distances on zero hours contracts, to reach people who have to see multiple different faces each week. Local authorities must start to commission for outcomes, not by the minute – which is a false economy when so many staff are quitting (Recommendation 16). And staff must be paid for travel time, since non-payment can push their earnings below the National Minimum Wage (Recommendation 18).

In the NHS, 12-hour shifts have become the norm. Yet it is not clear whether this is compatible with maintaining compassionate care, especially when looking after patients with complex needs. The perspective of healthcare assistants must be taken very seriously when this is investigated by NHS England (Recommendation 17).

Conclusion

This Review can only ever be a first stage on a long journey. These recommendations are intended to start that journey, by ensuring that support staff are treated as a strategic resource in health and social care. For some of them are the most caring of all.

A handwritten signature in black ink, reading "Camilla Cavendish". The signature is written in a cursive style with a large initial 'C' and a long, sweeping tail.

Camilla Cavendish

Summary of Recommendations

Recruitment, Training and Education

1. HEE should develop a "Certificate of Fundamental Care", in conjunction with the Nursing and Midwifery Council (NMC), employers, and sector skills bodies. This should be written in language which is meaningful to the public, link to the framework of National Occupational Standards, and build on work done by Skills for Health and Skills for Care on minimum training standards.
2. A "Higher Certificate of Fundamental Care" should also be developed, linked to more advanced competences to be developed and agreed by employers. The Department of Health should hold HEE and Skills for Care to account for ensuring that there is step-change in the involvement of best employers.
3. The Care Quality Commission should require healthcare assistants in health and support workers in social care to have completed the "Certificate of Fundamental Care" before they can work unsupervised.
4. The NMC should recommend how best to draw elements of the practical nursing degree curriculum into the Certificate; HEE, LETBs and employers should seek to have nursing students and HCAs completing the Certificate together.
5. HEE, with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training, which links funding to outcomes, so that money is not wasted on ineffective courses.
6. Employers should be supported to test values, attitudes and aptitude for caring at recruitment stage. NHS Employers, HEE and the National Skills Academy for social care should report on progress, best practice and further action on their recruitment tool by summer 2014.

Making Caring a Career

7. HEE and the LETBs should develop new bridging programmes into pre-registration nursing and other health degrees from the support staff workforce in health and social care, working with Skills for Care, NMC and Skills for Health; and explore the Barchester proposal for a Higher Apprenticeship.
8. HEE and the LETBs should set out a clear implementation plan, with robust measures, to take forward the objective in the HEE mandate to widen participation in recruitment to NHS-funded courses: and develop innovative funding routes for non-traditional staff to progress.
9. The NMC should make caring experience a prerequisite to starting a nursing degree, and review the contribution of vocational experience towards degrees so that staff with strong caring experience can undertake 'fast-track' degrees. Skills for Care should work with Higher Education Institutions to look

at how care experience can be recognised in enabling people to enter social work, therapy and advanced social care courses.

10. NHS Employers, HEE and Skills for Care should work with employers to set out a robust career development framework for health and social care support staff, linked to the simplified job roles and core competences.

Getting the Best out of People: Leadership, Supervision and Support

11. Employers should allow HCAs to use the title "Nursing Assistant" on completion of the "Certificate of Fundamental Care", where appropriate.
12. Regulators, employers and commissioners in health and social care should define a single common dataset for their purposes, and commit to using it, to relieve the pressure on first line managers and other staff.
13. Trusts should empower Directors of Nursing to take greater Board level responsibility for the recruitment, training and management of HCAs, from day one.
14. The Secretary of State for Health should commission the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal of unsatisfactory staff, the legal framework around this, and the relationship with referrals to professional regulators.
15. Skills for Health should refine its proposed code of conduct for staff, and the Department of Health must review the progress of the social care compact: and substitute a formal code of conduct for employers if a majority have not acted upon it by June 2014.

Time to Care

16. The Department of Health should explore with the social care sector how to move to commissioning based on outcomes; and aim to eliminate commissioning based on activity by 2017.
17. NHS England should include the perspective of HCAs and support workers in its review of the impact of 12-hour shifts on patients and staff.
18. Statutory guidance should require councils to include payment of travel time as a contract condition for homecare providers.

1. Introduction

- 1.1. It has been a great privilege to have been asked to carry out this independent review by the Secretary of State for Health. Given the context of Mid-Staffs and Winterbourne View, I had not expected this journey to be so uplifting.
- 1.2. While I have heard about some worrying examples of poor care, I have also met many extraordinary, dedicated carers:
- 1.3. At Barchester's Queens Court Care Home in South London I met Arceli, a young woman who came to this country to look after elderly people and who, 8 years on, is now training as a nurse but still working at the care home every weekend. She positively glowed when talking about old people and when I asked how she copes with the strain of it all she at first looked a little blank, then answered: "it's easy if you love what you do".
- 1.4. At the Queen Elizabeth Hospital in Birmingham, I met Christine, a lady in her fifties who told me that she had wanted to do something for herself after her children left home. For her, "doing something for myself" meant becoming a domestic at the hospital, and then being promoted to an NHS Band 2 Health Care Assistant. Christine is thrilled, because "I love talking to the patients, trying to help them feel better".
- 1.5. At Crosby Close, a home for severely disabled people in St Albans run by MacIntyre, I listened to senior care assistant Siobhan talking about how lucky she is to work with "naturals": people whose vocation is to care. Hearing her describe how the team helped a woman with severe learning disabilities who has no verbal communication learn to make her own coffee – after noticing the way her eyes followed them around the kitchen from her wheelchair – I knew I was watching a natural at work.
- 1.6. It is no accident that all three of these women work for top class organisations which value them as part of the team. These organisations are clear about what the role of the support worker is, and what their values are, and they do not accept second-best. In fact the best employers have already invented many of the solutions to the challenges we detail in this Review. The challenge for Government is to align incentives, define and enforce standards, to spread the best more widely.
- 1.7. I could never do the jobs these women do, let alone do it with the glow they bring to their work. I have come away from this project thinking that our society is incredibly lucky to have so many people with a dedication to caring. But I also fear that if we continue to take them for granted, if we do not fix dysfunctional systems of commissioning and regulation, we may find as we grow old that they are not there to look after us.

2. Overview

2.1. Aims of this Review

- 2.1.1.** In the wake of the Francis Report and other reports highlighting poor care in health and social care, the Cavendish Review was established to investigate what can be done to ensure that all people using services are treated with care and compassion by healthcare assistants and support workers in the NHS and social care settings¹.
- 2.1.2.** Concerns have been growing about this workforce since scandals at Maidstone and Tunbridge Wells, Mid-Staffs and Winterbourne View. The Willis Commission on Nursing² heard concerns that “skill mixes were being diluted by the expanding, uncontrolled use of non-registered and often untrained staff to carry out tasks previously the domain of registered nurses. Patients are often unaware of the level and qualifications of staff caring for them. These rapidly, locally driven modifications in the shape and functions of nursing workforce include valuable innovations, but are sometimes poorly implemented and not evaluated, raising concerns about public protection”. In his report on Mid-Staffs³, Robert Francis QC demanded a national code of conduct and national standards of training for healthcare support workers. He said that they should be clearly identifiable and distinguishable from registered nurses, and should not be allowed to give personal care in any healthcare setting without first being registered. The Department of Health’s⁴ review found that, by the time of filming of Panorama, Winterbourne View had become “dominated to all intents and purposes by support workers rather than nurses” and there was “little evidence of staff training in anything other than restraint practices”.
- 2.1.3.** The Review’s terms of reference were to consider whether there might be better ways to recruit, train and support and supervise these staff, to make patients and users feel more confident, and to ensure that the care they receive is compassionate and competent – outside of mandatory registration for the workforce.

2.2. Our approach

- 2.2.1.** In the 14 short weeks available, we have focused as much as possible on the frontline of care, talking to staff in hospitals and care homes, meeting with domiciliary care workers, healthcare assistants, personal assistants, nurses and registered managers. We have also sought out some of the most respected, innovative organisations in health and social care, to see what can be learned from them.

¹ See Appendix for full terms of reference

² *Quality with compassion: the future of nursing education*. Report of the Willis Commission on Nursing Education, 2012. Published by the Royal College of Nursing on behalf of the independent Willis Commission

³ Francis Inquiry

⁴ Transforming Care: A national response to Winterbourne View Hospital. Department of Health, December 2012

2.3. We have conducted:

- Four large focus groups in Birmingham, London, Leeds and Salisbury with healthcare assistants from the NHS (acute and community settings) and support workers from social care (care homes and domiciliary care), nurses and social care managers
- A small focus group arranged in London by UNISON
- A seminar for social care employers
- An online survey for healthcare and support workers which received 4,000 responses
- Meetings with staff in hospitals and care homes around the country
- A webinar with healthcare assistants working in district nursing teams around the country
- Two roundtables hosted by MacMillan and Reform
- An informal consultation which received over 100 responses from organisations and individuals

2.3.1. For the purposes of this review we have drastically simplified the number of titles and tasks by referring to unregistered workers in the NHS as healthcare assistants (HCAs), and those in social care as support workers (SW), while being conscious that this covers a vast multitude of roles and settings⁵. Although it is not always correct to describe this as a single workforce, we have tried to identify and focus on common themes.

⁵ The term "HCA" is used in this document to refer to healthcare assistants and auxiliaries, Assistant Practitioners, healthcare support workers and those giving technical support to clinical roles in the NHS. The term "care support worker" denotes adult social care workers giving direct care in residential and nursing homes and hospices, home care workers and domiciliary care staff, and personal assistants.

3. The Frontline of Care

Summary

There are over 1.3 million unregistered healthcare assistants and support workers working on the frontline of care: although a profusion of job titles and lack of role clarity means that an exact count is not possible, even within the NHS.

In the NHS, advances in medicine, a growing burden of paperwork on nurses and a rapidly ageing population mean some healthcare assistants are performing tasks, including invasive procedures, which were once the preserve of nurses, even doctors. Yet there is little correlation between pay band and performance, no consistent or compulsory training and no national job descriptions. The fact that the NHS recruits and trains nurses and HCAs in separate silos exacerbates uncertainty, among some nurses, about what they can safely delegate.

The social care support workforce dwarfs that of health. As clients become older and frailer, support workers are taking on more challenging tasks. The distinction between nursing and residential care homes is blurring. And in domiciliary care, a combination of low pay and time pressure has sent attrition rates soaring. It seems doubtful that health and social care can be successfully integrated on the backs of workers whose turnover rates are so high and pay so low.

These workforces are set to grow. There is an urgent need to acknowledge them, support them, and plan for them.

"A disenfranchised part of the workforce which looks after the most vulnerable patients."
(Professor Scott McLean, Bart's and the London NHS Foundation Trust)

"One of our staff said, 'I'm only a carer': that's just wrong." (Mike Rogers, Mears Group Plc)

- 3.1.1.** There are over 1.3 million⁶ people in the unregistered care workforce who are not Registered Nurses or social workers but who now give the bulk of hands-on care in hospitals⁷, nursing homes, care homes, and in the houses of individuals who need help to live independently. This chapter briefly summarises the roles they play and new challenges they face.

⁶ 2011-12 data for unregistered staff delivering direct care (NHS and social care). Health and Social Care Information Centre, and National Minimum Dataset – Social Care, managed by Skills for Care.

⁷ A healthcare assistant does twice as much direct patient care on the wards as a nurse: University of Oxford 2010 <http://www.sbs.ox.ac.uk/research/organisationalbehaviour/Pages/supportworkers.aspx>

Key statistics for healthcare assistants and support workers		
	Health	Social care
Size of workforce⁸	106,500 (2012; narrowest definition) (Robert Francis fig: totals around 332,000 comprising of: 270,000 providing support for doctors and nurses and a further 62,000 among the scientific and technical staff)	1.225 million (2011)
Where do they work?	Over half work in the acute sector (acute, elderly, general)	Almost half work in domiciliary care (providing care in a person's home)
Average age	45	35 (new starters), with no evidence of an ageing workforce
Gender	84% female	84% female
Ethnicity (Black and minority ethnic groups)	15%	29%
Average number of years in post	4.1 (average across England)	59% spent between two and six years in post, with 31.9% having been in post for more than six years
Turnover	14%	19.8%
Pay	56% paid between £14,294 and £17,425 pa (Agenda for Change Band 2)	£13,974 pa (average)

Figure 1: key statistics for health and social care

Source: Health and Social Care Information Centre (Health) & National Minimum Data Set (Social care)

3.2. Healthcare assistants in the NHS

- 3.2.1.** Most people understand the difference between a Community Support Officer and a Police Officer. But many patients are unaware that the staff they assume are nurses are in fact healthcare assistants (HCAs). Some turn to HCAs for clinical advice, without realising that they do not necessarily have clinical expertise.
- 3.2.2.** Confusion is exacerbated by the profusion of job titles (over 60 at the last count). Job descriptions are determined locally, and vary from employer to employer. Some managers do not permit HCAs to

⁸ Latest year for which complete data is available

write in a patient's nursing notes (although HCAs are frequently the ones making the observations), others let them do so.

- 3.2.3.** The use of so many different titles for the same category of staff means that it is difficult to make a precise count of the number of HCAs in the NHS. Data from the Health and Social Care Information Centre (H&SCIC) suggests a figure of 215,000 (for 2011 including bank staff), which comprises nursing assistants and auxiliaries, healthcare assistants, and workers giving clinical support to scientific, therapeutic and technical staff. The narrowest definition, from the H&SCIC, gives 106,500 nursing auxiliaries, healthcare assistants and assistant practitioners in 2012, compared to 329,294 nurses. This suggests that the group this Review is considering makes up around 24%⁹ of the nursing care workforce.
- 3.2.4.** Recent workforce data from the H&SCIC shows that, in the 12 months between September 2011 and 2012, the number of registered nurses in England dropped by 2,283. The number of HCAs rose by 2,691 during the same period. This may suggest that, as recession bites, HCAs have been substituted for nurses.
- 3.2.5.** This may be a temporary phenomenon, however. It must equally be noted that the same dataset shows that the number of nurses employed in the NHS has grown since 2002 by 36,800, in contrast to a fall in the care support workforce of 13,700.
- 3.2.6.** Nursing itself accounts for 59% of the care workforce in the NHS¹⁰, leading delivery of care and support across many settings from hospital to home, from birth to the final hours, regardless of the circumstances of the individual being cared for. Nurses' skills set encompasses helping people to stay healthy and well for longer, and promoting independence, all the way through to supporting others to recover from or live with illness. Their conduct, ethics and performance are open for scrutiny and governed by the Nursing and Midwifery Council¹¹.

3.3. The HCA role is not new

- 3.3.1.** There have always been nursing aides, dating back at least to the Crimean War. When nursing was established as a registered profession under the 1919 Health Care Act, unregistered nursing assistants and auxiliaries continued to work and were formally recognised in 1955. The two-year assistant nurse qualification did not permit registration as a nurse, but to inclusion on a Roll of Nurses, which in 1961 was designated State Enrolled Nurse (SEN). SENs – the "little greenies" – wore green uniforms and did two years of practical training. Entry required 2 O-Levels or CSE's at Grade 1. Would-be State Registered Nurses (SRNs) who failed their exams at the third attempt were able to enter the register as SENs.
- 3.3.2.** SEN training was discontinued when nurse training was reorganised under Project 2000 (although the role remained for some years with many SENs undertaking conversion courses to become registered nurses). The new approach to nurse training saw a shift from an apprentice, "shopfloor" model, rooted in hospital schools of nursing, to one based on classroom learning in a university setting, and practical skills learned on placements, where the students were largely supernumerary. This reduced the opportunity for registered nurses to use student nurses as support for delivering patient care, leaving auxiliaries as the main source of help. Moreover, the government provided enough funds for

⁹ Health and Social Care Information Centre

¹⁰ Health and Social Care Information Centre

¹¹ Nursing and Midwifery Council Code of Conduct 2008

only about half of the new student nurses to be replaced on the wards when they stepped out of practice to study¹².

- 3.3.3. The 1990 NHS and Community Care Act introduced a new grade of HCAs, into which nursing auxiliaries were gradually incorporated. HCAs were explicitly seen as the replacement for the support from student nurses. It was clear that registered nurses should remain responsible and accountable for the care that patients received.
- 3.3.4. The UK Central Council for Nursing, Midwifery and Health Visiting proposed that the new HCAs be called "nursing aides" and have three months of induction and preparation before delivering patient care¹³. Neither was implemented. HCAs could acquire vocational qualifications, NVQs 2 and 3, but these were not compulsory or a requirement for entry to the role.
- 3.3.5. In the NHS, HCAs were allocated to Bands 1-3 on the Agenda for Change (AfC) framework. More recently a new higher level of HCA has been introduced with the Band 4 Assistant Practitioner (AP). APs deliver care and undertake tasks that were previously within the remit of registered professional staff, in areas such as outpatients, endoscopy and renal, and now also on some general wards. The AP role was designed to be protocol-based care, supporting registered nurses in achieving better patient outcomes.

3.4. Pay levels

- 3.4.1. Today, HCAs in the Level 2 pay band earn £14,294-£17,425 per annum, more senior HCAs at Level 3 earn £16,271-£19,268 and Assistant Practitioners at Level 4 earn £18,838-£22,016. This compares to AfC Level 5 (nurses): (£21,388- £27,901). The AfC pay bands 1-4 do not relate to any national standard of training or performance. Grading of staff in the independent and voluntary sectors does not correspond with NHS banding¹⁴. Today, the majority of HCAs are employed at Band 2, as illustrated in Figure 2 below.

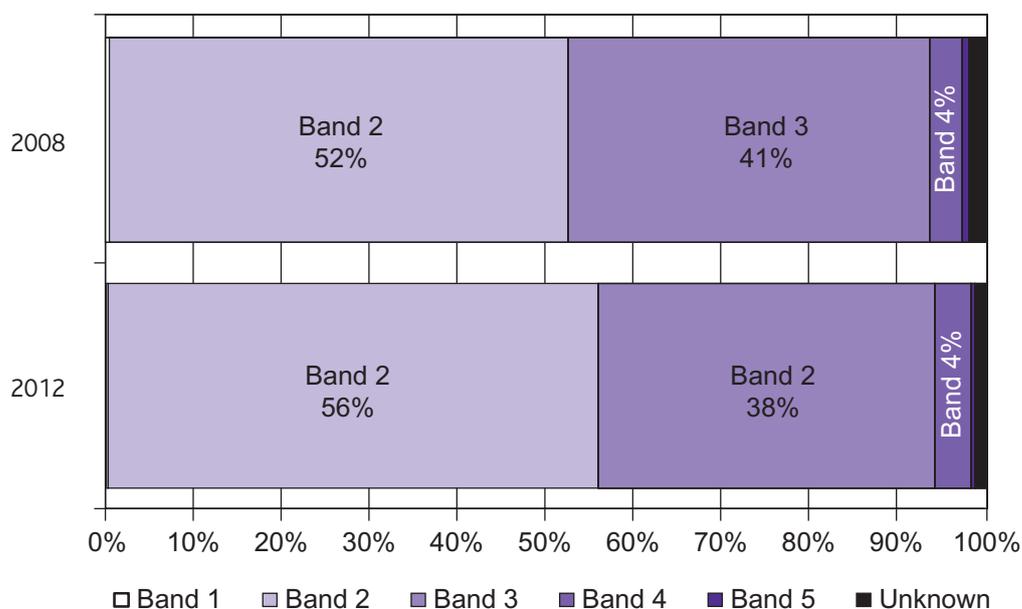


Figure 2: HCAs AfC Pay Bandings

Source: H&SCIC

¹² Kessler, I., Heron, P. and Dopson, S. (2012). *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford: Oxford University Press

¹³ *Project 2000: A New Preparation for Practice*, UKCC

¹⁴ King's College Nursing Research Unit, 2010

3.5. The nature of the work done by healthcare assistants

3.5.1. HCAs support registered nurses in a variety of ways. Many nurses see them as an extra pair of hands, someone to whom they can delegate routine tasks. Other nurses (and some doctors) say that the best HCAs are their “eyes and ears”, feeding back information or picking up warning signs that something is wrong with a patient. Some have used them as translators. In other cases, experienced HCAs can be an important source of guidance and advice to student nurses and the newly qualified. The nurses and nurse educators who attended the Review focus groups were very positive about HCAs, citing them “the backbone of the NHS”.

3.6. Routine tasks

3.6.1. The routine tasks which HCAs are expected to do include making beds, helping patients to eat and bathe, monitoring and recording patient’s glucose levels, temperature, pulse, respiration and weight, carrying out simple dressings and escorting patients to theatre. A number of studies have found HCAs reporting that their involvement in direct bedside care means that they spend more time with patients than registered nurses do¹⁵.

3.6.2. This chimes with the views of HCAs in our focus groups. As a result of the time registered nurses have to spend on care planning, liaison and discharge, HCAs sometimes have more opportunities to develop relationships with patients. In fact, some told us that they no longer want to become nurses now they have seen how much time nurses are spending on paperwork.

3.6.3. A detailed three-year study by Ian Kessler, Paul Heron and Sue Dopson^{16,17}, completed in 2010, found that the “core” of patient care has shifted from tasks performed by nurses to those performed by HCAs. The study involved ward observations and interviews with over 1,000 staff and patients. It found that HCAs spent the majority of their time on a typical early shift carrying out direct and indirect care, whereas nurses spent the largest proportion of their time on organisational tasks such as answering the phone and handovers¹⁸.

3.7. Advanced tasks

3.7.1. Partly as a consequence of nurses spending increasing time on organisational tasks, some HCAs are now doing a wide range of more advanced tasks traditionally undertaken by registered nurses. These include female catheterisation, cannulation (the insertion of an IV drip or tracheotomy tube), applying complex dressings, monitoring diagnostic machines, setting up infusion feeds, giving injections, preparing medication and administering it to patients, making ECG tracings, taking blood samples, liaising with medical staff, relating medical information to relatives, and developing and updating care plans¹⁹

¹⁵ Spilsbury K, Meyer J (2004) Use, misuse and non-use of healthcare assistants: understanding the work of healthcare assistants in a hospital setting. *Journal of Nursing Management*; Kessler et al 2010

¹⁶ Kessler, I., Heron, P. and Dopson, S. (2012). *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford University Press

¹⁷ The Modernization of the Nursing Workforce: valuing the healthcare assistant is based on recently completed research exploring the role of HCAs in acute hospitals. Whilst a supporting role working alongside registered nurses has been a longstanding feature of the NHS, the contemporary HCA role has become increasingly central to the process of health service modernisation.

¹⁸ <http://www.sbs.ox.ac.uk/research/organisationalbehaviour/Pages/supportworkers.aspx>

¹⁹ King’s College National Nursing Research Unit 2010: “Moving forward with healthcare support workforce regulation”

- 3.7.2.** The submissions made to this Review suggest that there is enormous variation in what HCAs are doing at different pay bands in different Trusts. The Review team met one group of HCAs from the A&E department of a busy hospital, are inserting IV drips, taking blood, doing electrocardiograms, and plastering. One is even teaching plastering, on study days. Yet this group is paid at Band 2, three levels below a nurse.
- 3.7.3.** Kessler et al's research supports the assertion that advanced tasks, such as electrocardiography and taking blood samples, that were once the remit of registered nurses are now more common for a certain kind of HCA²⁰.

3.8. Boundaries are blurring between registered nurses and healthcare assistants

- 3.8.1.** There are two main differences between the registered nurse and the HCA. Only the registered nurse can give the full range of prescription only medication; and HCAs are under the supervision of the nurse. The nurse's role is to assess, plan, implement and evaluate the care; and to delegate tasks to the HCA within that framework.
- 3.8.2.** The NMC guidance makes clear that nurses are responsible for delegating to an HCA who is competent and willing to perform the task required; and that the HCA is then responsible for that task. But the lack of clear job descriptions and competences in some places can make nurses unsure about what they can delegate^{21,22}. Some worry that they are accountable for any mistake made by the HCA, because they have a Personal Identification Number (PIN) linked to their registration and HCAs do not.
- 3.8.3.** However, as more Trusts say they intend to make more use of APs, and some develop more generalist AP roles, this creates a fundamental challenge to what we mean by nursing²³.
- 3.8.4.** There are three main reasons behind HCAs having taken on greater responsibilities than were anticipated in the 1980s:
- 3.8.5.** First, nursing developed a range of new specialist practitioner roles which took parts of the profession away from basic nursing care and into more advanced clinical jobs. This increased the load on HCAs. (Similar trends were seen in the US, Canada, France and Finland²⁴).
- 3.8.6.** Second, the European Working Time Directive shortened the working hours of junior doctors. As a result, some of their tasks were delegated to nurses. A 2005 Royal College of Nursing (RCN) study of 700 nurses²⁵ found that 60% of nurses were the first to have taken blood from a patient or carried out cannulation. By 2012, only seven years later, nurses were sometimes delegating those tasks to HCAs.

²⁰ Kessler, I., Heron, P. and Dopson, S. (2012). *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford: Oxford University Press, page 25

²¹ Royal College of Nursing, *The principles of accountability and delegation for nurses, students, health care assistants and assistant practitioners*. October 2011

²² Maben J, Latter S and Macleod Clark J. *Nursing Inquiry* 2007; 14: 99–113, *The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study*, page 105

²³ Buchan, J & Seccombe, I. *A decisive decade – mapping the future NHS workforce*. Queen Margaret University, July 2011

²⁴ Kessler, I., Heron, P. and Dopson, S. (2012). *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford: Oxford University Press, page 25

²⁵ *Ibid*, page 26

- 3.8.7.** Third, an audit- and targets-based performance culture, coupled with the drive to discharge patients as quickly as possible, has meant that nurses spend more and more time on paperwork. In April 2013, an RCN survey of 6,387 members found that 86% of nurses believed the amount of non-essential paperwork, such as filing, photocopying and ordering supplies, that they carry out had increased in the past two years.
- 3.8.8.** In 2007, the NMC noted that: "there are significant changes in the way that services are delivered to patients. 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"²⁶.

3.9. Backgrounds of healthcare assistants

- 3.9.1.** Like nurses, HCAs are predominantly female. But they tend to have stronger local links than nurses: they are more likely to work close to where they grew up. Research by Kessler, Heron and Dopson (in the NHS) (Figure 3) illustrates that many HCAs go from retail or factory work either directly into the HCA role or into some other post in health or social care before becoming an HCA. There is also a strong route from social care into healthcare, which reflects the higher wages and better terms and conditions in health. This was evident from our survey, where 22% of respondents from health related settings had previously worked in nursing/residential settings, compared to 4% from social care settings, and for 28% it being their first job.

²⁶ *Advanced nurse practitioners: An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation, (2012) Page 5*

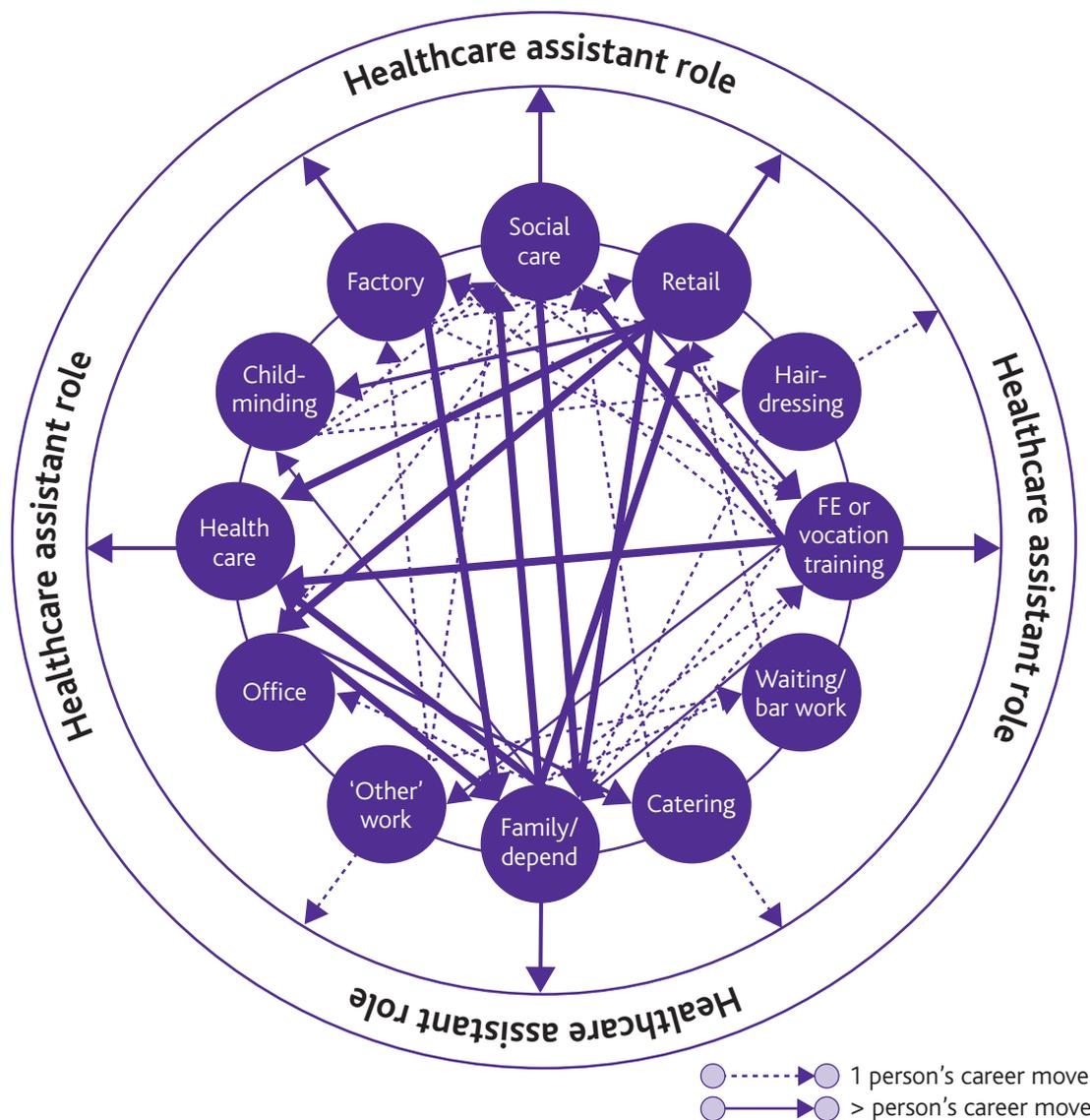


Figure 3: Career pathways for HCAs
 Source: Kessler et al. 2012

3.9.2. The educational backgrounds of HCAs vary widely. While we have met two HCAs with doctorates, many do not possess A-Levels. Employers have told us that many HCAs are “eager to learn”, having missed out on education the first time around. This suggests that relevant, appropriate training can make a real difference to this group.

3.10. Support workers in social care

“Not surprisingly given the poor conditions they work under, individual social care staff often appear to have low self-esteem. When asked about their work the response is generally prefaced with ‘Well I just.....’ they then go on to describe a complex mix of psychological insight, knowledge, practical creativity and skill.” (Richard Banks, submission to Cavendish Review)

- 3.10.1.** Social care is the way that people stay connected to their community, independent and out of hospital. It is vital to maintaining a standard of caring for the vulnerable, while at the same time keeping the NHS affordable. As the population ages, and hospitals discharge patients faster, the social care landscape has become increasingly complex, and the job of caring increasingly challenging.
- 3.10.2.** The paradox is that some of the lowest paid care workers are those who we expect to work the most independently, walking into the homes of strangers, and having to tackle what they find there, without any direct supervision. This requires a high level of maturity and resilience. Calling this “basic” care does not reflect the fact that getting it right is a deeply skilled task.
- 3.10.3.** The paid adult social care workforce is largely made up of staff employed by private and voluntary organisations, with a growing number of personal assistants. (In addition, it has been estimated that around 3.4 million volunteers are also working in social care and health²⁷).
- 3.10.4.** The challenge of counting support workers in adult social care suffers from similar problems of title confusion as the NHS. This is compounded by the fact that the main data source, the National Minimum Dataset for Social Care (NMDS-SC), managed by Skills for Care, is not a compulsory return – and it has to monitor a sector with very high turnover rate.

“Completing the NMDS is like painting the Forth Bridge – almost as soon as we’ve entered the data, the staff leave.” (CEO of independent domiciliary care agency, Bedfordshire)

- 3.10.5.** What that data set shows, is that the number of adult social care workers has increased from 1.7 million to over 1.8 million between 2010 and 2011, with over 1.2 million providing direct care. These staff are spread across 22,100 organisations with 49,700 individual establishments.

Job role group	Sector ->	All sectors	Local Authority	All Independent	NHS	Direct payments recipients ²⁸
	Type of service					
Direct care	Residential	425,000	26,000	412,000	0	0
	Domiciliary	597,000	19,000	332,000	0	262,000
	Day	60,000	11,000	51,000	0	0
	Community	144,000	28,000	65,000	55,000	0
	All Direct care		1,225,000	84,000	861,000	55,000

Figure 4: Total number of people working in adult social care jobs by sector, service type and job role, 2011²⁸

Source: NMDS-SC, Skills for Care

²⁷ Skills for Health, 2009

²⁸ Direct payments recipients figures are known to be overestimates and will be revised down in the next publication (September 2013)

3.10.6. The number of personal assistants is expected to grow as the Government pursues its personalisation agenda and increases the number of direct payments²⁹. As personal budgets become more widely available and direct payments are utilised by more and more individuals to buy care, support workers are going to need skills in supporting self-directed care and person-centred planning.

3.11. Pay levels

3.11.1. Frontline workers in social care are generally lower paid than those in the NHS, with terms and conditions that are rarely as good. The NMDS-SC reports the average wage as £6.72 per hour, equating to £13,974 per annum. Care workers earn less than social workers, outreach workers, and every other worker in the social care space. Measured by money, direct, hands-on looking after people is the least valued job. Figure 5 below shows the variation in annual pay between adult social care roles.

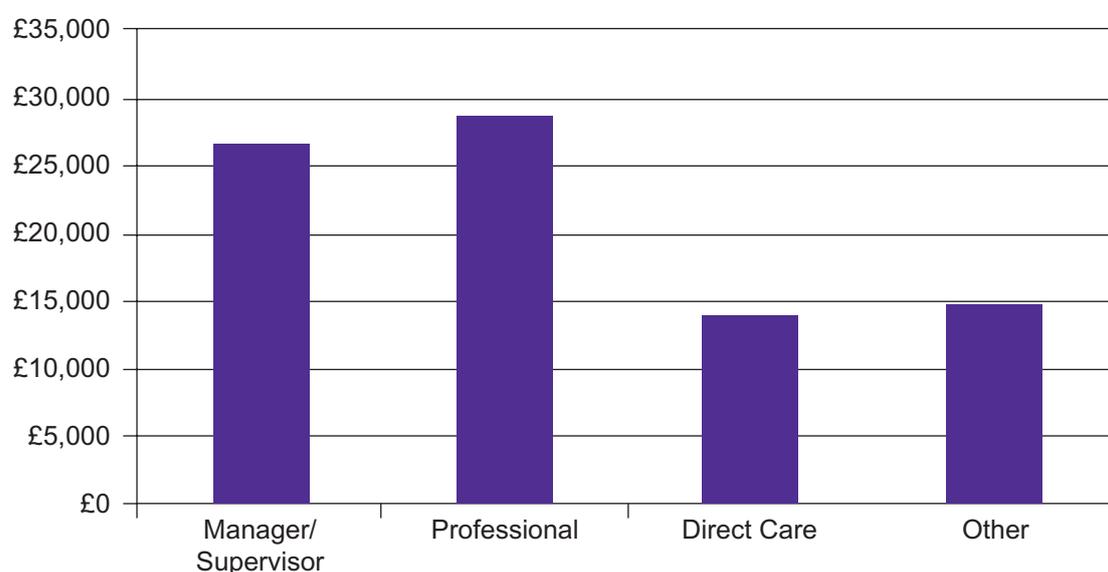


Figure 5: Pay levels of those in adult social care roles

Source: Skills for Care, National Minimum Data Set – Social Care

3.11.2. Perhaps as a result of low pay, attrition rates are very high: around 19%³⁰ a year in care homes and between 20.9% and 30% in domiciliary care³¹. This creates enormous problems of continuity for people who use these services. It also creates significant recruitment costs for employers. Even during the current economic downturn, care homes and domiciliary care agencies are struggling to recruit. When economic growth resumes, there will be an urgent need for greater workforce planning.

3.12. The nature of the work done by support workers in social care

3.12.1. If the rise of the HCA in the NHS challenges what we mean by nursing, changes in the landscape of social care are also making greater demands of social care workers.

²⁹ Capable, Confident, Skilled. A Workforce Development Strategy for people working, supporting and caring in adult social care. May 2011. Skills for Care

³⁰ National Care Forum Personnel Statistics Report, July 2012 http://www.nationalcareforum.org.uk/viewNews.asp?news_id=229

³¹ Vacancy and turnover, NMDS-SC Briefing 12

3.12.2. The range of tasks done undertaken by support workers varies enormously: from helping someone get to the shops after an operation; to diabetes management, changing dressings and managing pressure sores. Some support workers are administering medication, taking venous blood samples, and inserting catheters. As in hospitals, these tasks are supposed to be carried out under supervision. But many care homes may only have access to nursing support by request, and in domiciliary care, the only contact with a supervisor is often by phone rather than face to face.

3.12.3. In care homes, the average resident is now 85 years old and often very frail. The definitions of "residential" and "nursing" care are becoming blurred: residential care homes are no longer hotels with access to nursing support, but places with more and more very frail residents, many with dementia. People who would have been in hospital or a nursing home 10 years ago are increasingly coming into residential homes.

"It used to be clearly specified what could be delivered in a care home, that was changed because it had meant forcing people to move to a different setting when very ill. But the result is that we are now seeing PEG feeding³² in domiciliary care, and catheterisation in care homes."
(Sheila Scott, National Care Association)

3.12.4. While this shift has made care more person-centred, it also demands more of the *individual* carer.

3.12.5. Workers delivering care in people's homes are also facing greater challenges due to cost pressures and changes in district nursing. The UK Home Care Association (UKHCA) says that its helpline is inundated with workers asking whether they are allowed to do invasive procedures, giving insulin, or assisting with medication.

"The local authorities assume that the care worker will do it because they are going in regularly. This puts managers in a difficult position, as nurses won't certify that care workers are OK to do these things." (Colin Angel, UKHCA)

3.12.6. Several domiciliary care providers told us that they felt they were having tasks pushed on them "which used to be done by district nurses".

3.12.7. As a result, questions about supervision and delegation by nurses are even more complex in this sector than in the NHS. While an 80-year old woman can inject her husband with insulin at home without supervision, some domiciliary care agencies will not even allow their staff to put on a pain patch, because of concerns about insurance.

"Protocols from institutional settings are not always enforceable in community settings."
(Bill Mumford, MacIntyre)

³² Percutaneous Endoscopic Gastrostomy (PEG) is a surgical procedure for placing a feeding tube without having to perform an open operation on the abdomen. The aim of PEG is to feed those who cannot swallow. (MedicineNet.com)

3.12.8. Varying levels of qualifications possessed by support workers can also increase the complexities of delegation of tasks to support workers. Figure 6 below shows this variation, with almost 40% of those undertaking direct care roles possessing no qualifications.

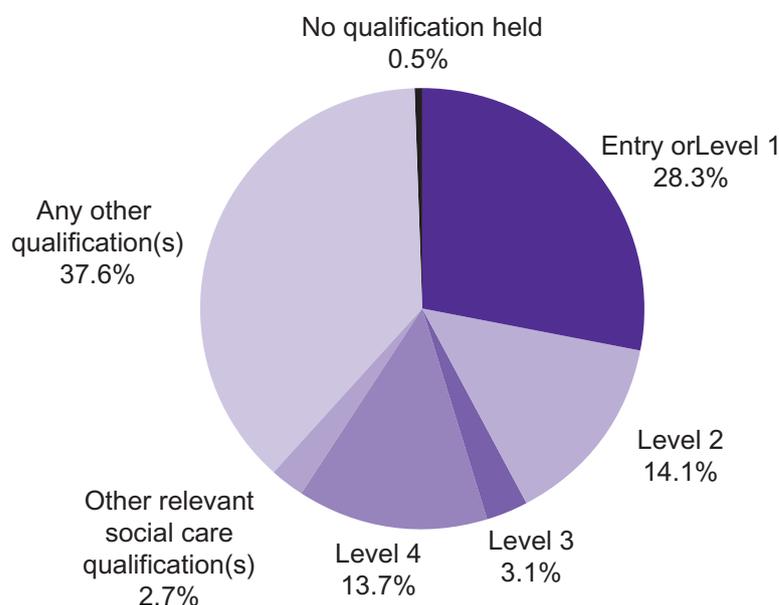


Figure 6: Qualifications those in direct care roles have achieved³³

Source: National Minimum Data Set for Social Care, Skills for Care

3.12.9. Although it seems likely that there will be further consolidation in the care home sector, the personalisation agenda will fragment responsibility as the number of personal assistants expands. Social care will become an even more complex landscape: and commissioners and regulators will need to review fundamental questions of accountability.

3.13. The status of caring in health and social care

3.13.1. The relatively low pay in many of these jobs reinforces what is often seen as its low status. Yet this is no longer consistent with the increasingly demanding and responsible roles that many support workers are undertaking. It seems unlikely that public understanding of the roles has caught up with the reality.

³³ Level 1 – e.g. GCSEs grade D-G, Foundation diploma; Level 2 – e.g. GCSEs grade A*-C, Higher diploma, NVQs at level 2; Level 3 – e.g. AS/A-Levels, NVQs at Level 3; Level 4 – NVQs at Level 4, certificates of higher education. For more information, visit <http://ofqual.gov.uk/qualifications-and-assessments/qualification-frameworks/levels-of-qualifications/>

“The first thing we think which will improve our position and therefore patient care is an appropriate valuing of healthcare support workers. Currently we often find that our voice is not heard despite us making constructive suggestions about care improvement. We think this stems from how we are viewed. We note that the media including the BBC talks about us doing basic tasks. We would say that we do a wide range of fundamental tasks such as feeding someone who has a swallowing difficulty which we think needs great skill and patience. We also do some technically complex tasks such as cannulation.”

(Submission to Review from group of 26 HCAs who are currently studying to gain a diploma)

“The image of care services is outdated and distorted. The public do not understand the complex and challenging nature of the social care task. The poor image of care services is influenced by scandals reported in the press, in ways which reinforce stigma and devalue the status of care in ways that are detrimental to both people receiving care support services, staff and potential recruits to the sector. Positive, pro-active public relations activity at a local level, is needed to promote care and carers.” (National Care Forum)

- 3.13.2.** The increasing reliance upon these staff, and the urgent need to integrate health and social care, makes it even more important to boost public understanding and respect. It also makes it imperative that minimum standards are met. There are quite a number of nurses who started as HCAs, and even some CEOs of social care organisations who started as carers, who would be positive role models for the workforce. At the end of the day, it is testimony from patients and people who use services that is likely to prove most powerful in helping caring to acquire the status it deserves. The more those testimonies can be collected and published, the better.

3.14. Conclusion

- 3.14.1.** Data available shows the number of support workers in social care far outstrip that in the NHS, although current reporting requirements make precise counts impossible.
- 3.14.2.** A profusion of job titles and local job descriptions results in confusion for patients, public and some staff in the NHS.
- 3.14.3.** The lines are blurring between the registered nurse and the support worker, with some home care workers being asked to undertake tasks which used to be the preserve of the district nurse, and hospital HCAs doing jobs that were once the remit of nurses. Some employers and service users expect support workers to perform tasks for which they may not be trained.
- 3.14.4.** HCAs in the NHS, on average, incur a higher wage than their equivalents in social care. However, both earn markedly less than the “professional” staff in their sector (registered nurses, physiotherapists, social workers). Low pay is contributing to high attrition rates in social care, particularly domiciliary care.
- 3.14.5.** Formal qualifications held by HCAs and support workers vary: some HCAs the Review has heard from have a doctorate while others have an NVQ. In social care, almost 40% of those delivering direct care do not have a relevant qualification.

4. The Voice of the Frontline

Summary

In general, frontline workers are very dedicated to those they look after; but frustrated that they cannot always spend enough time with them. Many feel underpaid and underappreciated. In hospitals, many HCAs feel that they do not get sufficient recognition for taking on more and more skilled tasks. In domiciliary care, the pressures of time are becoming really challenging. In both sectors, caring does not seem like a career with a clear progression route. Workers in both sectors cite paperwork, and staffing levels, as the main barriers to being able to do their jobs properly.

- 4.1.1.** Our focus groups brought together frontline workers from a diverse range of roles and specialities. Each session lasted three hours, with participants grouped around tables facilitated by volunteers from Skills for Care and HEE. While they are not a scientific sample, some common themes emerged which chime with other research carried out by UNISON, by academics and by the Journal of HCAs. These are summarised below.

4.2. Job satisfaction comes from building relationships

- 4.2.1.** HCAs and support workers from every setting talked enthusiastically about the privilege of getting to know users and their relatives. Many from hospital settings saw themselves as a key source of information about patients: and said that they no longer wanted to become nurses because they wanted to stay close to patients and not get sucked into office paperwork. Some in social care talked passionately about being advocates for the people they look after. While there were plenty of frustrations raised about other things, not a single one of these workers said anything negative about the people they look after.

What do you most enjoy about your job?	
Healthcare	Social care
<p><i>"We have the time to talk to patients and can identify if something else is going on, and raise concerns."</i></p> <p><i>"You get to know the patients really well – you know things even their family are not aware of – it's a privilege."</i></p> <p><i>"I hope it comes over in this review how passionate we are about our jobs."</i></p>	<p><i>"Most of my work is long term care and building relationships and all the tiny things, like where the soap is, in someone's home, need to be learned so I can support them – I like working with people like this."</i></p> <p><i>"If you know what they like – how they have the curtains drawn, their favourite breakfast cereal and if you really know your clients and build relationships, that's what I really enjoy."</i></p> <p><i>'You make a difference. You might be the only person they see in a day.'</i></p>

4.3. Some workers report that their work increasingly encroaches on that of nurses and social workers

4.3.1. Many HCAs and support workers voiced their frustration around not receiving recognition for tasks they perform, as well as confusion around what tasks they are and aren't expected to undertake. Managers also raised issues around "blurring of roles" across registered and non-registered staff.

Are there any activities that you always do rather than a nurse or senior care assistant?	
Healthcare	Social care
<p><i>"It varies, between wards and between trusts, what health care assistants are allowed to do. So that also creates confusion for nurses."</i></p> <p><i>"I'm doing things I shouldn't, like appointment referrals and invasive procedures."</i></p> <p><i>"Five years ago a nurse would have done these things ... and we receive no recognition or get paid pay for it."</i></p> <p><i>"Nurses need to come onto the floor more and see what is actually done, because they don't have a clue how stressful it can be."</i></p> <p><i>"A nurse told me to suction – I said, I haven't had training. She said, I don't care just do it. But that only happened once."</i></p>	<p><i>Hands-on' care is delivered almost by exclusively by care assistants."</i></p> <p><i>"Providing an assessment of patient health and wellbeing e.g. pressure ulcer prevention/reporting."</i></p> <p><i>"Companionship and chatting."</i></p> <p><i>"We interpret for our non-verbal clients for example when someone goes into hospital, we go in at key times such as meal times to support."</i></p> <p><i>"The nurses rely on us as interpreters."</i></p> <p><i>"She couldn't ask for a drink, so in the end I put a sign above her bed saying 'I can't speak'."</i></p> <p><i>"We administer medication. We're trained in stoma care and how to look after contact lenses. We also do dressings and catheter care – have had training to do this."</i></p>

4.4. Paperwork and staffing levels were cited as the biggest barriers to better performance

4.4.1. For social care in particular, staffing levels were cited as a major barrier to delivering the highest quality care, but the issue of paperwork spanned both sectors and levels of staff. When even the most junior staff feel that paperwork has become a problem for them, let alone for their supervisors, something has gone badly wrong with our system of regulation.

What, in your view, prevents you from doing your job better?	
Healthcare	Social care
<p><i>"Having to write everything twice, on paper and computer."</i></p> <p><i>"We are a major part of the NHS but we have never had a voice."</i></p> <p><i>"We are not funded to have enough staff – and they bring in agency staff which is more expensive, they could fund a permanent post with it. If you had a bigger pool of regular staff then everyone would be better off."</i></p> <p><i>"My big bugbear is when a nurse turns round and says - "I'll get the unqualified one to help you". The relatives hear that, some people won't speak to you. "You're only the HCA, I'd like to speak to the nurse"". We are trained. We are qualified. Just in a different way".</i></p>	<p><i>"There's been a real increase in paperwork and evidencing which takes time and there's only one computer between seven staff."</i></p> <p><i>"I could probably see three more people a day if I didn't have to do paperwork."</i></p> <p><i>"We need a lower staff turnover to make people feel more confident."</i></p> <p><i>"Paperwork is huge these days."</i></p> <p><i>"Staffing is a big issue – we use agencies but prefer permanent staff to be on site."</i></p>

4.5. Many support workers cannot see a clear career path for themselves

4.5.1. Attendees had widely differing experiences of training. Some had studied for a foundation degree or NVQs and found them helpful. Others mentioned positive experiences of manual handling courses, communications, infection control and dementia training (45% of respondents to our survey had had dementia awareness training). Others did not have access to much training and were unable to comment as a consequence. Some felt that supervisions need to be more frequent. Most attendees said that they wanted a proper induction period, and on-going training available for all front line staff, not just professional staff.

Would you know what to do if you wanted to take up a more senior position?	
Healthcare	Social care
<p><i>"I could only do it [progress] with a big loan – no secondments now for three years."</i></p> <p><i>"I got on the NVQ Level 3 but not sure why. There are no jobs at Band 4!"</i></p> <p><i>"There was a pilot for Assistant Practitioner roles: we were teased with it then they took it away."</i></p> <p><i>"Not all of us want to be nurses- we want to be healthcare assistants but there are no senior healthcare opportunities at Band 4. More Band 4 jobs would allow HCA staff to move on in their careers."</i></p>	<p><i>"We get fed up that there is nowhere to progress. We know our job inside out, so some get apathetic."</i></p> <p><i>"I would like more information on what is available."</i></p> <p><i>"I have done this job for 26 years and haven't progressed anywhere since. I'm in the same place. The agency pays on just what hours you do."</i></p> <p><i>"In our small home care organisation some carers are now managers. Others were nurses. There's no set progression route in my organisation."</i></p>

4.6. There were wide variations in whether support workers felt appreciated by managers and employers

- 4.6.1. Many HCAs and support workers agreed that who you work with is just as important as the job you do when considering whether you enjoy your job. However, experiences of feeling part of a team varied significantly across health and social care. The best examples of HCAs and support workers feeling part of a team involved them having role models – either peers or supervisors – and being able to approach other team members for support and advice.
- 4.6.2. In contrast to the best examples, other responses corresponded to UNISON’s finding in its 2010 survey. In that survey, 29% of support workers who had considered leaving their job cited inadequate pay as the main reason, but a much greater number, 60% cited feeling unappreciated by employers.³⁴

³⁴ UNISON Survey 2010: dedicated to healthcare, 2010 HCA survey results.

Where you work, what makes you feel part of the team?	
Healthcare	Social care
<p><i>"We're allowed to self-roster. Don't always get what you ask for, but usually pretty close." [This HCA felt he worked in a very positive team environment. This was in contrast to others who felt they had no control over shifts.]</i></p> <p><i>"On my ward, there's no hierarchy, everyone just works together. I think I've just had a really good experience."</i></p> <p><i>"My experience has been brilliant. This is my first role. Everyone on the team was very helpful towards me. I felt I could approach anyone."</i></p> <p><i>"Nurses say [to patients] oh – he is an HCA, he doesn't know much – this makes you feel undermined and not part of the team."</i></p> <p><i>"They sit in an office and they don't even know the names of the patients."</i></p> <p><i>"Because I've been there longer and I'm specialised, I've been told I'm a role model for the nurses – obviously they've got the qualifications as regards the medication etc."</i></p>	<p><i>"I have good relationships and feel supported but I don't know the rest of the team who support my clients – we're like ships that pass in the night."</i></p> <p><i>"I can go several days without seeing another member of staff."</i></p> <p><i>"If you have a disjointed team the residents really pick up on that, so communication is really important."</i></p> <p><i>"Managers support the staff so they can support the people we look after."</i></p> <p><i>"Somebody asking you to do a job and trusting you to do it makes me feel part of the team."</i></p>

4.7. Some HCAs and support workers are under pressure to do tasks they do not feel capable of

- 4.7.1. In some cases, responses indicated that the desire to help patients and service users is a reason why HCAs and support workers performed tasks they did not always feel capable of undertaking. However, especially in the NHS, HCAs are under pressure from more senior staff, especially during periods of staffing shortages.

In your current role, have you ever been asked to do anything which you feel is beyond your current level of competence?	
Healthcare	Social care
<p><i>"I think people get asked to do things they aren't supposed to but when you're short staffed you do it. Probably happens to everyone."</i></p> <p><i>"It's usually the doctors who ask us to do the things that that we aren't supposed to do but we are able to say that we are not supposed to do that."</i></p> <p><i>"Sometime I get grief from consultants when I cannot do certain tasks. There is no standard approach."</i></p> <p><i>"[It's hard] being asked to show other staff how to do things, when unsure yourself and worried that you are perpetuating the wrong way of doing something."</i></p>	<p><i>"We are not qualified to put on dressings so if I am asked by a patient in the community to put on a dressing I phone the office and they send a nurse to come and do it."</i></p> <p><i>"Sometimes it's about judgement; I'm not supposed to but I'd change a light bulb in a service users house rather than leave them in the dark, but I wouldn't change their bandage."</i></p> <p><i>"Supervision and appraisal are often delivered by staff with insufficient guidance and support."</i></p> <p><i>"The hours I worked at the other firm were like emotional blackmail when they couldn't get cover. Being affected by tiredness made it difficult at times."</i></p>

4.8. Conclusion

- 4.8.1. The feedback the Review received from HCAs and support workers from the focus groups suggests that employers and commissioners need to value these staff and tie pay more honestly to performance. There needs to be clarity around job roles and a clear career path, preferably common to both sectors, that makes caring feel more like a career with real value. Additionally, regulators and managers need urgently to drive down paperwork; not react to the Francis Inquiry by demanding even more.

5. The Voice of the Users

Summary

Submissions to this Review suggest that patients and users of social care services want three things above all. To be cared for with kindness, compassion, dignity and respect by people who are able to see them as individuals and respond to their needs; to know that those who care for them have met national standards of competence; and, in the NHS, to have more clarity about the difference between nurses and healthcare assistants and who is in charge.

5.1.1. The Review received submissions from charities, campaign groups, individual patients and users of services. While the submissions covered a very wide range of subjects (and individual patients and service users are not directly quoted here to preserve their anonymity), three strong themes emerged which are summarised here very briefly:

5.2. The systems need to be organised around the individuals being cared for

5.2.1. In social care, it was felt that staff needed to learn how to build relationships with each individual they care for, not just focus on a list of tasks performed mechanically. The future workforce will need not just to be “competent” (the word most commonly used in both sectors), but to start learning from their first day about how to act with compassion and respect. This is also very relevant to health: the NHS has much to learn from social care about communications skills, dementia and end-of-life care.

5.2.2. In the NHS, there were calls for greater clarity about who is in charge, and what patients can expect of each member of staff. There were suggestions that healthcare assistants should wear easily distinguishable uniforms or badges, to make them more identifiable. This echoed one of the recommendations in the Francis Report. Some submissions suggested display boards listing photos, job titles and responsibilities of each staff member. There was also a demand for fewer titles, and a title that would give more status to support workers. The ‘healthcare assistant’ title was felt to be “demeaning”.

5.2.3. The idea of making it easier to distinguish nurses and HCAs by their uniforms is very attractive, from the point of view of helping patients understand the hierarchy. However, this Review does not make a firm recommendation that HCAs and nurses should wear distinct uniforms, because so many Trusts already developed their own, and it is not clear how such a recommendation could be implemented across England. This Review does, however, recommend a single job title for HCAs (see chapter 8).

5.3. HCAs and support workers need to be consistently trained

- 5.3.1. There were many calls for clear national standards of training for support workers in both sectors. There was a widespread view that HCAs in the NHS are functioning much as SENs once did, but without the same levels of training or accountability.
- 5.3.2. The Patients Association and other groups called for formal registration to ensure “appropriate feedback and a consistency in recruitment, training and professional development”. While formal registration is outside the scope of this review, the challenge is clearly how to achieve higher national standards in the absence of registration. Related to this, there needs to be a stronger sense that caring is a career.

“While training...is vital, it is important that a view does not develop that simple one-off training programmes can meet the challenge of ensuring the workforce has necessary skills, either in dementia or elsewhere. Learning should be built into practice and learning should be an ongoing process focussing on upskilling the workforce, rather than an exercise aimed at demonstrating compliance.” (Alzheimer’s Society)

5.4. Managers need to recruit support workers with the right values, and then support them to do emotionally draining jobs

- 5.4.1. Many submissions suggested that value-based recruitment is the right step to support the development of a high quality workforce. But, this should not be the end of the story: an environment where staff are supported and their emotional well-being is considered once they are in post is also vital in sustaining a workforce that is able to cope in times of stress.

“Compassionate values and behaviours should be considered a core attribute in recruitment, and built into performance review and on-going training.” (Age UK)

“The values-based approach to recruitment needs to apply to all roles in organisations delivering care services, not just care staff. This will help to shape the ethos of the whole organisation in which health care assistants and care assistants work, as the values managers demonstrate in their day-to-day actions are often carried through the organisation.” (Epilepsy Society)

“HCAs must be valued, through regular supervision and support, including support for their mental wellbeing.” (Mind)

“Pay and opportunities for progression are poor – this is hampering recruitment.” (Alzheimer’s Society)

“There needs to be a culture change: senior clinical staff need to value and recognise the contribution of healthcare and care assistants. There should be routine independent clinical supervision, with the option to request emergency support in difficult situations.” (Multiple Sclerosis Trust)

“Good listening skills, able to respond to complex needs, managers responsive to staff needs, ring fenced training budgets, clear outcomes set, measured and achieved, plentiful feedback and a sense of belonging and ownership [are all important].” (Mental Health Foundation)

5.5. Conclusion

- 5.5.1. Submissions to the Review from those with first-hand experience suggested that the recruitment of support workers should include some assessment of their values and likely behaviour under stress, and that training must be consistent and person-centred. This was a point made particularly strongly by charities and those in social care. In the NHS, there was a strong feeling that there should be fewer titles, clearer role descriptions and more clarity about who is in charge: either through distinct uniforms or badges.

6. Recruitment, Training and Education

Summary

In all the discussions about values, standards and the quality of care in the NHS and social care, the support workforce has received the least attention. As a result, there are unacceptable variations in the competence of this workforce. Yet the public needs to know that support workers can work safely, competently and with kindness.

There are pockets of excellence: organisations which recognise that this workforce is a critical resource. These organisations recruit people for their values and commitment to caring; they invest in rigorous training and development; and they ensure that training translates into day to day practice. They prioritise this in tough financial times, knowing that it improves care and staff engagement.

But overall, training is neither sufficiently consistent, nor sufficiently well supervised, to guarantee the safety of all patients and users in health and social care. In domiciliary care, we have heard of instances of staff being sent unsupervised into clients' homes with no training.

Considerable amounts of money have been spent on a vast array of vocational qualifications and training courses without clear evidence that the training HCAs and support staff receive improves outcomes. The array of courses and providers is hard to navigate, especially for small employers. A rigorous quality assurance mechanism is urgently needed, to police a market in which it is very easy to set up as a training provider, and in which too many workers are signed off as 'competent' without necessarily being so.

Training should not be seen as an end in itself: what matters is that workers are competent, and kind. The best organisations are beginning to base their recruitment and training strategies around values. They are screening applicants for aptitude; they are helping them to learn *why* they are doing tasks, as well as *how*; and they are constantly refreshing the lessons learned through supervision and practice.

The support workforce is increasingly going to need to be flexible across health and social care. While the actual skills required will vary between settings, workers in both sectors are increasingly going to need to draw on similar core knowledge and approaches. A golden thread of values should run through all training in health and social care, defined by employers on the frontline.

There is now an opportunity to create a "Certificate of Fundamental Care" which will not only build on the minimum training standards called for by Robert Francis QC but will also improve the image of caring. It will reduce complexity, duplication and confusion by linking explicitly to the nursing curriculum. Eventually, it should be open to volunteers and unpaid carers, who are shouldering so much fundamental care. And it will be the foundation stone of a series of national competences which emphasise what is common to health and social care, and what is common to registered nursing and support work, rather than what is different. For the airline industry has demonstrated that common goals and a common language, training junior and senior staff together, are a cornerstone of safety.

6.1. Overview

- 6.1.1.** At a minimum, the public needs to know that support workers are able to work safely, with the basic knowledge relevant to their job. For many workers this will mean knowing first aid, and how to lift someone properly. It may also mean understanding how to correctly dress a wound or change a catheter, both of which done incorrectly are major infection risks which can raise morbidity and create serious extra costs in the system.
- 6.1.2.** Beyond the minimum, the public expects workers to be competent. It expects – and deserves – workers to be kind, capable, and able to communicate clearly.
- 6.1.3.** What the public actually get is very mixed. There are pockets of excellence: but too much variation. The best organisations are trying to reduce variation with rigorous training and supervision. Many have developed their own training courses in order to set a standard. There is much which should be learned from them to raise standards and reduce duplication.
- 6.1.4.** The airline industry trains its cabin crews together, to reduce the risk of accidents. This Review proposes a “Certificate of Fundamental Care” developed along similar lines.

This chapter considers these issues in three sections:

- The challenges
- What the best organisations are doing
- The way forward

6.2. The challenges

- The system does not currently guarantee public safety
- Qualifications and tick sheets do not always denote performance on the job
- Employers’ lack of faith in the system has led to duplication and wasted resources
- Staff do not always achieve recognised, transferable skills
- Training does not always relate to the needs of the patient/service user
- Training can reinforce professional silos rather than contribute to team-building and shared responsibility
- Caring does not always feel like a career, with clear routes to progress

6.3. The system does not currently guarantee the safety of the public

- 6.3.1.** There are no minimum educational requirements to begin working as a HCA or support worker in the NHS³⁵ or social care. Even literacy and numeracy are not always tested.

³⁵ Webb SC (2011) Education for healthcare assistants working in acute NHS hospitals. *Nursing Standard*. 25, 41, 41-46. Date of acceptance: April 4 2011. (NHS Careers 2009)

"Only seven of us were given a literacy test before being appointed to our job. We think this is essential." Submission to Review from group of 26 HCAs currently studying to gain a diploma (experience in group ranges from 4 to 22 years)

- 6.3.2.** According to research undertaken at the Universities of Oxford and York into the NHS, around two thirds of acute trusts are now using numeracy and literacy tests to screen Band 2 candidates across most of their organisations³⁶. But a third do not. Most NHS Trusts theoretically require HCAs to have NVQ Level 2 on joining at Band 2, but the research found that only 39% of the trusts surveyed required Band 2s to achieve training targets before being confirmed in post.
- 6.3.3.** In the NHS, there is very little guidance about the training needs of HCAs. The RCN has found that qualified staff are not always aware of the educational courses available for HCAs in their organisations, and that this can cause qualified staff and managers to display negative attitudes towards HCAs³⁷. In the NHS, the unfortunate coincidence of the nomenclature of vocational qualifications at Levels 2, 3 and 4 with the NHS pay bands 1-4 has exacerbated frustration among HCAs, who expect to be promoted to Band 3 if they achieve Level 3, and are disappointed when this does not occur. Since there is no national record of HCA qualifications, however, it is not possible to know the extent of this.
- 6.3.4.** Academic research has suggested that some HCAs who know how to carry out a procedure may not fully understand the consequences of something going wrong³⁸; and that some of those who monitor a patient's observations are unable to interpret the results³⁹. This is of great concern to nurses.
- 6.3.5.** In social care, mandatory training varies according to the specific role that a support worker is required to carry out. Most workers we have spoken to have taken mandatory courses in food hygiene, moving and handling, safeguarding, and health and safety.
- 6.3.6.** However, the Review has also heard from home care workers whose "induction" consisted of being handed a DVD to watch at home, before going out to a client. We have heard from two care workers who claim that they were asked to pay for mandatory training out of their own pockets. One said she had quit as a result, and would never consider a caring role again.
- 6.3.7.** The Common Induction Standards (CIS), developed by Skills for Care in 2005, are supposed to be completed by all adult social care practitioners within 12 weeks of starting a job. CIS includes three days' training in first aid, moving and handling, infection prevention, dementia awareness, nutrition and hydration, and dignity. Guidance from Skills for Care advises that lone working should not be permitted until the CIS are completed or until competence has been assessed and a manager 'signs off' that a practitioner is 'safe to leave' to work alone.
- 6.3.8.** However employers and Skills for Care have told us that completion of CIS is not always verified by inspectors. The United Kingdom Healthcare Association (UKHCA) told us that the guidance is "only a recommendation with no commitments on what training standards and timescales should be

³⁶ 2011 Nurse Support Workforce Survey Initial Results: Ian Kessler, Paul Heron, Karen Spilsbury, NIHR SDO project number 10/1008/17

³⁷ Webb SC (2011) Education for healthcare assistants working in acute NHS hospitals. *Nursing Standard*. 25, 41, 41-46. Date of acceptance: April 4 2011.

³⁸ Thornley C (2000) A question of competence? Re-evaluating the roles of the nursing auxiliary and health care assistant in the NHS. *Journal of Clinical Nursing*.

³⁹ Wheatley I (2006) The nursing practice of taking Level 1 patient observations. *Intensive and Critical Care Nursing*.

achieved....as a result providers have little guidance on what an agreed standard...should be". The UKHCA suggests that HCAs and support workers should shadow more experienced colleagues "at a minimum" until the worker is regarded as safe to work independently – but again, this does not always happen.

- 6.3.9.** Inconsistently applied rules do not guarantee patient safety. It is commonly assumed that support workers are acting under supervision. But this is not always the case.

"People talk about HCAs as though they're fully supervised: but they're not. That doesn't need to be a problem. But they need to understand what they are doing and why."
(Kay Fawcett, Chief Nurse, University Hospitals Birmingham NHS Foundation Trust)

- 6.3.10.** The problem is particularly acute in the community because supervision is remote; no one sees what a support worker does except the service user. As community care becomes more complex, and new organisations enter the market, consistent standards will be needed to protect the public. HCAs and support workers themselves will also need the confidence and competence to meet increasing demands from commissioners and providers.
- 6.3.11.** It is important to recognise that it is the performance of each worker that matters, not training per se. Data from NMDS-SC shows that in 2011, around 40% of those working in direct care roles in social care had no relevant qualification. But this does not mean that they are doing a bad job. Following the Health and Social Care Act 2008, the requirement that 50% of staff should have completed NVQ Level 2 was removed, in favour of one that staff should be "appropriately trained".
- 6.3.12.** Given what the Review has heard about the low value of some vocational qualifications (see below), it is correct to place the emphasis on staff performance, rather than qualifications. But more clarity is needed about what constitutes "appropriate" training, and whether staff are adequately supervised.

The Department of Health, in response to the Francis Inquiry, has asked the Care Quality Commission (CQC) to look at the induction arrangements for HCAs and support workers across the NHS and adult social care.

The CQC is conducting the thematic probe to obtain a baseline picture of the current situation about how well healthcare assistants support workers are prepared (through induction) to start caring for people unsupervised. If any information found suggests that there is evidence of non-compliance with one or more of the quality and safety regulations, CQC will follow this up as part of the normal inspection methodology and as such publish findings as part of the inspection report.

6.4. Qualifications and tick sheets do not always denote performance on the job

- 6.4.1.** A bewildering array of modules, certificates and vocational qualifications have been developed by a large number of training providers chasing changing fashions in public funding. Trying to navigate this sea of courses and funding puts a huge burden on already stretched employers, who find the opaque

language of vocational training virtually unintelligible. And they feel the value of many of these courses is questionable.

“Some people gain FE qualifications without ever seeing a resident. Apprenticeships are far better because they’re based with employers.” (Care home owner and end of life specialist)

“We had staff coming with NVQ3s and they hadn’t a bloody clue.” (Domiciliary care agency)

“As a sector, we want to see a qualification which actually means something. A person can have an NVQ3 and know nothing about care.” (Care home owner)

“In our Trust we are considering not having NVQ2 as a requirement for Band 3 – we have found that it is often not worth the paper it is written on. We have found that the candidates we assess internally who don’t have NVQ2 are actually often better suited for our own competency programme for Band 2 to 3 progression than those who have completed NVQ2.” (Senior nurse educator, London Hospital)

“There is very little connection between qualifications and competence.”
(Local authority area manager in social care)

“Assessors change all the time, there’s no continuity, they’re lowly paid and not properly valued themselves.” (Domiciliary care manager)

6.4.2. The CQC told us that it frequently receives calls from social care employers seeking advice about what training to give their staff, and which are the best training providers. CQC advises employers to refer to the Skills for Care CIS, and to the units or qualifications relevant to the job role as advised by Skills for Care. However, it cannot advise on training providers, as there is no national rating of providers or quality assurance mechanism.

6.4.3. In addition, the way the market is funded can create incentives for trainers to sign off as many people as possible as quickly as possible. The Review has heard of small care homes being offered free training from providers which are supposed to ask the employers to co-fund, but which simply take government money and shorten the courses. It is a mystery why governments should have paid up for so long, with so few questions asked.

“I’m horrified at what I see out there. We teach Level 2 End of Life care in four days, over a period of a month. But I’ve seen it taught in one day: the training providers don’t think they will come back otherwise. They don’t get the funding until the person completes. People go back to the organisation and wave their piece of paper, but there’s nothing to say they’re competent.”
(Palliative care nurse)

“QCF qualifications have credit values; each credit represents up to 10 hours notional learning, dependent on learner need. As such it is hugely concerning to see QCF Level 2 qualifications of 3 credits taught and summatively assessed in a classroom in six hours. I have examples of funded programmes in London where this is happening.” (Sally Garbett, former policy advisor for QCF qualification development and training)

- 6.4.4.** In too many cases, in both health and social care, staff seem to be handing in tick sheets to be signed as a record of their performance, without sufficient checks that they really understand their training. The Review heard examples of care home staff being asked by supervisors to bring in six months' and even eight months' worth of sheets in one go, to make the process of "sign off" easier. Training needs to be part of an ongoing process of assessment and supervision.

"I'm not sure we are testing competences as part of training. In medical training you have competency simulation tests which have to be passed. Why aren't the competences of HCAs tested?" (Senior nurse educator, London focus group)

"There is no long term assessment of the impact training is having. The HCA may be able to demonstrate a competency at the end of the training day, but what about the following week or year? There is no follow-up." (HCA development clinical lead, London focus group)

- 6.4.5.** However good the competency booklet, there is no substitute for standing next to someone and watching them to see if they can actually do the job.

6.5. Employers' lack of faith in qualifications leads to duplication and wasted resources

- 6.5.1.** Lack of faith in the quality of some of the training on offer has led many organisations to develop their own in-house training. Some of this is excellent, but it leads to duplication, with employers retraining new staff irrespective of what they have learned elsewhere.

"We have given up on training providers except to get our staff the qualification: then we train them ourselves from scratch again. They can get the qualification but they're not competent in practice. And the training providers aren't competent either." (Care home owner)

6.6. Staff do not always achieve recognised, transferable skills

- 6.6.1.** In-house training is rarely accredited: leaving support workers unable to prove what they have learned to clients, or when moving to a new employer. HCAs in the NHS express frustration at being trusted to perform tasks in one Trust that they are then prevented from doing when they move. Home care support workers particularly need to be able to reassure people using their services, who in turn should be able to verify the experience and qualifications and those looking after them.

"For a national health service there is nothing national about it. When they move from one [Trust] to another they are expected to undertake different training and assessment to achieve it." (Focus group attendee)

- 6.6.2.** This also means that the skills of individual workers depend very much on the quality of local teaching and supervision. Training is often an ad hoc mixture of tasks, not a comprehensive preparation for a role.

6.7. Training does not always relate to the needs of the patient/ service user

- 6.7.1. Some training programmes encourage the impression that caring is a list of tasks, rather than a skill which involves compassion and the ability to adapt to someone’s needs. An HCA at one of our focus groups claimed that in her hospital the training said to “let people fall” rather than to catch them and risk injuring yourself. “This,” she commented, “goes against every caring instinct.”

“We value compassion and personal skills. But you can train that out of people if you insist too much of doing things in a certain way, feeding everyone at a certain time or taking everyone to the toilet after every meal is not respecting the individual or their dignity.” (Care home manager)

“We expect the workers to know enough about each resident’s medical condition, the appropriate therapeutic regime, awareness of the importance of appropriate medicines, their diets and allergies and of course, the crucial relevance of nutrition and hydration, as well as to keep and share appropriate records. Often, the role is one of brokerage and representation, not something which is apparent in most training programmes.”

(Judy Downey, Relatives and Residents Association)

6.8. Training can reinforce professional silos rather than contribute to team-building and shared responsibility

- 6.8.1. Support workers and HCAs are often last in line for training, reinforcing divides between different groups.

“In terms of training we often find that we come after others; if there is online training that must be done, we often do not get the time to do it and other nursing staff are prioritised. We also find that Trusts put on training which is suitable for us as front line staff but then say “for qualified staff only”: but actually it is very important that we understand that topic.”

(Submission to Review from group of 26 HCAs currently studying to gain a diploma)

- 6.8.2. Given their importance to patient safety, excluding them from key training may not be a sensible use of resources.
- 6.8.3. In addition it is clear that society is increasingly going to need a flexible workforce that can operate across the boundaries of health and social care, with more and more shared knowledge. While a huge range of different skills is required in different settings, some will need increasingly similar core skills. A community facing support worker, for example, may need to learn how to monitor vital signs; the hospital and healthcare assistant will need to learn about personalisation and discharge.
- 6.8.4. Social care employers increasingly feel there is a core of knowledge and skills common to both health and social care: and that these should be taught in the same way to everyone, in the same language.

6.9. Caring does not feel like a career, with clear routes to progress

- 6.9.1.** Some care home owners have told us that they are directly competing for staff with local supermarkets and high street shops. Yet health and social care do not yet offer the kind of clear, simple career ladders available to staff who join Tesco, or Specsavers. A school-leaver with few GCSEs can join a high street optician as an optical technician and work their way up into administration, management, or optometry. Such commercial companies routinely train staff in customer service – something that social care organisations such as the Caring Homes Group are beginning to do. A clearer career path in health and social care would make it easier to attract and retain staff; particularly given the pay rates. At the moment, many workers are not sure they can see the way forward.
- 6.9.2.** The concerns detailed in this section suggest that there is an urgent need for a rigorous quality assurance mechanism to link training to outcomes; for consistent national standards; and for a clearer career path. They also suggest that NVQs were too inflexible. The Qualifications and Credit Framework (QCF), the national credit transfer system for education qualification in England, Northern Ireland and Wales, has now replaced the National Qualifications Framework and is designed to provide greater control over what is learned, and how. Some social care employers we spoke to welcomed the greater flexibility offered by QCF; others felt that it was too complicated; many others had not heard of it.

Qualifications and Credit Framework

The Qualifications and Credit Framework (QCF) is a structure that shows how the different types of qualifications interrelate and allow credit from assessments to be transferred flexibly between qualifications.

The Office of Qualifications and Examinations regulation (Ofqual) work with the government and are responsible for regulating QCF qualifications and assessments to maintain standards.

Every unit and qualification in QCF has a credit value (where one credit represents 10 hours of learning time). There are three different sizes of qualification:

- awards (1 to 12 credits)
- certificates (13 to 36 credits)
- diplomas (37 credits or more).

In addition, each qualification has a level of difficulty from Entry level (Key Stage 3) at the bottom to Level 8 (Doctorate) at the top.

If a qualification includes a unit that has already been awarded, the unit already taken can be put towards that qualification. Units awarded by different awarding organisations can be combined to build up qualifications.

6.10. What the best organisations are doing:

6.10.1. The Review has heard from a wide range of organisations, some of which are leading the way in terms of their thinking about how to ensure that HCAs and support workers treat people better, consistently. This involves:

- Recruiting people with the right values, attitudes and behaviours
- Training people how to be kind and responsive as well as how to carry out a list of tasks
- Setting high minimum standards with ongoing supervision

6.11. Recruiting for values

6.11.1. Many experts interviewed by this Review have said that they do not think it is possible to train people to be caring, if they do not start off with the right attitude and aptitude. To get the right quality of care, it is therefore vital that the right people are recruited to caring roles.

6.11.2. The next three case studies describe organisations which have increased staff retention and user satisfaction by ensuring that new staff understand the reality of caring roles before they start work, and by testing their aptitude for caring. The success of these schemes suggests that in social care especially, organisations which recruit for values may start to find this an excellent way of differentiating their offer to the public.

Case study: MACINTYRE

MacIntyre is a national charity providing support and care for people with learning disabilities. Working with an occupational psychologist, they profiled high-performing staff members to identify character traits. This showed that they had a distinctive psychological profile: more empathetic and also more introverted, in the sense of being more reflective, observant and principled in the service of others. From this, they created the “MacIntyre Profile”, which is used when recruiting all new staff. The approach makes no assumptions that previous experience will bring better support staff, but rather focuses on a person’s predisposition to care work and more importantly, to working in a facilitative and reflective way.

MacIntyre has found that this approach has led to better staff retention, less sickness and absence and fewer performance management issues. Families of users have commented positively on the quality of care and support received.

Case study: YORK NHS FOUNDATION TRUST

York Hospitals NHS Foundation Trust noticed high attrition rates amongst HCAs three years ago, and decided to start recruiting for values rather than for training. York dropped the requirement for applicants to have an NVQ and made all potential applicants attend Open Days where talks and videos explained the job in detail. York also introduced a longer induction, and a buddy system. Since the new measures were implemented:

- turnover has been reduced from 17% to 12 %
- sickness has reduced from 8% to 5%
- the "did not attend" rate for interview has dropped from 25% to 0%: suggesting that those who apply are the ones who understand and want the job.

Case study: HERMANN MEMORIAL HOSPITAL, TEXAS

This successful American hospital chain uses the Hartman Values Profile Tool in recruiting nursing staff both Registered and Enrolled. The tool is an axiological inventory (philosophical study of values) that measures a person's capacity to make value judgements concerning the world and themselves.

Hermann Memorial states that the use of this tool has resulted in higher staff performance and increased quality of patient care; it has also reduced staff turnover by between 25% and 33%.

- 6.11.3.** These kinds of recruitment approaches are something that all employers should be considering. Some already do it intuitively; several care home managers have described to the Review the way they ask candidates about caring experience in their own lives, and watch how interviewees interact with residents. But as Bill Mumford of MacIntyre says, thinking of caring as a "vocation" can underestimate the psychological make-up required for emotionally demanding jobs.
- 6.11.4.** This Review welcomes the Department of Health's commissioning of the National Skills Academy, Skills for Care and MacIntyre to produce a value-based recruitment tool for the social care sector. This has been tested by employers and has been positively received. It will be rolled out in summer 2013 and will be available to all employers in the sector on a trial basis whilst it is refined and further developed⁴⁰.

6.12. Training people to be kind and responsive as well as competent

- 6.12.1.** Some patients and user groups complain that staff treat caring as a list of tasks to be achieved, whereas real caring is the ability to adapt to each person as an individual. Many organisations are exploring ways to train staff to put themselves in the shoes of others, and to actively reflect on their own practice. Here are three examples:

⁴⁰ Department of Health correspondence

Case study: MACMILLAN

While patients find it hard to define 'dignity' or 'respect', they are nonetheless very aware of behaviours that signify their opposite. The Macmillan Values Based Standard has been developed through an 18 month engagement process with over 300 healthcare staff and people living with and affected by cancer across the country. It is structured around eight behaviours that can be used as indicators of service quality. These are designed to effect positive change in staff/patient relationships, to drive up performance – especially in patient experience, satisfaction and outcomes – and protect care rights. The eight behaviours are:

- Naming – “I am the expert on me”.
- Private communication – “My business is my business”.
- Communicating with more sensitivity – “I’m more than my condition”
- Clinical treatment and decision-making – “I’d like to understand what will happen to me”
- Acknowledge me if I’m in urgent need of support – “I’d like not to be ignored”.
- Control over my personal space and environment – “I’d like to feel comfortable”.
- Managing on my own – “I don’t want to feel alone in this”.
- Getting care right – “My concerns can be acted upon”.

For each of these areas, the Macmillan Values Based Standard includes an associated list of staff behaviours, leadership behaviours, and prompts to encourage staff to set themselves personal goals that challenge what they do on a day-to-day basis.

Case study: GREAT INTERACTIONS

'Great Interactions' is a project developed by MacIntyre that involves observing and videoing the “natural” staff who are best at building relationships with users, then using that information to develop a recruitment, training and development strategy to help all frontline staff emulate the naturals. It focuses on making staff more reflective about their practice while learning ten facilitation skills, the soft people skills, which provide a better understanding what it means to deliver personalised services centred on the individual.

Case study: BARBARA'S STORY

Guy's and St Thomas' NHS Foundation Trust have developed a powerful, award-winning film about Barbara, a woman with dementia. The film tracks her experiences during a hospital visit and shows how “it's the smallest things that can make the difference”: the nurse who is kind to her is doing something that staff who are carrying out their tasks perfectly well are not. Almost every one of Guy's 12,000 staff has now watched this film as part of an innovative training session; and reports are very positive.

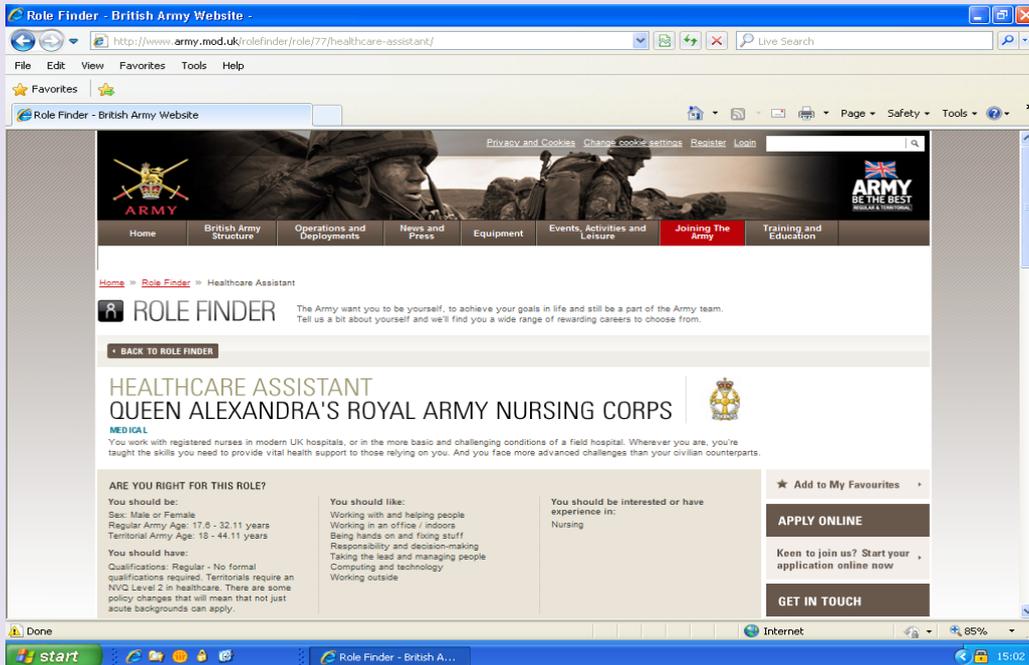
6.13. Setting high minimum standards with ongoing supervision

- 6.13.1.** The best employers in health and social care are developing longer, more rigorous induction programmes, linked to continuous professional development with high expectations. York Hospitals NHS Foundation Trust has created a two week induction period for HCAs, with a heavy focus on values, personal responsibility, care and compassion. This leads to a preceptorship (supervised training period) of one year, where every new recruit has an experienced HCA buddy and a registered nurse mentor. York is currently looking at how to get its training accredited, so that the HCA gets a recognised and transferrable qualification at the end of the first year.
- 6.13.2.** St Christopher's Hospice, one of the leading organisations in palliative care, runs a week – long induction in which potential staff are closely supervised, both in groups and individually, interacting with elderly people and with each other. Staff are only offered jobs if the management are in unanimous agreement about their attitude, commitment and potential. Supervision is rigorous and ongoing throughout a career.

"We do all our training ourselves. If you're going to train someone properly you've got to be a role model, you go out with them and show them how to do it. When we have clients who need two carers, I go and be one." (Deborah Holman, Advancing Practice Nurse and Social Care Project lead, St Christopher's Hospice)

- 6.13.3.** Lancashire Teaching Hospitals NHS Foundation Trust runs an eight-day induction before HCAs can operate in clinical areas, after which they are mentored on the wards and have
- 6.13.4.** Heart of England NHS Foundation Trust has developed a series of online knowledge test for doctors and nurses called Virtual Interactive Teaching and Learning (VITAL). Nurses are expected to repeat the (randomised) questions until they score 100% on 14 elements of basic care. The Trust has tested this with other hospitals, and is now developing a version for HCAs, who will be expected to score 100% within six months of joining.

Case study: THE BRITISH ARMY



Within the military the role of the HCA is unique to the British Army and they are members of the Queen Alexandra Royal Army Nursing Corps (QARANC), working as an integral part of the multidisciplinary team and in close partnership with the Registered Nurses specifically to care for both civilian and military patients in the UK and overseas.

New recruits to the Army have 14 weeks basic military training. Would-be HCAs then spend a further 14 weeks on a training package where the constant emphasis is 'the patient is the centre of their care'. *"They all understand very early in their career that 'care' is not a list of tasks but is about communicating with and involving our patients at all levels."* (Capt Alison Game, Queen Alexandra's Royal Army Nursing Corps)

Additionally they also mandate City and Guilds Diploma Level 2 in Clinical Healthcare Support (CHS) which all HCAs start whilst in their 14 week training programme. They are expected to complete within one year.

The Army is an accredited centre for City and Guilds. It trains its own Assessors and Verifiers within the military in order to allow HCAs to access and complete the Diploma Level 2 in CHS wherever they are required to work, and progress to Level 3 in a similar way. The military HCA career pathway moves on beyond Diploma Level 2 and 3 if they wish to, if they are suitable and are recommended, to Foundation Degree and Assistant Practitioner.

The military HCA has knowledge and skill sets that enable them to fully understand and apply the theory to the practice, which ensures all patients get the right care, in the right way, at the right time. By continuing to maintain both their theoretical and practical competences through their Diploma work and skills updates they are the heart of the care team within the QARANC.

- 6.13.5.** It is striking that the Army sets high standards for its HCAs and sees them as an integral part of the team, with joint training. The army is also scrupulous about assessing its staff. For no matter how many training courses someone has passed, at the end of the day, there is no substitute for standing next to someone and observing them at work.
- 6.13.6.** At University Hospitals Birmingham NHS Foundation Trust, members of the “Dignity in Care” team of highly trained registered nurses will periodically spend two to three hours simply observing staff practice in a single hospital bay. They will intervene to stop bad practice, but otherwise they simply report back to the Chief Nurse on the interactions they observed between staff and patients, and whether that particular ward is a good environment in which to train other staff.
- 6.13.7.** In social care, some leading organisations are also seeking to achieve high standards of training and ongoing supervision through innovative use of technology, combined with face to face observation, to keep costs down.

Case study: HC-ONE

HC-One provides dementia, nursing, residential and specialist care for older people, with homes located throughout the UK. The company was created as part of the rescue of care homes formerly run by Southern Cross. The much-publicised demise of that operator left HC-One with a legacy of low morale among staff and its inevitable risk to service quality. But the new business has risen to the challenge and placed a culture of kindness at the heart of its work to re-engage and re-invigorate staff.

By focusing on kindness, HC-One is recognising the crucial vocational aspect of being a care professional. In the outcomes of the 2013 annual staff survey, colleagues overwhelmingly cite "*making a difference to people's lives*" as the goal that is most important to them.

HC-One has created an innovative blended corporate learning programme called '*touch*', to support colleagues throughout the organisation. *Touch* delivers a wide range of mandatory and specialist learning courses through e-learning, video, podcasts and other online formats, including ground-breaking courses in dementia care and dignity. It also blends a wide range of conventional training approaches such as workshops and supervisions.

Personal accountability is the heart of safe and kind care, and HC-One has made staff learning and development a key driver of this principle. *Touch* learning materials place the emphasis on what is expected of *you*, and on *your responsibility* for ensuring good practice. Personal accountability also means having the confidence to speak out if you think something is not right, and *touch* is supporting that.

HC-One is also using *touch* to promote involvement. Throughout the learning materials, case studies and scenarios are used to connect training to the everyday work experience of carers.

HC-One is using its *touch* learning and development platform to promote partnership working and the development of effective role models at every level. *Touch* learning activities are specific practical exercises that colleagues complete in the home where they work, often under the supervision of a more experienced colleague. HC-One is also developing a range of support tools for Home Managers and shift leaders to help them promote good practice and personal development within their teams.

Seven months since its launch, over 90% of colleagues are active participants and have between them completed a staggering 140,000 online courses (plus a huge number of workshops and other face-to-face training assignments). A detailed evaluation of the learning experience has been completed by more than 4,000 colleagues, who give average approval ratings over 90% across a range of measures of quality and effectiveness. In the 2013 staff survey, colleagues were asked 'what is the best thing HC-One has done for you this year?' The top answer was 'training'. As care worker Tanya Welch puts it "*touch* has generated great enthusiasm and is helping our work on a daily basis".

6.14. A way forward

- 6.14.1.** We have seen that the current system is not working well for many employers, especially small employers in the care sector, who struggle to navigate the minefield of funding and qualifications. It does not provide adequate safeguards for the public. Nor does it help support workers to demonstrate transferable skills. Lack of faith in qualifications, and the lack of central quality assurance mechanism, has led to duplication and wasted resources.

- 6.14.2.** We have also seen leading employers are more ambitious for their care support staff, recruiting them on the basis of aptitude, then training them to higher standards as part of ongoing supervision and assessment and career progression. These measures seem to have the effect of increasing staff engagement and reducing attrition rates, and therefore cost.

6.15. Set a higher standard

- 6.15.1.** The Review does not wish to place overly onerous burdens upon employers, given the harsh financial environment. There is no point making demands on employers which are not heeded or which put good, small care homes out of business. But several large care organisations, social care trade associations and NHS Trusts have told the Review that they would welcome a system of agreed national core competences for their staff, both at and beyond the minimum, to which they could then add their own modules and values. They believe that these would help to improve safety, raise the status of caring and potentially save money.

“Transferable and nationally-recognised certification would be immensely valuable both to the employee and the service provider. It would go a long way towards standardising practices and lift basic standards. It would not only reduce the cost of constantly duplicating training, but also create a national standard under which all staff would have to operate.”

(Chai Patel, Chairman, HC – One)

- 6.15.2.** The Review concludes that the system should be more ambitious in the standards demanded of support workers, and in the support given to them. But the system should also be more ambitious in another way: it should seek to bridge the divides between health and social care, and between healthcare assistants and registered nurses.

6.16. Train the caring workforce as one workforce

- 6.16.1.** What is striking about the training of the caring workforce is that individuals are being taught different courses, or bits of courses, in silos. Yet from the public’s point of view, it would surely make more sense to teach care workers the fundamentals of care in the same way and in the same language. Why is every care assistant not learning the best way to lift or move someone safely, from the experts? (The Review heard from one trainer who believes that many lifting and handling courses are inadequate). Why is every care assistant (to whom it is relevant) not learning the latest way of understanding dementia, from people who have figured out how to communicate this simply and powerfully? Why are healthcare assistants in the NHS not learning the same fundamentals of care jointly with registered nurses, in the same language? Nurses already learn basic life support/ resuscitation, infection control, moving and handling, and other elements of fundamental care. There is no reason why that learning should be acquired by nurses and HCAs in different places, using different curriculums.
- 6.16.2.** Training people in different places, to varying standards, is inefficient. It is also a safety risk. This is something that the aviation industry figured out long ago.

Case study: “HUMAN FACTORS”- TRAINING IN THE AVIATION INDUSTRY

In the 1970's, US investigators discovered that more than 70% of air crashes involved human error rather than failures of equipment or weather. A National Aeronautical and Space Administration (NASA) workshop examining the role of human error in air crashes found that the majority of crew errors consisted of failures in leadership, team coordination, and decision making. Some errors stemmed from no one questioning the word of the Captain.

In 1980, United Airlines created a formal training programme which combined technical and human factors training. This started in the cockpit but gradually moved to encompass the whole “crew”: flight attendants, mechanics, dispatchers, and everyone who had a responsibility for the safe completion of the flight. This has become known as Crew Resource Management (CRM) training: it was adopted by British Airways in 1989 and is now mandatory for commercial airlines.

CRM supports the avoidance, management, and mitigating of human errors. The secondary benefits of effective CRM programmes have improved morale and enhanced efficiency of operations.

- 6.16.3.** Airlines realised that passenger safety improved when everyone whose job had any bearing on safety shared an explicit common goal, and common training. Today, airline’s cabin crew, engineers and pilots undergo the same technical and human factors training, in the same room at the same time. This helps reduce the sense of hierarchy, and make people feel more comfortable in challenging each other.
- 6.16.4.** There is a powerful analogy here with health and social care, where patient safety should be paramount but where training is currently fragmented. This is neatly put by Professor Martin Green:

“On something like infection control, if you get it right you get it right. When we fragment training (across the sectors), it causes problems, because everyone is not on the same page.”
(Professor Martin Green, CEO, English Community Care Association)

- 6.16.5.** Infection control is a good example of something that should be taught effectively, in the same way, to every member of staff. In 2007, Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of, or a contributory factor in, approximately 9000 deaths in hospital and primary care in England. Healthcare-associated infections are estimated to cost the NHS approximately £1 billion a year⁴¹. And the risk of infections is rising in social care, as more and more invasive procedures are performed.
- 6.16.6.** The opacity of the language of vocational qualifications, and the profusion of training courses and modules, has obscured that fact that there is a simple common core of knowledge – such as infection control – that most support workers need to learn to ensure public safety. Moreover, the widespread assumption that support workers are lowly figures who cannot understand certain concepts has obscured the potential for teaching them within the clinical team, especially with nurses who ought to be setting the standards. Whether it is first aid, infection control, how to prevent a pressure sore, or how to communicate with someone with dementia, the same techniques should apply. The fact that

⁴¹ NICE clinical guidelines, March 2012

nurses need to learn additional skills, such as medicines management, should not mean that more basic learning cannot be shared.

6.17. The “Certificate of Fundamental Care”

- 6.17.1.** There is now an opportunity to raise standards, improve transparency, reduce duplication, raise the status of caring, and bridge divides in the system, by creating a “Certificate of Fundamental Care”. This would encompass the minimum competences that support workers in health and social care should achieve before they can start working in intimate caring roles. It should build on what nurses already learn, rather than being developed and delivered in a separate silo. It would mark a fresh start to assure public safety and raise the status of caring.
- 6.17.2.** The “Certificate of Fundamental Care” would build on the National Minimum Training Standards (NMTS) developed and published by Skills for Health and Skills for Care, in March 2013 as part of its response to the Francis Inquiry⁴². These suggested the minimum content that an HCA or support worker should know.
- 6.17.3.** The Certificate should be written in plain English and be accompanied by guidance written in plain English. This is very important to reassure the public: some employers and experts who were consulted about the minimum standards complained to the Review about the bureaucracy and opaque language involved.
- 6.17.4.** The content of the Certificate would be linked to the National Occupational Standards, with a more transparent emphasis on what most matters to patients and the public. The Alzheimer’s Society has made a strong case to the Review that dementia training should be a mandatory requirement, since providing care to people with dementia is now “a core business of healthcare and care workers”.
- 6.17.5.** Support workers surveyed by UNISON agreed, wanting the NMTS to include compulsory training on dementia and mental health issues⁴³. The proposed minimum standards currently include dementia training as an option in the glossary. This takes account of the fact that some support workers may be working with children or in other settings where it is not appropriate. However, dementia awareness teaches dignity and communication skills which are relevant to all workers.
- 6.17.6.** Workers who achieved these standards would receive positive recognition in the form of the “Certificate of Fundamental Care.” The term ‘fundamental care’ is more positive than ‘basic care’, which understates the skilled nature of many tasks. “Mandatory minimum”, while accurate, does not give workers the chance to feel pride in their achievements. Achieving the “Certificate of Fundamental Care” should be a badge of honour, a first step on a caring career.
- 6.17.7.** In the NHS, the new standards present an opportunity to bring nurses and HCAs together. The NMC should help determine which elements of nursing education should be drawn across into this Certificate and taught jointly to first year students and HCAs. A few Trusts are already running joint induction for nurses and HCAs: this Certificate should be taught jointly to those groups, and wherever possible to care support workers in the same place. Ultimately, this Certificate should also be made

⁴² National Minimum Training Standards for Healthcare Support Workers and Adult Social Care Workers in England, funded by Department of Health, March 2013

⁴³ Skills for Care/Skills for Health consultation on code of conduct for adult social care and healthcare support workers. Feedback from UNISON’s survey

available to volunteers and family carers, who shoulder so much of the caring burden – which in turn would help to promote transparency and quality.

- 6.17.8.** Of course, the suggestion that this new training be grounded in the nursing curriculum raises questions about whether nurse training itself is fit for purpose. Concerns have been expressed to the Review, by some NHS Trusts and HCAs, about the variable quality of practical nurse education. These concerns echo the comments of the Willis Commission about student placements. The higher education partnerships being developed by University Hospitals Birmingham NHS Foundation Trust, and separately by Heart of England NHS Foundation Trust, are a sign that leading Trusts want to take greater control of the practical elements of the nursing curriculum. The views of those Trusts will be particularly relevant to the development of the Certificates of Fundamental Care. For unless practical nurse training in fundamental care is of the highest standard, the junior workforce will not have the right role models or supervision.
- 6.17.9.** The creation of Health Education England (HEE) offers an opportunity both to improve practical nurse education, and to link this to new standards for support workers. This is the first time that a single organisation has had responsibility for all NHS staff education, recruitment, training and development. Through its mandate, HEE is committed to developing a strategy and implementation plan to improve the capability of the HCAs and support workers, working with employers and building on the NMTS. This is also an opportunity to identify the best places to train; and make training a badge of honour.
- 6.17.10.** This Review proposes that HEE should commission the “Certificate of Fundamental Care”, building on the work already done by Skills for Health and Skills for Care. While HEE will need to work in partnership with those bodies, the NMC, and employers, it is vital that the Certificate is not commissioned by committee. However HEE must take full account of the needs of social care, as the largest workforce. Skills for Care will play a pivotal role here, and in mapping to the National Occupational Standards and the QCF. And the five main trade associations in social care will need to play a leading role.

6.18. “Higher Certificate(s) of Fundamental Care”

- 6.18.1.** The “Certificate of Fundamental Care” would only be a first step. No induction training should exist on its own. Good employers link induction to a probationary period, clear job descriptions, supervision and continuous assessment over time. As we have seen, many good employers are now linking induction training to 6-month or year-long probationary periods after which they expect a defined level of competence to have been reached. Some NHS Trusts are also streamlining Bands 2 and 3 to try and get a more explicit, consistent relationship between banding and competence.
- 6.18.2.** As described earlier in this chapter, there is now an opportunity to develop an agreed set of national competences in health and social care which would underpin what could be called a Higher Certificate (or Certificates) of Fundamental Care. To be fit for purpose, such a Certificate (or Certificates) would need to encompass a common core, with modules appropriate to different settings. Over time, the goal would be to develop a clearer, more integrated education offer for health and social care workers.
- 6.18.3.** The “Certificate of Fundamental Care” should mark a fresh approach to training, with a step-change in employer involvement. The best employers, especially small employers in social care, know what

really works on the ground. But they also have little time to attend lengthy committee meetings and little patience with bureaucratic language. This Review has no interest in burdening employers with additional work for the sake of it. The process of drawing up new core competences will only be worth undertaking if employers are prepared to define what knowledge, skills and attitudes they think are most relevant to the frontline and to the future; and do not delegate this work to quangos.

- 6.18.4.** What has been made clear, by some of the most innovative care organisations, is that training needs to embed values from the very start. While the actual skills needed will vary between settings, there should be a golden thread of values running through all training in health and social care. Workers in both sectors are increasingly going to need to draw on similar knowledge and approaches as health and social care integrate: there needs to be a shared set of language and values, drawing in health from the values expressed so clearly in the NHS Constitution.

Recommendations

Recommendation 1: HEE should develop a “Certificate of Fundamental Care”, in conjunction with the NMC, employers, and sector skills bodies. This should be written in language which is meaningful to the public, link to the framework of National Occupational Standards, and build on work done by Skills for Health and Skills for Care on minimum training standards.

Recommendation 2: A “Higher Certificate of Fundamental Care” should also be developed, linked to more advanced competences developed and agreed by employers. The Department of Health should hold HEE and Skills for Care to account for ensuring that there is step-change in the involvement of best care employers.

Recommendation 3: The CQC should require healthcare assistants in health and support workers in care to have completed the Certificate of Fundamental Care before they can work unsupervised.

Recommendation 4: The NMC should recommend how best to draw elements of the practical nursing degree curriculum into the Certificate; HEE, LETBs and employers should seek to have nursing students and HCAs completing the Certificate together.

6.19. A rigorous quality assurance mechanism

- 6.19.1.** There is no point in creating minimum standards or national competences unless there is a robust mechanism for ensuring that they produce competent workers with the right values and behaviours. Currently this does not exist. A rigorous quality assurance mechanism is needed, to weed out poor training providers, tie funding to outcomes and user feedback, and put stronger emphasis on the responsibility of the employer to ensure and demonstrate that their staff are suitably trained, backed up by assurance by CQC that fundamental training standards have been met.
- 6.19.2.** Organisations that support registered professions, such as the NMC, RCN and RCM for nursing and midwifery, the General Medical Council and Medical Royal Colleges for doctors and the College of Social Work for social workers⁴⁴, set the standards for training of registered professionals and seek to

⁴⁴ The Health Care Professions Council (HCPC) is the regulator for social workers in England.

drive up the quality of the training provided. For non-registered professions, the situation is less clear-cut. Although employers are ultimately responsible for ensuring HCAs and support workers have the right training, but the sector skills councils also play a vital role by linking training standards to QCF and the National Occupational Standards⁴⁵ across both health and social care.

- 6.19.3.** HEE, as reflected in the Government's mandate, also has a key role to play in driving up the standards of training and improving the capability of this staff group. In developing a strategy to achieve this, HEE will need to work with partners including employers, patients, service users, CQC and sector skills councils. The newly created LETBs also have a direct interest in the quality of the non-registered healthcare workforce, and a small amount of funding to secure training and development for that group. We propose that HEE develop, with LETBs, proposals for validating training.
- 6.19.4.** It is painfully clear that staff shortages and turnover, and low fees paid by commissioners, make it very difficult for some care providers to gather staff together for training, or to provide cover for an individual so that clients receive care while an individual is training. It will be important to find a way to increase the flexibility without compromising the quality and continuity of care. This may be through imaginative use of online training and videos: but there still need to be practical, real-life observations of how staff actually perform.
- 6.19.5.** It is the duty of employers to ensure that their staff demonstrate the right values and behaviours, and are competent to perform the tasks they are asked to do. The NHS Constitution sets out an admirable set of pledges which are simply not being put into practice in too many NHS Trusts. In social care, an equivalent "compact", or code of conduct, is being drawn up for employers. Both of these will need to be acted upon.
- 6.19.6.** These proposals should also take into account the Quality Mark (QM), a stamp of approval being developed by Skills or Health for the quality of delivery of training programmes. It is currently being piloted with ten education/training providers. The QM is awarded for two years, with a one year mandatory review. If pilots are successful then consideration should be given to whether it is possible to develop a single QM, with Skills for Care, for both health and social care.

Recommendations

Recommendation 5: HEE, with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training, which links funding to outcomes, so that money is not wasted on ineffective courses.

Recommendation 6: Employers should be supported to test values, attitudes and aptitude for caring at recruitment stage. NHS Employers, HEE and the National Skills Academy for social care should report on progress, best practice and further action on their recruitment tool by summer 2014.

⁴⁵ National Occupational Standards (NOS) are statements of the standards of performance individuals must achieve when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding. NOS describe what an individual needs to do, know and understand in order to carry out a particular job role or function. NOS are national because they can be used in every part of the UK where the functions are carried out. NOS are developed for employers by employers through the relevant Sector Skills Councils (Skills for Health and Skills for Care).

6.20. Conclusion

- 6.20.1.** Consistent minimum training standards are essential to protect the public. But they also provide an opportunity: to give the public a better understanding of what support workers do, and to develop training which can focus on the core of fundamental care that is common to nursing, social care and healthcare assistants.
- 6.20.2.** Many employers are striving to recruit, train and motivate staff under considerable financial pressure. But the best organisations are showing that taking the time to develop good recruitment and training strategies, with proper oversight, can pay off. It is well known that engaged, well-supported and well-motivated staff deliver better quality care.
- 6.20.3.** 6.20.3. Support workers are often said to be working "under supervision". But the reality, particularly in social care, is that this cannot always be the case. Workers need to be capable of acting independently and making the right judgements in what can be challenging and stressful situation. The best organisations regularly observe them on the job to ensure that standards are maintained.
- 6.20.4.** 6.20.4. There is an opportunity to create more integrated, rigorous training across health and social care to underpin the flexible workforce needed for the future; and to build public confidence by making this transparent and intelligible.

7. Making Caring A Career

Summary

To many workers caring does not feel sufficiently like a career, with opportunities to progress.

The decision to make nursing an all-degree profession has cut off talented HCAs and support workers who have traditionally been promoted onto degree courses, and supported, by some of the best employers in health and social care. These employers are concerned that workers will now be demoralised by the imposition of a “glass ceiling”. They have also lost the opportunity to promote workers into nursing who they know from personal experience are right for the job. This is a waste of potential and undermines the attempt to raise the status of caring.

With very high drop-out rates on university nursing courses for students entering straight after A-Levels, there is a strong case for improving access to nursing courses for experienced carers.

Talented HCAs and support workers need access to affordable, part-time study. The Review recommends a number of possible ways to achieve this. It recommends that caring experience be made a requirement of university entrance, and should be given more weight when considering applicants.

“There is no clear and consistent route for talented carers with vocational qualifications into degree programmes.” (Skills for Care)

“The notion of the skills escalator in the NHS does not work for HCAs.”
(Paul Heron, University of Oxford)

“I’ve been declined twice from university. It’s really knocked my confidence. So I’m not good enough to get on the nursing course, but they expect me to show the student nurses what to do. Then they drop out and I think, ‘That could have been my place.’”
(HCA, Salisbury focus group)

- 7.1.1.** Any job that is rewarding needs to have a sense of progression. While not many HCAs or support workers will go into nursing, therapy or social work, it is vital that the opportunity exists.
- 7.1.2.** The NHS Career Framework depicts a neat ladder rising from Band 1-9, implying a smooth progression. Unfortunately, the reality is very different. The leap from Band 4 (AP) to Band 5 (registered nurse) has become even more challenging with the requirement that, from this September, all new student nurses must be enrolled on a degree programme. This raises the bar for applicants without A-Levels⁴⁶, which many dedicated carers in health and social care do not have.

⁴⁶ Most courses also require A-C GCSE in Maths and/or English

- 7.1.3.** Good employers are already feeling the impact. Guy's and St Thomas' NHS Foundation Trust usually puts 10 or 12 HCAs into nursing courses each year: this year only two of its HCAs have been accepted, because the others do not meet the academic requirements. Similarly, University Hospitals Birmingham NHS Foundation Trust used to put between 12 and 24 of its best HCAs onto nursing programmes each year. But now it expects a big drop off.

"We're creating a glass ceiling we don't need: we'll end up with a group of frustrated people who can go nowhere."

(Kay Fawcett, Chief Nurse, University Hospitals Birmingham NHS Foundation Trust)

- 7.1.4.** The impact is also being felt in social care:

"Since the all-degree nursing programme came in we have had no apprentices through that route even though we do so much more on our pre-nursing apprenticeship programme. In fact we had a couple of calls from HEIs⁴⁷ to say that we shouldn't be offering a pre-nursing apprenticeship as they wouldn't recognise it as an entry qualification."

(Dr Terry Tucker, Director of Learning and Development, Barchester)

- 7.1.5.** Not all HCAs and support workers wish to become nurses⁴⁸ or other health professionals, and it is important that they should be supported to enjoy their existing roles. But there needs to be a simple, affordable career ladder which they can pursue if they want to. Not least because some HCAs and support workers have the right experience, dedication and attitudes to make great nurses, occupational therapists or social workers. There is some evidence to suggest that if they are supported, non-traditional learners have higher completion and retention rates than traditional student nurses⁴⁹. With drop-out rates among traditional student nurses running at 27%⁵⁰, and each nursing degree costing the taxpayer £17,516 per annum⁵¹, there is a potential for a clear, funded route for care workers to prove cost neutral.

- 7.1.6.** In previous years, staff who obtained a foundation degree, or an NVQ diploma at Level 3 or above, were considered by some universities as eligible to apply for degree courses. Some HCAs became full-time students; others had the option to study part-time on secondment from their employer, to whom they were expected to return on graduation. Until 2006-7 the secondment route was very successful. It had the advantage that employers could spot and promote the best. After Strategic Health Authorities reduced funding, however, the numbers plummeted.

⁴⁷ Higher Education Institutes

⁴⁸ UNISON (2010) *Dedicated to healthcare: HCA survey results 2010*. [available on line] www.UNISON.org.uk/acrobat/19489.pdf

⁴⁹ UNISON (2008) *A course out of crisis: a study of attrition and the changing nature of the nursing and midwifery workforce* [Available on line] www.UNISON.org.uk/file/A3784b.pdf

⁵⁰ Department of Health Financial Information Management System (FIMS) return. 2011-12 data for 2007-8 intake. It can take up to five years for a complete cohort to move through the system, as trainees can defer for reasons such as maternity leave.

⁵¹ Department of Health

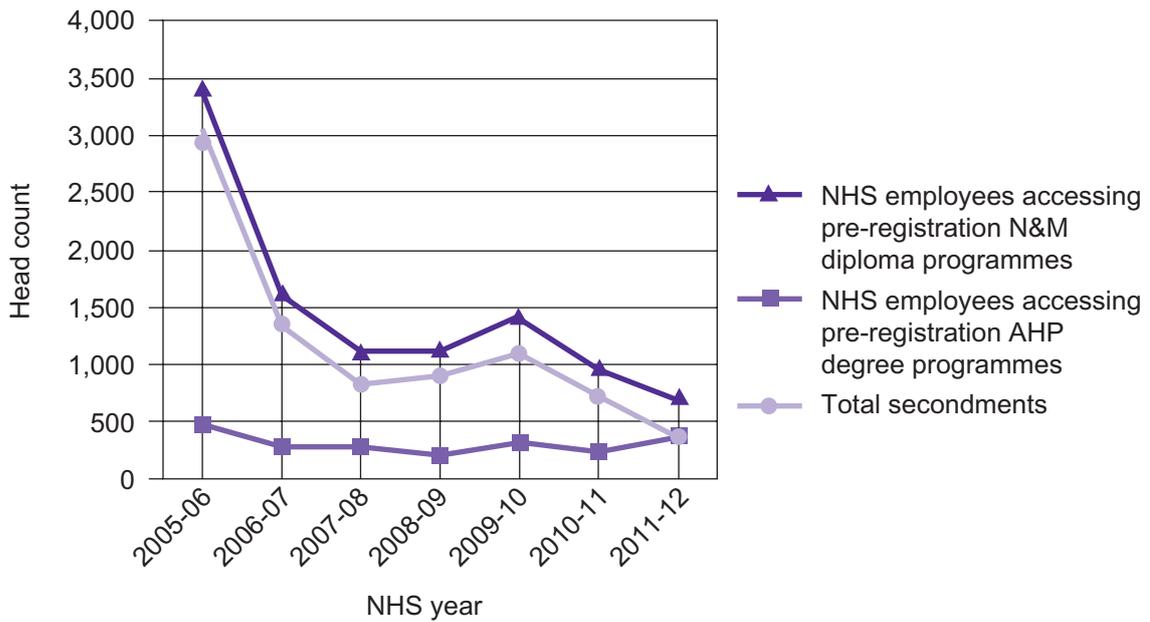


Figure 7: Number of secondments from NHS employees 2005-6 to 2011-12
 Source: Department of Health Finance and Information Monitoring return

Case study: THE OPEN UNIVERSITY

In health, the Open University (OU) has a good track record of pre-registration nursing programmes as part of its mission of widening participation in healthcare. At 89%, its retention rates are good. Its learning and development framework is a part-time, work-based, system which is designed to minimise the challenge for employers of releasing staff from the workplace.

The OU has recently adapted its curriculum to meet the challenge of the move to all-degree nursing, but it has not raised its entry requirements. It continues to demand only the minimum NMC requirements of numeracy and literacy. The system could learn a great deal from the way that the OU recruits and screens candidates, involving a panel of service users to identify applicants with the right values, and the way that it supports them to graduate.

7.2. How a new career ladder might work

7.2.1. There are several possible ways of bridging the gap. Richard Griffin from the Institute of Vocational Learning at Buckinghamshire New University, commissioned by the Department of Health, has proposed three possible bridging programmes which build on existing routes of apprenticeship, diploma or foundation degrees⁵². These link to the QCF and National Occupational Standards, and are set out in Figure 8:

⁵² Richard Griffin and David Sines, Buckinghamshire New University, 2013 "Widening Participation into Pre-Reg Nursing Programmes"

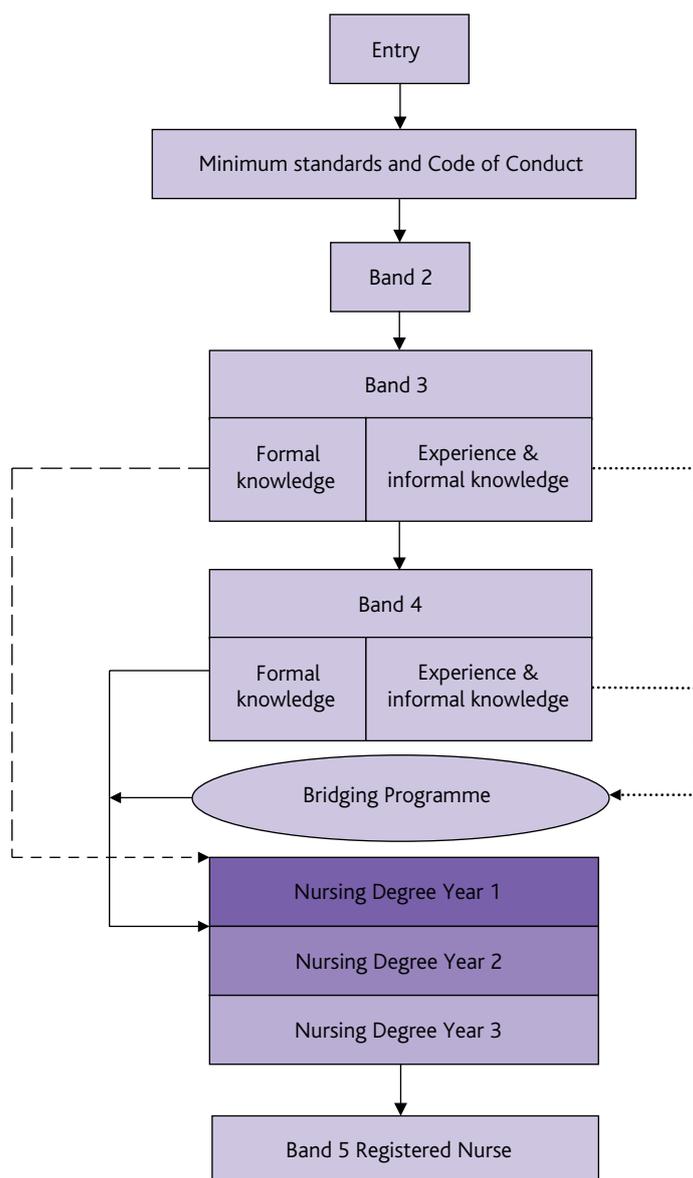


Figure 8: Bridging programmes for progression of HCAs and support workers into nursing programmes

Source: Re-produced slides from Richard Griffin- Buckinghamshire New University 2013- Widening Participation into Pre-registration Nursing Programmes

7.2.2. These models have the merit of building on existing frameworks and routes with which employers are already familiar. One model would permit progression from a foundation degree into the second year of a nursing degree, thus allowing the best students to complete a nursing degree in two years rather than three. Another model would enable progression from a health and social care Level 3 diploma into a pre-registration nursing programme. The last model would allow progression from a higher level apprenticeship into a pre-registration nursing programme.

7.3. Apprenticeships

- 7.3.1.** Apprenticeships are becoming more widely developed as alternative work-based pathways to professional status and registration, for example in Law and Accountancy. Higher Apprenticeships have potential to deliver high level skills tailored specifically to individual organisation requirements, allowing the learner to be employed full time and developing their skills in the workplace. In March 2013, Skills for Care launched a Higher Apprenticeship in Care Leadership and Management which is designed to lead into careers in therapy or social work. The Higher Level Apprenticeship in Health (Assistant Practitioners) was issued by Skills for Health in April 2013.
- 7.3.2.** Barchester Healthcare has proposed a higher-level apprenticeship, including literacy and numeracy qualifications that would take the best carers straight into nursing. This is an attractive idea. It could potentially provide a joint ladder of part-time, on the job learning, for talented staff in both health and social care.
- 7.3.3.** We recommend that all three proposed bridging programmes be commissioned, and that a costing exercise be carried out to identify possible cost savings from lowering attrition rates and enabling HCAs to do two years of study rather than three, if they have the appropriate knowledge, experience and attitudes. We also recommend that consideration be given to Barchester's proposal.
- 7.3.4.** Many universities give some weight to prior care experience, when considering candidates from social care and health⁵³. This includes volunteering, looking after a relative, as well as paid work: experience which may indicate likely staying power and good performance on the job⁵⁴. We suggest that all universities should now require previous experience in caring before starting a nursing degree. We would also like to see work done to look at the equivalence of functional skills qualifications and the entry requirements for pre-registration programmes, as recommended by the Council of Deans and Skills for Health.
- 7.3.5.** In "Patients First and Foremost"⁵⁵, the Secretary of State for Health announced a pilot, led by HEE and the NMC, under which every student seeking NHS funding for a nursing degree should serve for up to a year as an HCA. He cited the Francis Inquiry's recommendation that "there should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse". During the course of the pilot it will be important to calculate how much that experience should count towards the degree course; and what milestones must be passed; this should inform the value put on caring experience by universities.
- 7.3.6.** If the objective is to generate more respect between student nurses and HCAs, and to ensure that no one can enter a degree course without demonstrating a commitment to high standards of basic care, then it will also be vital that this experience takes place only in the best settings, which achieve the highest rankings from the new Chief Inspectors for Hospitals and Social Care.

⁵³ Accreditation of Prior Learning (APL) and Accreditation of Prior Experiential Learning (APEL) is used in Further Education, adult education and Higher Education for the purpose of: entry onto a course or programme, advanced standing on a course or programme, or credit against some of the outcomes of a course or programme that count towards an award. APEL is an extension of APL (which recognises academic credit) so that it includes assessed learning gained from life and work experiences. Arrangements for APL and APEL vary between institutions and providers. For more information visit www.nmas.ac.uk

⁵⁴ Bill Mumford, MacIntyre

⁵⁵ Patients First and Foremost: The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, March 2013

Recommendations

Recommendation 7: HEE and the LETBs should develop new bridging programmes into pre-registration nursing and other health degrees from the support staff workforce in health and social care, working with Skills for Care, NMC and Skills for Health; and explore the Barchester proposal for a Higher Apprenticeship.

Recommendation 8: HEE and the LETBs should set out a clear implementation plan, with robust measures, to take forward the objective in the HEE mandate to widen participation in recruitment to NHS-funded courses: and develop innovative funding routes for non-traditional staff to progress.

Recommendation 9: The NMC should make caring experience a prerequisite to starting a nursing degree, and review the contribution of vocational experience towards degrees so that staff with strong caring experience can undertake 'fast-track' degrees. Skills for Care should work with Higher Education Institutions to look at how care experience can be recognised in enabling people to enter social work, therapy and advanced social care courses.

Recommendation 10: NHS Employers, HEE and Skills for Care should work with employers to set out a robust career development framework for health and social care support staff, linked to the simplified job roles and core competences.

7.4. A ladder that is affordable

"If they had to resign from their posts, their income would be reduced by about two thirds. Seconding them on their Band 3 salaries would remove this barrier."
(Queen Elizabeth Hospital King's Lynn: submission to Cavendish Review)

- 7.4.1.** Few experienced carers will take the financial risk involved in entering a full-time degree. They need affordable, part-time study courses. Decisions on the most appropriate investments in HCAs and support workers will now be made by LETBs in partnership with employers and other stakeholders. The Education Outcomes Framework makes clear that the system – and the new LETBs – have a responsibility to widen participation. It will be important that HEE uses its proposed Accountability Framework to focus LETBs on delivering these outcomes, and release funding to ensure that non-traditional students can progress in their careers.

7.5. Conclusion

- 7.5.1.** HCAs and support workers in social care must have a clear line of sight from the most junior rungs of their careers through to jobs in nursing, social work, physiotherapy or occupational therapy, if they want to. It is vital that the move to all-degree nursing does not cut off opportunity. The Review recommends that bridging programmes proposed by the Institute of Vocational Learning should be commissioned.

- 7.5.2.** The Review also recommends that prior learning and experience of a caring role should be a pre-requisite for entry onto a pre-registration nursing programme, and is encouraged that HEE and the NMC will be piloting this.
- 7.5.3.** HEE's mandate for widening participation is an opportunity to ensure that non-traditional students from a HCA or support worker background can progress in their careers.
- 7.5.4.** Further action will also be needed to ensure that qualifications and competences are portable, so that staff are able to move jobs and continue to progress in their careers.

8. Getting the Best Out of People: Supervision, Leadership and Support

Summary

Training alone cannot ensure that people are treated with care and compassion. To perform well, HCAs and support workers need to be part of positive, self-reinforcing teams. The best organisations around the world are demonstrating that teamwork is a fundamental component of improving staff engagement and care outcomes.

The role of the first line manager – whether a ward sister, midwife or community lead, or registered manager in a care home – is critical to ensuring that workers are properly valued, supervised, and held to account. First line managers need more recognition and support. There must be a concerted drive to reduce the paperwork burden under which they struggle.

In social care particularly, it will be important that talented carers do not have to move away from the frontline to get promotion.

Leadership also means being intolerant of poor performance. In parts of the NHS, a mythology has grown up that it is too difficult to sack people. This must be reviewed and challenged.

In the NHS, Directors of Nursing should take back full responsibility for HCAs from HR and give them a voice at Board level. The number of HCA titles should be reduced, to improve clarity and accountability, preferably to the single title: Nursing Assistant.

Employers must also be accountable for poor performance. The pledges in the NHS Constitution are not always acted on in some Trusts. And social care employers need a code of conduct.

- 8.1.1.** In the airline safety industry, human factors studies show that the most junior staff can be the most important links in the safety chain⁵⁶. HCAs and support workers are the backbone of many parts of health and social care. So the question of how best to manage and support them, to make them the best they can possibly be, is paramount.

Where HCAs feel a valued part of a team I have seen them give 110%. They have often been the loudest champions of best practice." (HCA clinical lead, London focus group)

⁵⁶ Porter TJ. Human factors: Importance of maintenance resource (mrm) training and values associated with civilian maintenance personnel. Embry-Riddle Aeronautical University, 1999.

- 8.1.2.** There is now substantial evidence about the importance of positive, self-reinforcing cultures and staff engagement in achieving better outcomes for patients and users⁵⁷⁵⁸. Some of the highest levels of staff and patient satisfaction in the world are found in organisations like the US Mayo Clinic⁵⁹, which organise systems around the patient and value every member of the multi-disciplinary team.
- 8.1.3.** Unless staff feel they are doing a worthwhile job in a supportive culture, no amount of training will result in the best care for patients. Our focus groups found striking differences between support workers who felt part of a positive team and those who did not.

8.2. Leadership, supervision and support in the NHS

8.2.1. Team building

"I often hear at the beginning of a shift: 'Right, there are three of us on the shift today' when in fact there are seven people standing there. It's as if the four HCAs didn't exist – only the registered staff actually get counted as 'being there.' (Nurse educator, London focus group)

"Our role models were the 'old' A-Grades, 'old school nurses' who are slowly dwindling away. They did the job caringly and compassionately and were not scared of making decisions."
(HCA, Birmingham focus group.)

- 8.2.2.** This Review has heard considerable frustration voiced by some HCAs about some registered nurses and managers.
- 8.2.3.** Some senior nurses have also expressed concerns to this Review about antagonism they have seen on the wards, and the challenge that some nurses face in managing junior staff. One recent academic study⁶⁰ found HCAs being routinely overlooked by nurse managers.
- 8.2.4.** The Chief Nursing Officer has set out a vision for nurses, midwives and care staff, aimed at "ensuring we have the right staff, with the right skills, in the right place"⁶¹. This makes clear that the NHS should be able to robustly recognise the whole contribution of the nursing team, user, care giver, nurse and support worker and plan accordingly – with the best intelligence and knowledge of the skills and competency mix. The Chief Nursing Officer has also urged all staff to have the confidence to challenge poor practice.
- 8.2.5.** Some of the best organisations have already taken up this challenge. They take the role of HCAs very seriously, and are moving to strengthen relationships within the clinical team. Guy's and St Thomas' NHS Foundation Trust has run a substantial programme of joint training to address concerns about care. As a result of Guy's success, St Bartholomew's Hospital in London is embarking on a similar exercise, involving 500 of its staff.

⁵⁷ Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T, Morrow E (2012a). Exploring the Relationship between Patients' Experiences of Care and the Influence of Staff Motivation. National Institute for Health

⁵⁸ Mannion R, Davies H, Marshall M (2005). 'Cultural characteristics of "high" and "low" performing hospitals'. Journal of Health Organization and Management

⁵⁹ "Doctors and Nurses" 2012, Reform

⁶⁰ An evaluation of Belfast Health and Social Care Trust's Band 3 Healthcare (Nursing) Support Worker Programme. Richard Griffin

⁶¹ Compassion in Practice, NHS England 2012. Action Area 5

Case study: GUY'S AND ST THOMAS' HOSPITAL

With 84 beds for older patients across three wards, Guy's and St Thomas' NHS Foundation Trust found there were inconsistencies in essential care in the 24 hour period even though the staff all participate in day, night and weekend work.

After a few formal complaints and some Patient Advisory Liaison Service (PALS) concerns, the Chief Nurse Eileen Sills felt that communication amongst the nursing team and wider multi-disciplinary team could be improved.

We wanted to develop from a 'good' to an 'excellent' unit and maintain consistency of care by all staff, 24/7. We wanted to ensure that the attitudes and behaviours of staff were appropriate and fitting for caring for older patients and that staff consistently demonstrated empathy, provided dignity and privacy, and had well developed interpersonal and communication skills. We commenced a two week programme including; nurse leadership, recruitment and retention, unit image. It was challenging to get all staff engaged as releasing staff from clinical duties proved challenging as was getting real momentum behind the programme and at this point Chief Nurse supported a refurbishment programme of the wards which meant that we could close each of the three wards for two weeks and develop the staff during the refurbishment.

Staff undertook learning needs analysis, developed learning outcomes, agreed a two week multifaceted, multidisciplinary training programme which included experiential learning and was patient focused. It was important for the whole team to be together including trained nurses and nursing assistants so that each other's roles would be understood and appreciated and they could set the vision and values together.

There were three main elements to this programme which included:

- Leading an excellent service – included all senior staff, consultants, sisters, and covered; agreeing the vision, gaining alignment, agreeing the standards, validation of good practice and agreeing the mission;
- Managing an excellent service – included staff nurses; including beliefs & choice – positive attitude and impression, responsibility – awareness of impact, role model – rising above negativity; and
- Providing an excellent service – included health care support workers, which included; sustaining the change, look up and see a change, look inwards and make a change and look out & change together

The programme also involved simulations such as deteriorating patient at night, delirium, multi-tasking busy ward, breaking bad news. All staff also took turns to wear an ageing simulation suit and undertake a task such as walking to the toilet, eating and drinking.

The simulation team ran a one day workshop with the whole ward team: ward clerk, consultants, junior medical staff, and all care staff. An art of caring day focused on empathy and kindness, and recognizing that caring for older people is a skill. Staff agreed a long list of "Dignity Never" events. These included: patients should never be left without easy access to their call bell, feel hungry, or be stigmatised as incontinent through the inappropriate use and storage of incontinence pads.

Continued overleaf...

Guy's and St Thomas' NHS Foundation Trust commissioned Kings College London, Patient Safety and Service Quality Centre (PSSQ) to independently undertake an evaluation of the programme. This demonstrated improvements in patient care and team work. Staff and patients reported improvements in:

- communicating with patients
- nurse handover
- team support
- empowerment to speak out
- engagement with senior colleagues

Since the programme, there has been a 14% decrease in concerns raised to Patient Advice and Liaison Service (PALS) across the three wards. Healthcare assistants say that they feel more integrated, respected and optimistic about their careers. And as part of a hospital-wide forum, they have recently voted to call themselves "Nursing Assistants and Senior Nursing Assistants".

To sustain this work, Guy's has put in place clinical supervision groups, role specific forums run by Matron and Head of Nursing (including an HCA forum), a leadership programme for Sisters (based on the Excellent Service programme), and a short version of the programme at induction for all staff.

- 8.2.6.** At the heart of Guy's programme was a determination to build respect among members of the clinical team, and clarify roles and responsibilities. This is important, for it is clear that there is too much uncertainty on some wards about who does what, what behaviour should be expected; and what action should be taken if this is not the case.
- 8.2.7.** There is already a move in some Trusts to develop clearer job descriptions for Bands 2 and 3, linked to probationary periods before staff can be confirmed in post. A 2011 survey⁶² found 74% of acute trusts had issued revised job descriptions for Bands 2 and 3. 65% had issued guidelines for the delegation of tasks to HCAs. Skills for Health have also developed transferable role templates, to help Trusts⁶³.
- 8.2.8.** More broadly, however the example of Guy's makes clear that every Trust should be ambitious about building strong teams encompassing junior doctors, consultants, allied health professionals, nurses and support staff. All should be coming together regularly as a team; and reacting to problems as a team. At University Hospital Birmingham (UHB) NHS Foundation Trust, the CEO calls in the entire ward team to explain itself if something goes wrong. This is a model that should be spread more widely. One of the most striking aspects of the Mid-Staffs tragedy was the way that doctors, pharmacists, physios and others stuck to their professional silos and did not question bad practice. The Guy's example, of getting staff to agree "Dignity Never" events, shows that team-building

⁶² 2011 Nurse Support Workforce Survey Initial Results: Ian Kessler, Paul Heron, Karen Spilsbury, NIHR SDO project number 10/1008/17

⁶³ Transferable Role Templates (TRTs) provide a structured approach to developing relevant, transferable and nationally endorsed roles across different locations and services. They can be used when undertaking role or service redesign or when addressing skills mix issues. The information in the templates provides a way to understand the skills and competences required for the role and to identify associated learning that is fit for purpose. Each template provides the competences required for the role (with the flexibility to add locally relevant competences where required), the career framework level descriptors and indicative learning and development needs.

empowers staff to set their own standards of what is acceptable, and to challenge colleagues who fall below that standard.

- 8.2.9.** One barrier to creating stronger teams was described to the Review by several nurses and nurse educators. They were concerned that HCAs have been traditionally “delegated to HR”: recruited and trained in a separate silo. Some ward sisters do not recruit their own teams or even attend open days; others find the language of HCAs’ vocational qualifications opaque. This situation has arisen more by accident than by design. In many Trusts, HR and workforce directors have tended to recruit and train HCAs because they have received monies for training. They then allocate them to wards.
- 8.2.10.** If the nursing team does not “own” each HCA from the very beginning (and indeed the domestic staff), it is harder for Directors of Nursing to get a single message through to all staff members about the values of the organisation, patient care and safety. It is also harder to build strong teams. In the best Trusts, with strong Chief Nurses, there is a clear line of sight from Board level through to ward sister level down to the recruitment, training and management of HCAs. But where HR departments are strong, and Boards have loaded Directors of Nursing with portfolios in addition to care, the picture is more confused.
- 8.2.11.** If management of HCAs is to improve, and strong teams are to be built, all Directors of Nursing must be empowered by their Boards to take greater responsibility for HCAs at Board level. These Directors must act to empower ward sisters to recruit and manage HCAs, and empower those nurse educators who are trying to support HCAs. The “Certificate of Fundamental Care” proposed by this Review is designed to aid this process of bridging the divide. For ultimately, it must be nurses who set the standards and hold healthcare assistants to account.

Recommendations

Recommendation 11: Employers should allow HCAs to use the title “Nursing Assistant” on completion of the “Certificate of Fundamental Care”, where appropriate.

8.3. Role clarity/job titles

“Nurses are not always sure what they can ask HCAs to do:” (Tanis Hand, RCN)

“It’s important to empower HCAs by giving proper recognition to the contributions they make to care. For example, if it is the HCA who washes and bathes a patient, why is it that the nurse who needs to write this on the documentation? The HCA should be able to have ownership of the task delegated to them and be able to enter this on patient record themselves.”

(Senior nurse educator at London Teaching Hospital, London focus group)

- 8.3.1.** Patient groups consistently call for clearer, simpler job titles to aid communication between staff and patients. Several HCAs with complex titles who attended our focus groups said they longed for a simpler title which would be meaningful to patients. Others felt upset that they were often referred to in front of patients as “unqualified”.

- 8.3.2.** Research by Ian Kessler⁶⁴ suggests that when patients know the difference between HCAs and nurses, they build better relationships. He quotes one patient in a focus group:
- 8.3.3.** *“The thing that’s really hit me in the last 20 minutes or so is that part of my experience and the bad part of the experience I had – now I can see – was because I was asking the wrong questions to the wrong people. So I was probably asking a healthcare assistant something that he or she wasn’t qualified to deal with...but didn’t deliver my expectation and made me more frustrated. So I think that really understanding who’s doing what role, and where their roles stop and the next role starts, that awareness I think helps the patient as much as it helps the system”.*
- 8.3.4.** Transparency builds better relationships. NHS Scotland has introduced a single job title – HealthCare Support Worker – for Bands 1–4. But most staff we spoke to prefer the title of “nursing assistant”: which would recognise them as part of the nursing workforce.
- 8.3.5.** A survey by the British Journal of Healthcare Assistants in April 2013 found 73% of HCAs agreeing with the question “do you think HCSWs should be regulated and renamed nursing assistants?”⁶⁵ Given that earlier questions had also concerned regulation, the Journal’s editor believes this represents a majority view in favour of the new title. There was little demand for such a title in social care.
- 8.3.6.** At Queen Elizabeth Hospital in Birmingham, HCAs are called Nursing Auxiliaries. And at Guy’s and St Thomas’ Foundation Trust in London, HCAs recently voted to call themselves Nursing Assistants. What is important about the adoption of “nursing” in the title is the implied recognition by these Trusts that HCAs are part of the nursing team: not a separate tribe.
- 8.3.7.** If simpler titles are linked to job descriptions, and staff photos in hospital wards, this should provide much more clarity to patients and relatives about what to expect. If the nurse in charge also wore a big red badge reading “I’m in charge”, as is the practice at some Trusts, that might also help to give a clear line of sight for everyone involved: from HCA to nurse to patient.

8.4. The crucial role of first line managers

- 8.4.1.** The single most critical factor in supervising and leading HCAs and support workers is the performance of the first line manager. First line managers are the lynchpin of every system in which HCAs and support workers are employed. Whether it is a registered manager in a care home, a ward sister in midwifery or a community lead in the NHS, these are the people who set the standard and whose leadership abilities are critical to outcomes for patients and users. Yet they are not always properly supported.
- 8.4.2.** In some hospitals, the job of ward sister attracts too few applicants. A profusion of nurse specialists has devalued the generalist role, and some ward sisters have been disempowered by a plethora of matrons above them. The burden of paperwork and administration can also be considerable⁶⁶.
- 8.4.3.** The initial findings of the 2013 NHS Confederation Review are that well over a third of NHS staff say they spend between one and three hours a day collecting data. The Review has found that nursing staff particularly experience considerable duplication of collection; paperwork that adds little value to

⁶⁴ Kessler, I., Heron, P. and Dopson, S. (2012). *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford: Oxford University Press

⁶⁵ British Journal of Healthcare Assistants. Support workers after the Francis Report – a BJHCA survey of 800 (May 2013)

⁶⁶ The NHS Confederation has been asked by the Secretary of State look into how it can reduce bureaucracy in the NHS. The Review welcomes this

patient care; and time consuming paperwork that is difficult to complete. This is a disgraceful distraction from their duties to patients; and must be rooted out.

- 8.4.4.** Trusts should be identifying people with the right characteristics early in their career and training them in performance management, teambuilding, and coaching⁶⁷. The Chief Nursing Officer has recommended that ward sisters, community nurse and midwifery leaders should be made supernumerary (supervisory), to give them time to lead⁶⁸. Compassion in Practice sets out a local objective for all organisations to review their options for introducing supervisory status for ward managers/sisters into their staffing structure, and demonstrate this work to commissioners.
- 8.4.5.** In social care, registered managers can face even greater management challenges given that they have far fewer professional staff and much higher staff turnover. They often have less training in supervision, and some have had no training at all. Yet turnover can be reduced, and user satisfaction increased, by investment in those key staff. CQC has demonstrated a clear link between the presence of a registered manager and the quality of outcomes that people experience. "In services where we have taken action, a change of registered manager – or the introduction of one where previously there was none – has been followed by a dramatic improvement in the quality of care provided"⁶⁹.
- 8.4.6.** Some of the best organisations are now investing more in first line managers than in any other single category of staff. One is the Priory Group.

Case study: PRIORY GROUP

The Priory Group operates about 300 sites across the UK, providing mental health services, special needs education, social care for people with learning disabilities and care homes for people with dementia. It takes the view that every site must have a strong manager to ensure that the values and culture of Priory are transmitted consistently across all settings.

Each new manager has a standardised three month induction including the assignment of a buddy and the setting of measures of success, which are reviewed at three and six-month probation periods. Each manager must complete leadership and management training before the end of their first year.

Managers are also given the tools to continually assess and improve the quality of care on their site through a set of agreed quality performance indicators. One of these is HCA training. The Priory cannot rely on their previous training to guarantee their skills and knowledge. So it has developed an award-winning programme called 'Foundations for Growth' in which every employee is expected to complete a series of mandatory training modules, the details of which depend on their job role. Every employee has a personal training record that is reviewed at supervision and appraisal.

- 8.4.7.** As social care expands, it will be more important than ever to ensure that a trained and competent cohort of experienced, new and aspiring registered managers is available to meet the demand.
- 8.4.8.** At the same time, it will also be important to confront another issue: that too many talented carers have to move out of direct care roles into management, in order to get pay rises. There should be a way of paying great carers to stay at the frontline rather than move into management. Social work

⁶⁷ Ibid, an investment of £40 million has been made to develop a training programme for leaders through the NHS Leadership Academy

⁶⁸ "Compassion in Practice", NHS England, 2012

⁶⁹ The State of health care and adult social care in England: An overview of key themes in care in 2011/12, Care Quality Commission

has developed senior practitioner roles, mentoring and supporting others, but remaining at the frontline. That is one potential model which should be developed.

Recommendations

Recommendation 12: Regulators, employers and commissioners in health and social care should define a single common dataset for their purposes, and commit to using it, to relieve the pressure on first line managers and other staff.

Recommendation 13: Trusts should empower Directors of Nursing to take greater Board level responsibility for the recruitment, training and management of HCAs, from day one.

8.5. Intolerance of poor performance

- 8.5.1. The single most critical factor in supervising and leading HCAs and support workers is the performance of the first line manager. First line managers are the lynchpin of every system.
- 8.5.2. First line managers have to be able to hold their staff to account. There is little point in an organisation hiring for values if it is not prepared to fire in line with values.

“People come and work really hard or they do nothing. It’s very hard to accept this as fair: something should be done.” (HCA, Birmingham focus group)

“A whole tier of nurse leaders would be invigorated by test cases showing how to performance manage bad people out of the NHS.” (Senior Nurse Manager)

- 8.5.3. A mythology has grown up in parts of the NHS that it is impossible to get rid of under performers. The situation in social care is slightly different. Some employers are hard-pushed to retain staff, and have little choice in who they hire. But others continue to set high standards.
- 8.5.4. The best organisations set high standards for their staff, and quietly manage out poor performers from the most junior staff members to the most senior consultant. They do so with long probationary periods backed up by clear standards and meaningful appraisals.
- 8.5.5. Salford Royal NHS Foundation Trust has one of the lowest mortality rates in the country. 92% of patients receive harm-free care and 95% of patients say they would recommend the hospital to friends and family. It also has a highly developed performance management system. It measures staff performance ranking employees from role model to unsatisfactory, and it links Agenda for Change pay increments to how staff contribute to the goals and values of the hospital. It is notable that this is very popular with staff: Salford has come top of acute trusts in the NHS Staff Satisfaction Survey for three years running.

“We are clear about the behaviour we expect, and clear about our values.”
(David Dalton, CEO, Salford Royal NHS Foundation Trust)

- 8.5.6.** International research shows that appraisals can be an important part of creating high involvement cultures⁷⁰. We know from the Francis Inquiry that the whistle-blower at Mid-Staffs had not had an appraisal for five years.
- 8.5.7.** Yet appraisals are another area where HCAs are sometimes overlooked. UNISON's 2010 survey reported that 26% of HCAs had not had an appraisal, and 42% had not been given a Personal Development Plan. In the 2012 NHS Staff Survey, 41.5% of Maternity Support Workers had not had an appraisal in the previous 12 months, compared to 27.6% of midwives. What is equally striking is how few staff seem to be receiving a *meaningful* appraisal.

"Appraisals are not worth the paper they are written on." (HCA Birmingham focus group)

- 8.5.8.** In some cases, overly generous appraisals have actually become a barrier to performance management. Employment lawyers describe workers who throw positive appraisals in the face of any new supervisor who tries to discipline them. This entrenches failure.
- 8.5.9.** To help senior staff get to grips with these issues, there is a strong case for looking at the processes for challenging poor performance in the NHS. The Professional Standards Authority for Health and Social Care (PSA) oversees the work of health and care professional regulators in the interests of patients, services users and the public. It also sets standards for organisations holding voluntary registers for people in unregulated health and social care occupations, and advises Government and others on matters relating to people working in health and social care. The Review proposes that the PSA should be commissioned to consider how employers can be more effective in managing the dismissal of unsatisfactory staff, the legal framework around this, and the relationship with referrals to professional regulators (where relevant).

Recommendations

Recommendation 14: The Secretary of State for Health should commission the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal of unsatisfactory staff, the legal framework around this, and the relationship with referrals to professional regulators.

8.6. Coaching and mentoring: NHS

"A national requirement that all new health/care assistants are mentored might have a very positive effect on new recruits, and also on the senior posts who may be acting as mentors."
(Multiple Sclerosis Trust, submission to Cavendish Review)

"Outstanding nurses are an inspiration." (HCA, Birmingham focus group)

⁷⁰ Authentic team working in health care: longitudinal survey of relationships with errors, staff safety and patient mortality. Michael A West, Jeremy F Dawson, Joanne Lyubovnikova, Matthew Carter.

- 8.6.1.** Good mentoring provides staff with positive role-modeling and support at critical times. It ought to be a badge of honour, which contributes to a career. But in the NHS, the mentoring of student nurse is too often regarded as a routine duty added to a shift, with no dedicated time provided⁷¹. Some students that complain they never see their mentors⁷²; many mentors find that they get little or no recognition for the work they do.
- 8.6.2.** Not all nurses who are currently chosen to be mentors want to do it, or are the best placed to help new nurses graduate onto the ward and give good patient care. Mentors can find it very difficult to “fail” a mentee.⁷³ In 2010, a Nursing Times survey found 37% of mentors saying they had passed student nurses that they believed were either poor or should not pass at all⁷⁴.
- “I’ve avoided mentoring, to be honest. I don’t want the responsibility. A friend of mine didn’t want to sign off a student and she was put under real pressure to change her mind.”*
(Nurse, Review focus group)
- 8.6.3.** HCAs often end up playing a major role in helping to train student nurses on placements, and providing newly qualified nurses with advice and support⁷⁵, but often by default rather than as the result of any positive planning. That role ought to be formally recognised as part of their career development, with training provided.
- 8.6.4.** Guy’s Hospital trains some of its Senior Nursing Assistants to support student nurses, in partnership with their registered nurse mentor. The Assistants do not assess or sign off any competency, but they can give feedback to the registered nurse about how the student is doing. The NMC standards around mentoring acknowledge that experienced HCAs can contribute to the learning of a student nurse. The standards set out what HCAs need to do to become a mentor for a student nurse and contribute to their learning⁷⁶.
- 8.6.5.** This partnership between student, mentor and Nursing Assistant has several positive consequences: it helps new nurses appreciate the role of the Assistants, it makes the Assistants more familiar with the nursing curriculum, and it builds team spirit.
- 8.6.6.** There is now an opportunity, for interested employers, to:
- Engage senior HCAs in communicating the values of the organisation and helping with practical skills, by formally recognising their role as coaches on nursing placements
 - Engage senior HCAs as formal coaches in the preceptorship year, which research demonstrates is a vital socialisation period for the values that nurses carry throughout their career⁷⁷

⁷¹ *Quality with compassion: the future of nursing education*. Report of the Willis Commission on Nursing Education, 2012. Published by the Royal College of Nursing on behalf of the independent Willis Commission

⁷² Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T, Morrow E (2012a). Exploring the Relationship between Patients’ Experiences of Care and the Influence of Staff Motivation. National Institute for Health

⁷³ Mentoring and pre-registration nurse education. M Chandan and C Watts, 2012

⁷⁴ Mentors passing students despite doubts over ability, Sally Gainsbury, Nursing Times, 27 April 2010

⁷⁵ Spilsbury K, Meyer J (2004) Use, misuse and non-use of healthcare assistants: understanding the work of healthcare assistants in a hospital setting. Journal of Nursing Management

⁷⁶ <http://www.nmc-uk.org/Educators/Standards-for-education/Standards-to-support-learning-and-assessment-in-practice/>

⁷⁷ Maben J, Latter S and Macleod Clark J. *Nursing Inquiry* 2007; 14: 99–113, *The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study*

- Provide each HCA with a nurse mentor: particularly giving an opportunity to very experienced nurses whose values and experience might not otherwise be shared.

8.7. Improving accountability for performance: codes of conduct

- 8.7.1.** The best organisations are transparent about what they do and accountable for the performance of their staff. This can be blurred when there is confusion among workers, line managers and employers about what support workers should be capable of, and what tasks they should not be allowed to do. Issues have also been raised about the capabilities of a workforce that is theoretically but not always under the supervision of professionals.

"Nurses are not always sure what they can ask HCAs to do:"

(Tanis Hand, Royal College of Nursing)

"Protocols from institutional settings are not always enforceable in community settings."

(Bill Mumford, CEO, MacIntyre)

- 8.7.2.** If the recommendations in this Review are to be successfully implemented, and the public kept safe, it is important to ensure that two things are clear:
- 8.7.3.** It is the responsibility of employers to improve the knowledge and skills of the workers, and ensure that they are able to perform the tasks they are given.
- 8.7.4.** It is the responsibility of the workers to work under supervision, take part in training, cooperate with appraisal, carry out tasks to the best of their ability and not operate beyond their capability. Many frontline workers, in both the NHS and social care, have told us of instances when they have been asked to do things for which they have not been trained or they do not feel they can do safely.
- 8.7.5.** On the second point, Skills for Health and Skills for Care published a code of conduct for support workers in March⁷⁸ in response to the Francis Enquiry⁷⁹. This code of conduct would benefit from three improvements to be more precise in clarifying roles and making patients safer:
- 8.7.6.** The Code should only include things that support workers can see how to apply to themselves in their real lives, and that employers or managers can actually enforce: every line should be tested against these criteria;
- It should include a right to refuse to do things for which a worker has not been trained or does not know how to do safely⁸⁰
 - It should include a right to mandatory training paid for by the employer (this is particularly important in social care, where we have been told of companies asking new staff to pay for mandatory training)

⁷⁸ Codes of Conduct and Minimum Training Standards for Healthcare Workers and Adult Social Care Workers in England, Skills for Health and Skills for Care 2013

⁷⁹ Francis Enquiry recommendation 195: there should be a uniform code of conduct that would apply to all healthcare support workers, prepared and maintained by the NMC in accordance with common national training standards

⁸⁰ Two of our focus groups heard HCAs saying they had been asked to move patients using hoists which they had not been trained to use. At another focus group, a nurse described seeing an HCA being told to prepare a dead body, which she had never done before and was afraid of doing; when she protested another HCA was told crossly to go with her

- It should correspond, for NHS employees, with the values and pledges set out simply and intelligibly in the NHS Constitution.
- 8.7.7.** On the first point, the Code of Conduct for workers should be matched by a similar commitment from employers that explicitly links employer responsibility for supervision to the code of conduct for staff. NHS Scotland has pioneered a code of practice for healthcare employers, which requires a board-level sponsor to oversee compliance. An independent evaluation of the pilot scheme suggested that this code has the potential to improve patient safety and public protection⁸¹.
- 8.7.8.** In England, the NHS Constitution contains an admirable set of pledges from the NHS to workers and patients – but these are not being put into practice in too many NHS Trusts. The Care Quality Commission will need to hold Trusts more closely to account here, as part of its overall focus on outcomes.
- 8.7.9.** In social care, the 2012 Government White Paper “Caring for our Future” set out the Department of Health’s commitment to work with care providers, service users and carers to develop a sector-specific compact, including a skills pledge, to promote culture change and skills development.
- 8.7.10.** This sector workforce compact is effectively a voluntary code of conduct for employers. It is intended to apply to all job roles across the adult social care workforce (including care workers, registered managers, social workers and roles operating across health and social care). It will incorporate an employer agreement, an employee agreement and some form of survey or evaluation mechanism to assess its impact.
- 8.7.11.** Were this Review to recommend a new code of conduct for social care employers, it is clear that this would cut across the work being done to achieve a voluntary compact. While it will take time to gain traction, it is essential that the compact is signed by employers.
- 8.7.12.** This Review therefore recommends that the Department should closely watch the progress of the social care compact, and take action if it does not gain traction with employers, by mandating a formal code.

Recommendations

Recommendation 15: Skills for Health should refine its proposed code of conduct for staff. And the Department of Health must review the progress of the social care compact, and substitute a formal code of conduct for employers if a majority have not acted upon it by June 2014.

8.8. Conclusion

- 8.8.1.** The new Chief Inspectors of Hospitals and Social Care will be considering whether organisations show the leadership required to shape and enable positive cultures of compassionate care. It seems likely that organisations which achieve high ratings will be those which place a priority on team-building, job clarity, intolerance of poor performance, support for first line managers, and accountability.

⁸¹ <http://www.scotland.gov.uk/Publications/2009/06/01144730/3>

8.8.2. In that context there is an urgent need to recognise the importance of first line managers in achieving better care: by relieving them of unnecessary paperwork, and reviewing the processes of challenging poor performance. Greater clarity over job titles and job roles will also be essential.

9. Time To Care

Summary

At its core, caring is about building relationships. Caring properly takes time.

Some low paid HCAs and support workers will heroically keep going as long as they feel they are still giving good care. But the advent of zero hours contracts, fee cuts and no payment for travel time is making it financially prohibitive for some domiciliary care workers to struggle on. Attrition rates are already dangerously high: and they will only increase when carers feel that they can no longer even give good care. Society will lose some talented carers unless the commissioning process changes radically and Government starts to move money from health to reward social care for its contribution to lowering NHS costs.

It is also questionable whether long shifts, of 12 hours and more, are conducive to compassionate care.

"I recently had a morning with myself plus a staff nurse to do 40 visits: you don't feel you have done the job as well as you could." (HCA in district nursing team, Review webinar)

"I sometimes get home and think, 'Oh my God, there's all that stuff I didn't do.'"
(HCA Band 2, Salisbury focus group)

- 9.1.1.** There is no getting away from a central truth: caring properly takes time. Lack of time is a real barrier to improving the quality of care⁸², and psychological evidence suggests that having to leave things undone is most painful for the most caring people, who want to do a good job.

"Our job is like a pinball machine, you have to remember 100 things from the porter, the relatives, the nurse – you walk out the door to go home and don't feel like you've breathed"
(Assistant Practitioner, Salisbury focus group)

"Leaving a patient who is lonely and afraid [is one of the situations I find most challenging]"
(HCA in district nursing team, Review Webinar)

- 9.1.2.** Patient groups complain that some staff treat care as a list of tasks to be rushed through, with little regard to the person. This corresponds to academic research which shows that people in intense

⁸² King's Fund, "Patient-centred leadership", 2013

emotional situations put up defences, including doing tasks to separate themselves from the patient⁸³.

- 9.1.3.** The very real financial constraints in the system make time pressures inevitable. But some apparent cost savings may prove to be false economies, if they lead to higher attrition rates. The first is care being commissioned by the minute; the second is employers and commissioners not paying for travel time; and the third is long shifts.

9.2. False Economy One: Local authority home care contracts

- 9.2.1.** The bulk of homecare is purchased by local authorities (nearly 200 million hours of homecare per year in England⁸⁴). Being under acute financial pressure themselves, local authorities almost exclusively now pay only for time spent in the client's home. They do not pay travel or for "back-fill" of staff replacing those being supervised or attending training: all that must be found from the rate paid for care. The rates paid leave little scope for small employers to invest in training, supervision, or to raise wages. This creates a false economy where experienced staff seek employment elsewhere and the employer is left spending the little money they have available on recruitment and induction of new and, often, less competent staff.

- 9.2.2.** Care is increasingly being bought "by the minute". Figure 9 shows 15 minute visits are commissioned, with the average visit lasting 30 minutes. Not surprisingly, service users report services being rushed, or lacking compassion, dignity care and respect, and little continuity of care. Elderly people with dementia are particularly upset by seeing so many different faces; and very high attrition rates place a real cost burden on employers.

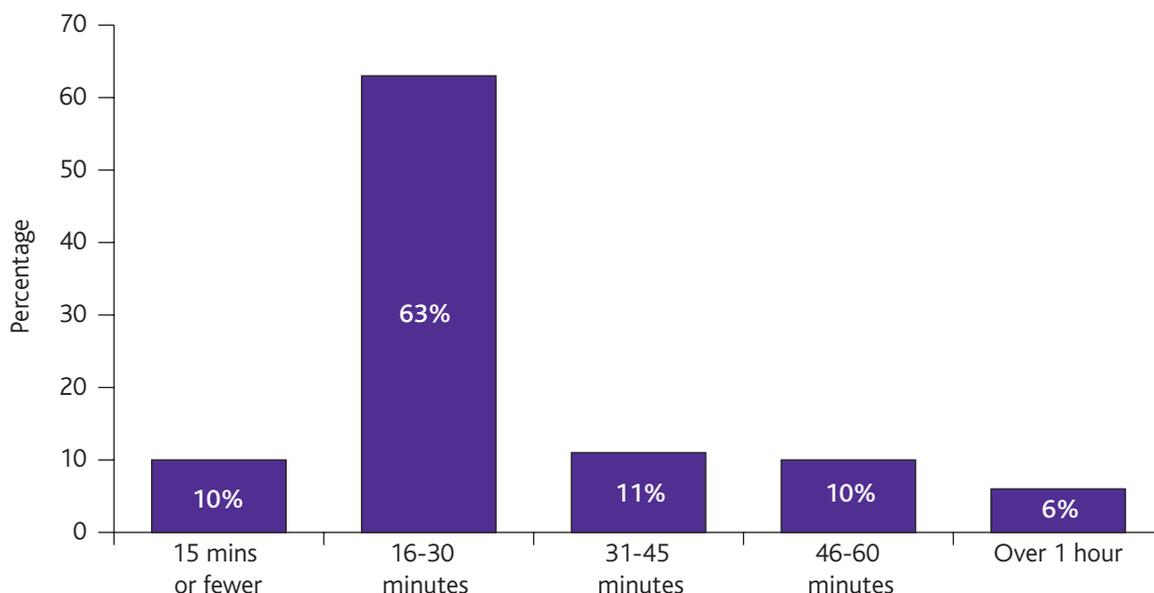


Figure 9: Homecare visit durations commissioned by councils in England

Source: UKHCA Commissioning Survey: Care is not a Commodity, July 2012

⁸³ 'Poppets and Parcels': the links between staff experience of work and acutely ill older peoples' experience of hospital care: King's College London 2012

⁸⁴ UK Home Care Association, evidence to Cavendish Review 2013

- 9.2.3.** A 2012 survey of homecare providers by UKHCA found 34% saying that councils required them to undertake personal care in such short visit times that the dignity of service users was at risk; 6% were concerned that safety could be compromised. The UKHCA told us that “we feel compelled to question whether inappropriate commissioning of short visits...amounts to institutional abuse”⁸⁵.

9.3. There is a better way: commissioning by results

- 9.3.1.** The best local authorities are pioneering a move towards paying by outcomes, rather than activity. Wiltshire Council is running a small pilot with cancer sufferers (see below). Community budgets funding pilots are being run in Hammersmith and Fulham, Kensington and Chelsea and Westminster (Tri-Boroughs) and North West London, to develop whole place approaches to improve outcomes for local people.

Case study: WILTSHIRE COUNCIL

Wiltshire Council has commissioned an integrated Help to Live at Home service, including re-ablement, equipment for daily living, telecare and personal support. Customers have support plans that say what they want to achieve. The service works first to help people recover their independence and then to stop their need for care growing. Re-ablement is available whenever people can benefit, not just for six weeks. Help to Live at Home seeks to achieve outcomes, centred on the personal goals of each end customer, and pays by results. Ultimately, the council buys services that help customers to help themselves and that keep them safe and well. The council applies a financial penalty when outcomes are not achieved.

- 9.3.2.** A growing body of evidence suggests that value and outcomes improve when services are organised around patient and patient pathways, rather than around provider interests. That is the thinking behind Capitated and Outcome-Based Incentivised Contracts (COBICS)⁸⁶. If it is possible to organise services in a way that provides better care at the same price, the Government should be moving to grow as many different pilots as possible.
- 9.3.3.** Another way of improving outcomes is by increasing the use of direct payments, or, if people do not want to handle the money themselves, using individual Service Funds to give customers control.
- 9.3.4.** The fundamental problem, however, is the imbalance between a ring-fenced NHS budget of £121 billion and a social care budget (held by local authority commissioners) of £8 billion. The institutional architecture must change to reward social care for preventing so many admissions to the NHS.

Recommendations

Recommendation 16: The Department of Health should explore with the social care sector how to move to commissioning based on outcomes; and aim to eliminate commissioning based on activity by 2017.

⁸⁵ Care is not a Commodity, UKHCA Commissioning Survey 2012

⁸⁶ <http://www.cobicsolutions.co.uk/what-are-cobics.php>

9.4. False Economy Two: Not paying home care workers for travel time

"I could employ 50 people tomorrow. But they don't want the job. There are all these unemployed young people but either they stand to lose out by losing benefits, or their car insurance premiums are prohibitively high. If they got a petrol subsidy or a discount on their car insurance, they might work." (CEO of independent domiciliary care agency)

- 9.4.1.** For home care workers on zero-hours contracts, who are not guaranteed a fixed number of hours work per week, the need to travel for longer distances to do fewer visits is making it harder to make ends meet. The fact that some employers will not pay for travel time between clients means that there are now serious questions about whether some workers are actually being paid less than the National Minimum Wage. UNISON has calculated that 200,000 care workers may be in this situation⁸⁷.
- 9.4.2.** It also has the effect of making these jobs increasingly unattractive. As workers quit in increasing numbers, the cost of recruiting new staff rises: a situation which will only worsen when the economy recovers.
- 9.4.3.** Homecare employers say that they need clearer guidance from Government about how to calculate the National Minimum Wage. Several domiciliary care providers, and UNISON, have also made the case to us that Government should find a way to subsidise petrol for these workers. We have been told that some community nurses get a "red diesel" discount and that in some areas, the council's own home care workers receive mileage allowance, car enhancements, and/or travelling time on top of their salary although they do the same job as domiciliary care workers employed in the independent sector. One domiciliary care agency told us that it is losing staff to the council as a result of this inequity.

9.5. False Economy Three: Long shifts

- 9.5.1.** There is plenty of evidence that tired staff are susceptible to higher stress levels and sickness rates⁸⁸. Our survey found 18% of social care respondents saying that they work 11-13hr shifts, and only 6% said that they preferred this option.
- 9.5.2.** In the NHS, 12 hour shifts have become standard in many Trusts. Many HCAs say 12 and even 13 hour shifts fit with their lifestyles. But it must be difficult to maintain compassionate care for the full period, especially when the population of patients is becoming increasingly challenging. The new pattern has also removed the traditional handover period in the afternoon, when there were more staff on the ward and there was time to mentor other staff. The apparent cost saving may prove to be outweighed by a rise in physical exhaustion, sickness rates and the loss of time to have proper debriefing sessions after things go wrong: something which HCAs in our focus groups have said they would value.

⁸⁷ UNISON press release, 6 March 2013, http://www.UNISON.org.uk/asppresspack/pressrelease_view.asp?id=2984

⁸⁸ Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T. and Morrow E. Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. NIHR Service Delivery and Organisation Programme; 2012.

Recommendations

Recommendation 17: NHS England should include the perspective of HCAs and support workers in its review of the impact of 12-hour shifts on patients and staff.

Recommendation 18: Statutory guidance should require councils to include payment of travel time as a contract condition for homecare providers.

9.6. Conclusion

- 9.6.1. Providing the best care for patients and service users takes time but the time available to care is reducing. One of the main reasons cited for support workers wanting to quit is not having enough time to give the standard of care they want. It is possible that the increasing trend towards long shifts is also diminishing the quality of care.
- 9.6.2. Financial constraints are increasing the pressure for care to be delivered in as little time as possible – with some local authorities commissioning care services by the minute and failing to pay staff for travel time in between each visit. However, any cost savings generated from commissioning in such a way may be off-set by higher attrition rates, a lack of continuity of care for individuals and, of course, negative impact on staff’s health and well-being. Similarly, not paying staff for travel time is a false economy which is making some of these jobs simply unsustainable.
- 9.6.3. The Review suggests that a smarter way to commission caring would be to base it on outcomes rather than activity. There is evidence that organising services around patient pathways (as some local authorities are doing) improves outcomes.

10. Overall Conclusion

- 10.1.** In all the discussions about values, standards and the quality of care in the NHS and social care, the support workforce has received the least attention. This Review has tried to give voice to frontline workers who have been largely invisible to the public and policymakers. Dedicated, sometimes fierce, advocates for the people they look after, many in this group are also frustrated at what they feel is a lack of recognition from managers, employers and/or commissioners.
- 10.2.** The public image of this workforce is outdated. Looking after the frail and vulnerable with intelligent kindness can rarely be described as “basic” care. And as the landscape of health and social care has become more complex and challenging, so too have the tasks carried out by many support workers – whether it is domiciliary care staff asked to do work that used to be the preserve of district nurses, or hospital workers stepping up to carry out invasive procedures.
- 10.3.** These increased levels of responsibility make it even more important to set clear, consistent national standards, and to hold employers accountable.
- 10.4.** The best organisations in health and social care recognise that this workforce is a strategic resource, critical to ensuring the safety of patients or clients. These organisations recruit people for their values and commitment to caring; they invest in rigorous training and development and ensure that this translates into day to day practice; they build teams which value all members of staff; led by empowered first line managers. They prioritise this in tough financial times, knowing that it improves care and staff engagement, which in turn reduces attrition rates and the costs of hiring
- 10.5.** As the 1946 model of “diagnose, intervene, cure” gives way to the twenty-first century reality of “diagnose, intervene, live with a chronic condition”, society urgently needs a flexible, caring workforce with a common base of values and knowledge. While the actual skills required will always vary between settings, junior workers in health and social care are increasingly going to need to draw on similar core knowledge and approaches. If we can bridge divides between health and social care, and between assistants and nurses, we can reduce costly duplication, create a more effective workforce, and raise the status of caring.
- 10.6.6.** The message from the frontline, and from the best organisations, is that it is time to start seeing these support workers as a strategic resource, to both the NHS and social care. That is what the Recommendations in this Review are designed to achieve.

Acknowledgements

Hundreds of people contributed to this Review, in a spirit of goodwill and candour for which I am very grateful. Their time was particularly precious, given that this Review coincided with a profound shift in the landscape of the NHS.

My special thanks go to Kay Fawcett of University Hospital Birmingham NHS Foundation Trust, Eileen Sills at Guy's and St Thomas' NHS Foundation Trust, Chief Nursing Officer Jane Cummings, Richard Griffin at Bucks New University, Gail Adams of UNISON, Bill Mumford at MacIntyre, Dr Terry Tucker at Barchester Healthcare, Lisa Bayliss-Pratt and Joe McArdle at HEE, and Sharon Allen, CE at Skills for Care.

I am indebted to the factual and background briefings provided by a number of teams at The Department of Health, and the Review Team – Mohini Morris, Emma Rush and April McMullen – led so ably and professionally by Dilbinder Dhillon.

Appendix 1: The Review's Terms of Reference

The objectives of the Cavendish Review were to:

- consider what can be done to ensure that all people using services are treated with care and compassion by healthcare and care assistants in NHS and social care settings
- make recommendations about the recruitment, training, management, development and support of those staff, who do a challenging but vital job in health and care settings

The main questions the review will be exploring are:

Recruitment:

- how can recruitment be strengthened to place the right people, with the right values, in the right setting?

Training and development:

- what further action is needed to raise training standards (including induction training), building on the minimum training standards recommended by the sector skills councils?
- how do we ensure that the people get the right training, development and feedback to provide compassionate and competent care in busy working environments?
- how do we ensure there is consistency in training standards which provide transferable competences and qualifications?
- what ladder can be put in place to enable people to progress to their potential, including senior health/care assistant roles and, where people wish to, enabling them to become registered professionals?

Leadership, management and supervision:

- on the job, do staff have role models with the right values?
- what kind of management and supervision do the best settings exemplify?

Engagement and support:

- what support do staff need to fulfil roles which can be emotionally draining, including ensuring that their work is properly valued?

Public confidence and assurance:

- what changes would make people using services, families and carers feel more confident in the service, with greater clarity on the roles staff have and their levels of training?
- what information would support greater public accountability for employers as to their investment in ensuring a suitably trained and qualified, well supported workforce?

Appendix 2: Tables and Diagrams

Figure 1: Key statistics for health and social care (Page 16)

Source: Health and Social Care Information Centre (Health) and National Minimum Data Set (Social care)

Figure 2: HCAs AfC Pay Bandings (Page 19)

Source: Health and Social Care Information Centre

Figure 3: Career pathways for HCAs (Page 23)

Source: Kessler, I. Heron, P. and Dopson, S. (2012). *The Modernisation of the Nursing Workforce: Valuing the Healthcare Assistant*. Oxford University Press

Figure 4: Total number of people working in adult social care jobs by sector, service type and job role, 2011 (Page 25)

Source: National Minimum Data Set for Social Care, Skills for Care

Figure 5: Pay levels of those in adult social care roles (Page 26)

Source: National Minimum Data Set for Social Care, Skills for Care

Figure 6: Qualifications those in direct care roles have achieved (Page 28)

Source: National Minimum Data Set for Social Care, Skills for Care

Figure 7: Number of secondments from NHS employees 2005-6 to 2011-12 (Page 70)

Source: Department of Health, Finance and Information Monitoring return

Figure 8: Bridging programmes for progression of HCAs and support workers into nursing programmes (Page 72)

Source: Re-produced slides from Richard Griffin. *Widening Participation into Pre-Registration Nursing Programmes*. Buckinghamshire New University, 2013

Figure 9: Homecare visit durations commissioned by councils in England (Page 95)

Source: UK Homecare Association Commissioning Survey: Care is not a Commodity, July 2012

Appendix 3: Contributors to the Cavendish Review

1. Action on Hearing Loss
2. Age UK
3. Alzheimer's Society
4. Barking, Havering and Redbridge University Hospitals NHS Trust
5. Birmingham Community Healthcare NHS Trust
6. Birmingham Women's NHS Foundation Trust
7. Black Country Partnership NHS Foundation Trust
8. British Dermatological Nursing Group
9. British Geriatrics Society
10. Canterbury Christ Church University
11. Care Quality Commission
12. Chartered Society of Physiotherapy
13. Cheshire and Wirral Partnership NHS Foundation Trust
14. Crystal Lemon Care Ltd
15. East Sussex Healthcare NHS Trust
16. Education for Health
17. Epilepsy Society
18. European Nurse Directors Association
19. Great Western Hospitals NHS Foundation Trust
20. Greenwich and Bexley Community Hospice
21. Health and Care Professions Council
22. Health and Social Care Information Centre
23. Help the Hospices
24. Independent Healthcare Advisory Services
25. Leeds Community Healthcare NHS Trust
26. Lincolnshire Workforce Advisory Board
27. London South Bank University, Faculty of Health and Social Care
28. Luton and Dunstable NHS Foundation Trust
29. MacIntyre
30. Manchester Metropolitan University
31. Mental Health Foundation

32. Middlesex University
33. Mind
34. Multiple Sclerosis Trust
35. National Care Forum
36. National Dignity Council
37. North East London Foundation Trust
38. North Norfolk Clinical Commissioning Group
39. Northampton General Hospital NHS Trust
40. NHS Employers
41. Northamptonshire County Council
42. Nottingham University Hospitals NHS Trust
43. Nottinghamshire Workforce Team
44. Nursing and Midwifery Council
45. Nursing and Midwifery Professional Advisory Board
46. Parliamentary and Health Service Ombudsman
47. Patients Association
48. Plymouth Hospitals NHS Trust
49. Professional Standards Authority
50. Profiles4Care
51. Public Health England, NHS Cancer Screening Programmes
52. The Queen's Nursing Institute
53. The Royal College of Midwives
54. Royal College of Nursing
55. Royal College of Physicians
56. Skills for Care
57. Social Care Association
58. Social Care Institute for Excellence
59. Stockport NHS Foundation Trust
60. Stoke-on-Trent LINK
61. Suffolk Brokerage
62. Sussex Partnership NHS Foundation Trust
63. Training and Assessment Support Services UK
64. UK Homecare Association
65. UNISON
66. Unite the Union
67. University College London Hospitals NHS Foundation Trust
68. University Hospital of South Manchester NHS Foundation Trust
69. Voluntary Organisations Disability Group

70. The Whittington Hospital NHS Trust

71. Wirral Autistic Society

In addition, the Review received 36 responses from individuals

Appendix 4: Meetings held by the Review team

1. Gail Adams, Head of Nursing, UNISON
2. Nadra Ahmed, Chair, National Care Association
3. Sharon Allen, Chief Executive, Skills for Care
4. Colin Angel, Policy and Campaigns Director, UK Homecare Association
5. Anita Bamford-Wade, Joint Head of Nursing/Senior Lecturer, Auckland University of Technology
6. Rebecca Baron, Head of HR, Care UK
7. Lisa Bayliss-Pratt, Director of Nursing, Health Education England
8. Yasmin Becker, Assistant Director Revalidation, Nursing and Midwifery Council
9. Paul Bennett, Director, Aged Care Channel
10. Peter Blythin, Director of Nursing, NHS Trust Development Authority
11. Peter Bradley, Editor, British Journal of Healthcare Assistants
12. Sally Brearley, Chair, Nursing and Care Quality Forum
13. Peter Carter, Chief Executive, Royal College of Nursing
14. Howard Catton, Head of Policy and International, Royal College of Nursing
15. Harry Cayton, Chief Executive, Professional Standards Authority
16. Liz Clark, Senior Lecturer, The Open University
17. Ann Clwyd MP
18. Tanya Cook, System Executive Human Resources, Memorial Hermann Healthcare System
19. Jessica Corner, Dean of Health Sciences, University of Southampton
20. Ian Cumming, Chief Executive, Health Education England
21. Jane Cummings, Chief Nursing Officer, England
22. Heather David, Registered Manager, Mid Yorkshire Care Ltd
23. Janet Davies, Director of Nursing and Service Delivery, Royal College of Nursing
24. Jagtar Dhanda, Head of Inclusion, Macmillan Cancer Support
25. Judy Downey, Chair, The Relatives and Residents Association
26. Roisin Dunne, Nursing Director, Mater Health Services
27. Baroness Emerton
28. Kay Fawcett, Executive Chief Nurse, University Hospitals Birmingham NHS Foundation Trust
29. Lt Col Sharon Findlay, Queen Alexandra's Royal Army Nursing Corps
30. Monica Fletcher, Chief Executive, Education for Health
31. Capt Alison Game, Queen Alexandra's Royal Army Nursing Corps

32. Sally Garbett, Qualification Development and Training Consultant
33. Jacqui Graves, Head of Health and Social Care, Macmillan Cancer Support
34. Martin Green, Chief Executive, English Community Care Association
35. Tanis Hand, Healthcare Assistant Advisor, Royal College of Nursing
36. Nicolaus Henke, Director, McKinsey and Company
37. Paul Heron, Saïd Business School, University of Oxford
38. Guy Hirst, Human factors Expert, Risky Business
39. Monica Hirst, Union Officer, UNISON
40. Mike Hobday, Director of Policy and Research, Macmillan Cancer Support
41. Deborah Holman, Advancing Practice Nurse, St Christopher’s Hospice
42. Emily Holzhausen, Director of Policy and Public Affairs, Carers UK
43. Jeremy Hughes, Chief Executive, Alzheimer’s Society
44. Sir Thomas Hughes-Hallett, Executive Chair, Institute of Global Health Innovation, Imperial College London
45. Lord Hunt of Kings Heath
46. Julie Inggs, Senior Designer, Regulatory Development Directorate, Care Quality Commission
47. Alison Innes-Farquhar, Head of People Development and Engagement, HC-One
48. Elisabeth Jelfs, Director of Policy, Council of Deans of Health
49. Sanil Joseph, Management Consultant and Training Faculty, Aravind Eye Care System
50. Aisling Kearney, Head of PR and Public Affairs, Barchester Healthcare
51. Patricia Kearney, Director of Innovation and Development, Social Care Institute for Excellence
52. Des Kelly, Executive Director, National Care Forum
53. Ian Kessler, Department of Management, King’s College London
54. Victoria King, Chief Nursing Officer, Memorial Hermann Healthcare System
55. Katerina Kolyva, Director Continued Practice, Nursing and Midwifery Council
56. Jo Lenaghan, Director of Strategy and Planning, Health Education England
57. Nicola Levitt, Head of Strategy, Health Education England
58. Susan Lowson, Clinical Advisor, Parliamentary and Health Service Ombudsman
59. Sheila Lycholit, Trustee, The Relatives and Residents Association
60. Christina McAnea, Head of Health, UNISON
61. Scott McLean, Director of Nursing and Governance, Emergency and Acute Care, Barts Health NHS Trust
62. Jill Maben, Chair in Nursing Research/Director, National Nursing Research Unit, King’s College London
63. Veronica Monks, Deputy Chair, The Relatives and Residents Association
64. Dame Julie Moore, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
65. Ros Moore, Chief Nursing Officer, Scotland
66. Bill Mumford, Chief Executive, MacIntyre/Chair, Voluntary Organisations Disability Group
67. Katherine Murphy, Chief Executive, Patients Association
68. Rajay Naik, Director of Government, The Open University

69. Jo Palmer, Quality Manager, Agincare UK
70. Mike Parsons, Chief Executive, Barchester Healthcare
71. Chai Patel, Chair, HC-One
72. Helga Pile, National Officer for Social Care, UNISON
73. Christina Pond, Executive Director – Products and Services, Skills for Health
74. David Prior, Chair, Care Quality Commission
75. Patrick Quinn, Chair, Spirit Care Ltd
76. Elizabeth Robb, Chief Executive, Florence Nightingale Foundation
77. Owen Rose, Managing Partner, Acteon Consultancy LLP
78. Dean Royles, Chief Executive, NHS Employers
79. Sheila Scott, Chief Executive, National Care Association
80. Mark Seale, Chief Executive, Health and Care Professions Council
81. Nick Seddon, Deputy Director, Reform
82. Sam Sherrington, Head of Nursing and Midwifery Strategy, NHS England
83. Eileen Sills, Chief Nurse/Chief Operating Officer, Guy's and St Thomas' NHS Foundation Trust
84. Leon Smith, Chief Executive, Nightingale House
85. Rob Smith, Health Education England
86. Paul Spooner, Electronic Staff Record Programme Director, NHS Electronic Staff Record
87. John Strangwick, Owner, Clarendon Home Care
88. Mandie Sunderland, Chief Nurse, Heart of England NHS Foundation Trust
89. Sally Taber, Director, Independent Healthcare Advisory Services
90. Chris Thompson, Chief Medical Officer, Priory Group
91. Andy Tilden, Head of Sector Development – Skills for Care
92. Alan Tinger, Director, Federation of Ophthalmic and Dispensing Opticians
93. Anne Trotter, Standards Compliance Manager, Nursing and Midwifery Council
94. Terry Tucker, Director of Learning and Development, Barchester Healthcare
95. Bridget Warr, Chief Executive, UK Homecare Association
96. Kate Webb, Policy Manager, Professional Standards Authority
97. Jean White, Chief Nursing Officer, Wales
98. Lord Willis of Knaresborough
99. Martin Wilson, Regional Director, North of England Healthcare and McKinsey Hospital Institute, McKinsey and Company
100. Cath Witherington, Team Leader, Apprenticeship Unit, Department for Business, Innovation and Skills,
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