Research Overview

NHS modernization and the role of HCAs

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Over recent years, the healthcare assistant (HCA) role has become central to acute healthcare delivery (Wanless, 2002). While a nurse support role has been a longstanding feature of the healthcare workforce (Stokes and Warden, 2004), a range of developments re-calibrating the distribution of nursing and clinical tasks and responsibilities has broadened the space within which HCAs perform their role. As the nature of registered nursing changes with the development of new, more specialist roles Royal College of Nursing (RCN) (2005), and as nurses become more preoccupied with the administrative fallout from the target-driven performance management regime in the health service, so the nurse support worker has emerged as increasingly key to healthcare provision. This is reflected in national policy pronouncements accompanying NHS modernization over the last decade, which have presented the HCA role as the vehicle for a number of reform objectives. Four such policy objectives can be discerned.

- A relief, taking over more routine activities from registered nurses, so allowing them to concentrate on more pressing tasks
- A substitute, performing more mainstream nurse activities
- An apprentice, providing a potential future source of nurses and assistant practitioners (APs)
- A co-producer, contributing to the quality agenda by bringing distinctive capabilities to healthcare.

As the Department of Health (2002) notes in highlighting the HCA role as a relief: ‘As existing staff develop into new roles…so the time of more highly-skilled staff can be used more effectively. For instance suitably skilled support workers could carry out some of the current task of registered nurses, freeing up these nurses to contribute more fully with their skills.’

These policy goals are founded on a number of assumptions about the nature of the HCA role, assumptions which to date have had a limited, fragile and fragmented evidence base. In a 3-year project on the Band 2 and 3 HCA role in secondary healthcare, funded by the Service Development and Organization Programme (SDO) of the National Institute of Healthcare Research (NIHR) (2010), researchers at the Said Business, University of Oxford, have sought to develop a stronger evidence base for such policy assumptions. This was pursued by considering the following questions:

- Who are HCAs, in terms of their background and motivations for taking on the role?
- What is the shape of the HCA role reflected in the tasks and responsibilities undertaken?
- What are the consequences of the role for key stakeholders, namely the HCAs who perform the role, the nurses they support and the patient they care for?

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The research questions were addressed in general medical and surgical wards in four case study acute trusts located in different parts of England as a means of picking up similarities and differences in the role between clinical division and hospital. In each, case data were collected from those with a stake in the HCA role: HCAs themselves, nurses, patients and managers.

A total of 360 interviews were completed. Nurses and HCAs were observed for almost 300 hours, and the views of around 750 HCA, 700 nurses and 1700 patient were captured by surveys in each trust.

The study has now been completed, with the full report available on the SDO website (NIHR, 2010). This article provides an overview of the findings as they relate to the three main research questions.

Backgrounds

In terms of personal characteristics, HCAs emerged as a distinctive group of workers, distinguishable from nurses in a number of respects. The study confirmed findings from previous studies (Unison, 2008) which suggested that HCAs were, in the main, mature women, with domestic responsibilities related to children and partners. However, the research revealed them as more deeply embedded in the local community than nurses and less ethnically diverse. The level and scale of these differences varied by trust, reflecting the demographics of their catchment areas. Nonetheless in all four hospitals the surveys found that more HCAs than nurses had attended a local school, while fewer came from black and minority ethnic groups. Clearly the social profile of HCAs is consistently different to the nurse, with possible implications for how they approach their work role and the patients.

The research highlighted the breadth of HCA experiences of work and indeed life.
They were revealed as having previously worked in a wide range of jobs and sectors. It was equally striking, however, that only a limited number of sectors proved to be gateways into the role. For example, in each trust around half of the HCAs had previously worked in the retail sector, but very few moved directly from this sector into the HCA role. Similarly, while close to a third of HCAs had been a full-time, non-paid carer, hardly any had become an HCA as their next career step. The most significant gateway into the HCA role was previous work in health or social care: in all four trusts at least half of the HCAs had been employed in these sectors immediately before moving into their present position. While barriers of entry into the HCA role are low, no formal qualifications typically being required, these findings suggest that there is a latent structure to the labour market for these workers, with trusts privileging those with recent health and social care work experience.

The shape of the HCA role

The research provided strong support for the suggestion that HCAs were taking on more direct care work relative to nurses. Certainly the snapshot view made it difficult to assess the scale of change, but analysis of the observational data indicated that on an early shift HCAs were spending twice as much of their time (30% of the shift) on direct patient care work compared to registered nurses (15%). These nurses were devoting considerably more of their time to technical and specialist tasks (28%) than HCAs (8%). It was equally clear, however, that the shape of the HCA role was extremely malleable, the tasks performed being sensitive to range of factors at trust, division and ward level, as well as being subject to job crafting by individual post holders.

As a means of developing a sharper picture of the forms assumed by the HCA role, cluster analysis was undertaken on survey data that asked HCAs whether they performed around a dozen tasks never, daily, weekly, monthly or annually, including patient and team-centred tasks, as well as those of a more or less complex technical kind. This analysis revealed five distinct HCA types, varying in the diversity and complexity of activities undertaken. (Box 1).

Consequences for HCAs

HCAs in all four trusts expressed considerable satisfaction with their job. Their only area of concern was pay, and few displayed signs of wanting to leave their jobs. This should not, however, detract from concerns that emerged, particularly in relation to management. It was noteworthy that the overwhelming proportion of HCAs, over 80% in all trusts, were in Band 2, with considerable unevenness between trusts in levels of accreditation. For example, in one trust only 23% and 17% had respectively National Vocation Qualification (NVQ) Levels 1 and 2, compared to a trust which had 0% of HCAs at NVQ 2 and another with 51% at NVQ 3. It was a situation that resulted in a considerable misalignment between pay band, qualification and tasks performed. This was particularly illustrated by HCAs at Band 2, sometimes with NVQ 3, performing quite complex tasks, such as electrocardiology (ECG). As a ward manager noted:

“We’d looked at skilling some [HCAs] up to Band 3s and some of them do bloods and do ECGs now, but the trust still just pays them Band 2s.”

There were also some frustrations about HCA career development opportunities within trusts. Just over a half of HCAs in all trusts wanted to remain an HCA, with around a quarter aspiring to become a registered nurse. But whether developing to become a better HCA or a nurse, there were a number of perceived barriers to progress: some of these rested with the HCAs themselves, such as a lack of confidence and time to train. Others were associated with trust systems and procedures, such as underdeveloped and communicated workforce planning, limited resources...
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Consequences for nurses

While nurses raised some concerns about their accountability for HCAs, particularly in the absence of any form of statutory regulation of the role, the qualitative research data indicated that, in general, nurses valued the HCA contribution to their working lives highly. The nurse survey evidence was a little more equivocal, with nurses more grudging in their evaluation of some aspects of HCAs' contributions, for example, as mentors to new staff members. It is interesting to speculate whether this disconnect in data sources reflects some ambiguity towards HCAs. As nurses seek to further their status by taking on more technical clinical tasks, do they feel at risk of forfeiting their claim to the unique provision of holistic patient care?

Consequences for patients

For patients, telling the difference between HCAs and nurses was often difficult. Over a third of surveyed patients were unable to do so. Among those who could distinguish, again there was a slight disconnect between the qualitative and quantitative data on whether patients related differently to HCAs than nurses. The qualitative data suggested a strong consensus between HCA, nurses and patients that HCAs were closer to patients than nurses: HCAs than nurses. The qualitative data indicated that, in general, nurses valued the HCA contribution to their working lives highly. The nurse survey evidence was a little more equivocal, with nurses more grudging in their evaluation of some aspects of HCAs' contributions, for example, as mentors to new staff members. It is interesting to speculate whether this disconnect in data sources reflects some ambiguity towards HCAs. As nurses seek to further their status by taking on more technical clinical tasks, do they feel at risk of forfeiting their claim to the unique provision of holistic patient care?

The survey material presented a more nuanced picture. Certainly HCAs appeared better able to deal with difficult or problematic patients than nurses, suggesting added value capabilities. However, once more nurses were less willing to acknowledge HCAs' distinctive contributions to care than the HCAs themselves, while surveyed patients still preferred to deal with nurses on particular issues.

Notwithstanding this complex picture, one of the clearer findings to emerge was that a patient's ability to distinguish between HCAs and nurses mattered: those who could distinguish had a better care experience than those who could not. This is a highly plausible finding: knowing who does what on the ward is likely to reduce frustration and improve the efficiency of care delivery. As one patient noted:

'I was probably asking a healthcare assistant something that he or she wasn't qualified really to deal with. [They did] their best to accommodate me but didn't deliver my expectation and made me more frustrated.'

Conclusion

The findings from this study constitute a significant step towards a stronger evidence base for some of the public policy assumptions underpinning the increasing use of HCAs to deliver secondary healthcare. Some of these assumptions have found support:

- The HCA role is being used to relieve the nurse of direct patient care tasks
- There are suggestions that HCA are acting as co-producers, bringing distinctive capabilities to bear in dealing with difficult patients
- There is a small but noteworthy stock of HCAs keen to use the role as an apprenticeship for registered nursing. At the same time, question marks have been raised against other assumptions:
  - The management practices used to support HCA career development are at best uneven
  - Most HCAs are looking to develop within the HCA role rather than move into nursing
  - The distinctiveness of the HCA contribution to healthcare is sometimes contested by registered nurses
  - Different sorts of data sometimes point in opposite directions, suggesting the need for further study.

Certainly the richness of the data collected in this study suggests that there is scope for more detailed analysis designed to provide additional insights into the HCA role. Indeed there are grounds for viewing these data as a resource to be further mined, particularly at a time of emerging financial constraint in the NHS, a time when the HCA role is likely to become even more important to efficient and effective patient care.

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