

Healthcare Support Workers in Scotland: Evaluation of a National Pilot of Standards and Listing in Three NHS Boards

HEALTHCARE SUPPORT WORKERS IN SCOTLAND: EVALUATION OF A NATIONAL PILOT OF STANDARDS AND LISTING IN THREE NHS BOARDS

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Responsibility for this report lies wholly with the authors.

Anne Birch and Claudia Martin

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EXECUTIVE SUMMARY

Background and Introduction

1. The pilot aimed to test out arrangements for a model of employer-led regulation of Healthcare Support Workers (HCSWs). Currently there is no statutory provision for the regulation of HCSWs in Scotland or anywhere else in the UK. The healthcare support worker role has been changing and developing over the last decade and some staff are extending their skills so that they can undertake work previously done by registered professionals. Consultation outcomes in Scotland indicated strong support for regulation (2004), and for the standards developed in the course of this project (2006). Following submission to the Review of Non-medical Regulation (Foster Review 2005) it was agreed that Scotland would test the model on behalf of the UK with strong support from the four countries. The pilot focused on currently unregulated staff employed in the name of NHSScotland.
2. The model consisted of a set of national minimum standards with the addition of a list of HCSWs who met the standards which was maintained as part of the pilot. The standards comprised three elements:
 - A set of induction standards for healthcare support workers
 - A Code of Conduct for healthcare support workers
 - A Code of Practice for NHSScotland Employers
3. This testing of the national standards represents a first step towards helping both employers and employees in NHSScotland fulfil their obligations towards patient safety and public protection as part of a future regulatory framework for HCSWs.

The Evaluation

4. The evaluation aimed to assess the implementation, operation and potential impact of the pilot. The evaluation, extended alongside the pilot to January 2009, comprised both formative and summative aspects and utilised a range of methods including: stakeholder and key informant interviews, individual case studies, surveys of participants, non-participants and supervisors and desk research.

Implementation of the Pilot

5. The Scottish Government Health Directorates' invitation to Health Boards to bid (July 2006) offered three elements of support for the pilot: funding for retrospective Disclosure Scotland checking of existing employees, funding for a Local Pilot Coordinator at each site, and the support of a National Pilot Coordinator based at NHS Quality Improvement Scotland.
6. The two initial pilots NHS Ayrshire and Arran and NHS Lothian commenced January 2007 and the third site NHS Lanarkshire joined later (July 2007). An independent health care site, Ross Hall Hospital also took part but was not part of the evaluation. The pilot was tested with vulnerable client groups in children's,

mental health and older people's services. The pilot was extended from one year to two (January 2007-December 2008) following delay in early implementation, largely due to: withdrawal of the original third site (NHS Glasgow and Clyde, early April 2007), slow recruitment of the National and Local Pilot Coordinators and slowness in establishing pilot steering groups and communication structures. Initial Guidance was well received but limited pre-pilot planning, concerning the level of coordination, information, training requirements and the format of planned individual and Board level assessment processes impacted on the pilot.

7. NHS Quality Improvement Scotland (NHS QIS) managed the pilot and coordinated both implementation of the standards and the monitoring of compliance. NHS QIS facilitation of the pilot required a difficult balance between 'governance' and 'support' roles and clarification of pilot requirements between SGHD, NHS Boards and NHS QIS was not always straightforward. Boards found some pilot processes more burdensome than anticipated. Pilots suffered from lack of funding for administrative support. There has been strong Partnership input to the pilot at national and local level throughout.

Development of pilot processes

8. Securing the time and motivation of the Workplace Supervisors (WPS) was key to the pilot's success. WPS experience of formal assessment processes varied. The delivery of training of WPS varied across site and flexible arrangements were required to facilitate weekend and evening staff participation in the pilot. The majority of WPS were willing volunteers, who supported the standards (84%) but thought them more appropriate for new starts. Fitting the task into busy jobs was problematic and only half felt sufficiently supported with this. The low ratio of facilities supervisors to support workers presented serious difficulties.
9. The assessment toolkit for HCSWs, consisted of an oral and observation assessment process supported by HCSW and WPS handbooks. A good degree of overlap between Knowledge and Skills Framework (KSF) outlines and the standards has been identified, but KSF cannot accommodate the behavioural aspects of some of the standards. The fit remains untested in practice due to the early stages of implementation of KSF at pilot sites but it is anticipated that evidence gathered from the standards can inform the KSF foundation review.
10. The clarification of arrangements with Disclosure Scotland was very time consuming. Two new counter-signatories were put in place at each site to facilitate monitoring of applications. It was found that not all HCSWs were legally eligible for Enhanced Disclosure as originally anticipated. The full potential burden on Disclosure Scotland was not tested as the number of applications was small. All sites had processes in place for dealing with undisclosed material.
11. The technical and practical aspects of setting up a simple local 'occupational list' on the Scottish Workforce Information Standard System (SWISS) have been tested. There are very mixed stakeholder views on the potential added value of extending arrangements to a national list. The evaluation identified a variety of technical and procedural matters requiring clarification before such a national list could be operationalised.

Numbers and Progress of Healthcare Support Workers

12. More than one in six (470) of identified eligible healthcare support workers (2961) were recruited to the pilot, of whom more than two thirds had an initial meeting with their Workplace Supervisor to plan for learning and assessment, more than half (263) completed all assessment and 193 were formally entered upon the 'occupational list' (SWISS database) after signing the Code of Conduct declaration.
13. Three quarters (341) of HCSW recruits were Nursing assistants/Clinical Support Workers and one in seven (66) were unqualified allied health assistants. Few (63) non-clinical staff were recruited.

Pilot operation – Views on Recruitment

14. The approach to engaging eligible HCSWs with the voluntary pilot was critical to its success; the two smaller sites Ayrshire and Arran and Lanarkshire were most successful and the latter's approach was most effective; the larger Lothian site faced most challenges. A great deal of Local Pilot Coordinator flexibility was required to engage weekend, night and bank staff. All sites faced difficulties in engaging facilities staff.
15. Participating HCSWs wished to help patients and improve patient safety and to take up a learning, development and potential career opportunity; they confirmed their participation was voluntary; and found face to face marketing most effective. Having enough time to take part was the major concern.
16. Non-participant HCSWs chose not to volunteer because the workplace was perceived to be too busy, they had personal commitments or were about to retire or change job. Some did not see the value of taking part. Returns were biased towards the largest site and the late added older people's service area. An untapped pool of potential volunteers had not been captured.

Pilot Operation – Views on Learning and Assessment

17. The majority of assessments were completed within two to three months as anticipated. However the Local Pilot Coordinator faced multiple logistical challenges in both linking up the Workplace Supervisor and HCSW and in ensuring all elements were in place for final completion, prior to entry on the 'occupational list'.
18. Participating HCSWs felt the standards had potential to affect their job and to improve confidence, knowledge and, most significantly, their ability to take action to keep patients safe. Prior achievements were considered for two-thirds but inclusion was not automatic; further development work was planned for a third. Approximately half the HCSWs undertook some preparation in their own time.
19. Assessment was reported to be a valuable and enjoyable experience, not too excessive a burden though the assessment paperwork required streamlining. It was considered most appropriate for new starts; however, little feedback was

received from new employees. HCSWs valued the certificate presentation ceremonies which emphasised appreciation of their role in the healthcare team. Four standards were not easily applicable to non-clinical roles.

20. There was a wide range of experience of both Personal Development Planning and Review and KSF across the three sites; just half the Workplace Supervisors were also KSF reviewers. Three quarters of WPS saw potential for the induction standards to fit with KSF.
21. Multiple reasons were given for the lack of success with facilities staff including: communication issues at national and local level; the pilot not being 'sold' to these groups; the voluntary nature of the pilot and these groups own lack of recognition of the title; the priority of existing commitments such as the Domestic Services Framework Workbook; and the low supervisor high support worker ratio.

NHS Board self-assessment and peer review

22. The Employer Code of Practice was generally supported but there were mixed views about the process (NHS QIS designed, Board self-assessment framework and peer review) to test compliance. The process was informative but a much more significant burden than anticipated. No serious gaps in human resource or clinical governance arrangements were found but there were challenges in applying a consistent approach to evidence for some criteria and in evidencing 'monitoring' of the standards. The early timing of the exercise meant it could not really address non-clinical workers, the standards fit against KSF, or the impact on HCSWs or patients.

Quality assurance of induction standards and pilot processes

23. There was a large degree of congruity between the NHS QIS additional quality assurance processes and the evaluation findings. External consultants reviewed the implementation of the learning and assessment process and examined completed assessment forms. They found further clarity is required in guidance given to WPS about describing whether and how HCSWs are meeting assessment criteria.
24. NHS QIS coordinated the collation of monitoring data from local sites. This was hampered to some degree by deficits in administrative support at pilot sites and technical support at NHS QIS. Future monitoring would require more resource.

Consultative Workshop

25. Day two of the Scottish Government Health Directorates Regulation event (October 2008) focused on the national healthcare support worker regulation pilot. It was attended by some 200 delegates including a broad range of representatives from healthcare professions and frontline staff. Discussion in facilitated workshop style sessions focused on national and Board level requirements, the standards and the assessment process.
26. Delegates expressed broad support for the Code of Practice for Employers (65%), the Code of Conduct for healthcare support workers (75%), for the

standards to be mandatory for all HCSWs (72%), and for the proposal for a positive national level 'occupational list'. Delegates felt that the standards would enhance the patient experience and that there was potential for the model of standards and listing to enhance public safety.

27. There were, however, very mixed views about the piloted assessment toolkit testing achievement of the HCSW induction standards and lack of opinion about the piloted Board accountability framework.

Other policy developments and research

28. The Protection of Vulnerable Groups (Scotland) Act 2007 scheme is likely to encompass all *clinical* support workers but it is not yet clear which *non-clinical* HCSW roles will be included in the scheme, although it is likely that those with a direct contact role will be. It will take at least four years to bring all of the relevant workforce under the scheme, via retrospective checking. The final details of decision making on listing (i.e. barring decisions) is still being developed. If an 'occupational list' for HCSWs is to be implemented then further work would be required to examine how it might articulate with the PVG scheme.
29. Parallel NHS Education for Scotland (NES) developments have relevance for the national pilot. A major scoping study has highlighted the ageing workforce, limited availability of accredited learning programmes and the need for more work to support literacy and numeracy needs. Education and Development Frameworks for facilities staff, developed jointly with Health Facilities Scotland, may have potential to incorporate the induction standards. The development of educational support for clinical support workers, beyond induction, has highlighted the need to support supervisor assessment skills.

Summary and recommendations

30. The pilot found that there was some important evidence that implementation of the standards had potential to improve patient safety and public protection. Participating HCSWs were motivated to take part in order to make improvements and felt they knew more about patient safety and felt more able to take action to keep patients safe. Supervisors were made more aware of the importance of the HCSW role. The employer's accountability framework tested made pilot staff more aware of relevant staff governance policies. Disclosure Scotland checks uncovered some (minor) undisclosed material.
31. The evaluation indicates that roll-out of the pilot across all NHS Boards in Scotland might potentially carry substantial resource implications and that this will be to some degree dependent upon future arrangements for integration of the standards with KSF and local Board arrangements for KSF implementation. We suggest NHS Board level resource may be required to cover the following:
- A lead officer/local coordinator role
 - WPS training and assessment
 - Assessment arrangements for work areas with low ratio of WPS to HCSW
 - Flexibility to cover all HCSW and WPS work patterns including bank, weekend, night staff and short shifts

- Administration and materials costs
- Disclosure Scotland applications, new and retrospective (including for some Workplace Supervisors)
- A national coordinator role

32. A clear communications strategy is required to inform healthcare support workers and the public of the proposed way forward, including the proposed timescale and proposals to bring existing employees into the model. Partnership representatives wish to be included in all aspects of future development and implementation and this would also be enhanced by the continued representation of patient and public interests.

33. The induction standards were unanimously supported but the standards and assessment materials required repackaging into a streamlined and more attractive format. There was consensus to implement them with clinical support workers but more exploration on the way forward for non-clinical support workers was required. The following can be recommended:

- The standards should be mandatory
- Implement the standards for *clinical* support workers
- Review how the induction standards apply to non-clinical support workers
- Explore possibilities for dovetailing the standards requirements with Health Facilities Scotland/NES Education and Development Frameworks for support staff
- Revise the standards and assessment tool kit, potentially to reflect 'core' and 'role specific criteria'
- Repackage the standards and assessment toolkit to remove duplication, make them a fully accessible, more attractive and more manageable task for both HCSW and WPS
- Clarify the maximum timescale for meeting the standards
- Clarify guidance on practice for HCSWs not meeting the standards within a given timescale
- Clarify the implications of not meeting the standards at Board and individual level
- Consider motivating factors for staff groups where regulation is not part of the existing culture and prepare such groups for undertaking assessment
- Improve guidance to WPS on utilisation of evidence to meet assessment criteria
- Map the standards with common SVQs and induction programmes to clarify applicability of prior evidence
- Support the maintenance of standards through the KSF development review process to minimise the burden on supervisors and Health Boards
- Ensure any recommendations relating to KSF are in line with the 4 UK health departments partnership agreement
- Consider whether behavioural aspects need to be in both the Code of Conduct and the Induction Standards

34. The Code of Conduct was unanimously supported, and the following can be recommended:

- Implementation of the Code of Conduct for Healthcare Support Workers in its current format
- Review how and whether the Code of Conduct might be referenced in HCSW job descriptions for both new and existing staff
- Review mechanisms for monitoring working to the Code

35. The Code of Practice was supported as codifying already existing best practice but there were mixed views as to whether the accountability framework tested was fit for purpose, and we suggest:

- Implementation of the Code of Practice in its current format
- Review options for compliance monitoring
- Explore the potential for the existing NHSScotland Staff Governance Standard and review process to incorporate the Code of Practice.

36. Stakeholders hold mixed views as to whether a national occupational list would be a proportionate response to the perceived level of risk, and we suggest:

- Undertake further work to clarify the potential added value of a national occupational list over the standards and Code of Conduct, taking into account forthcoming outcomes and risk assessment guidance from the UK Extending Professional Regulation Group
- Undertake further work to articulate the links between the proposed HCSW 'occupational list' and the Protection of Vulnerable Groups scheme
- Consider whether a 'positive' means of acknowledging the achievement of the standards / code of conduct is required

1 BACKGROUND AND INTRODUCTION

Introduction

- 1.1 This chapter sets out the policy background to the national pilot testing the employer-led model of regulation of Healthcare Support Workers (HCSWs) within three NHS Health Boards in Scotland. It outlines the previous consultations on proposed regulation and national minimum standards for HCSWs and current developments in UK regulation policy and sets out the background and format of the Scottish pilot.

Background

- 1.2 Healthcare support workers (HCSWs), defined for the purpose of the pilot as those who provide a direct service (that is, having a direct - although not necessarily a direct 'hands on' role - on patient care/treatment/relationships) to patients and members of the public in the name of NHSScotland, play a vital role in the National Health Service in supporting healthcare professions and provide a wide range of ancillary services. The healthcare support worker role has been changing and developing over the last decade and some staff are extending their skills so that they can undertake work previously done by registered professionals.¹ Currently there is no statutory provision for the regulation² of HCSWs either in Scotland or anywhere else in the UK. The Regulation of Healthcare Support Workers in Scotland is not a matter reserved to Westminster.
- 1.3 In 2007-2008 Scotland tested a model of employer-led regulation, in three NHS Boards and one independent hospital. The other three UK health departments are awaiting the outcomes of the pilot.
- 1.4 The elements of the employer-led model tested are:
- a set of induction standards that focus on concepts considered to be important for public protection
 - a Code of Conduct for Healthcare Support Workers
 - a Code of Practice for Employers
 - a centrally held list of names of those who meet the standards required
- 1.5 The model focuses on currently unregulated groups of staff, collectively known as Healthcare Support Workers (HCSWs). This includes those in support roles to the healthcare professions (such as care assistants) and those who provide

¹ *Consultation on the regulation of health and social care staff* (2004)

² The act of regulating an occupational or professional group. Regulation can take a number of forms (statutory/legislative, professional self-regulation, employer-led regulation, individual self-regulation and so on) and focuses on ensuring that members of the occupational or professional group reach and maintain the minimum threshold standard/s that is expected of that occupational or professional group in relation to, for example, conduct, practice, education and competence. The purpose of regulation is protection of the public. Any regulation operates within a broader framework of regulatory procedures, such as complaints and capability procedures, clinical governance and staff governance.

ancillary services (such as porters, domestics, unqualified laboratory workers and mortuary attendants).

- 1.6 Any support worker who 'provides a direct service to a patient in the name of NHSScotland' and who is not already statutorily regulated, or due to be (e.g. psychologists; healthcare scientists, pharmacy technicians), has the potential to be included. Annexe B provides the list of healthcare support workers who were to be involved in the pilot (any other group was not to be included).

Consultation on the regulation of healthcare support staff

- 1.7 Some form of regulation for support workers was considered by stakeholders³ as key to promoting the safety of the public. In 2004 two parallel consultations were undertaken in the UK to explore opinion on proposals for widening regulation to support workers, the need for regulation, and what form regulation should take.
- 1.8 The devolved Scottish administration issued the *Consultation on the Regulation of Health Care Support Staff and Social Care Support Staff in Scotland* (open May to August 2004). The purposes given for extending regulation were: to protect the public; to capture the changing roles of unregulated support staff; to close existing loopholes (whereby suspended or dismissed staff might apply for alternative posts); and to meet the needs of the Joint Future agenda with increasing numbers of joint health and social care teams and changes in worker roles.
- 1.9 The Scottish consultation paper sought opinion on the groups to be included in formal regulation. It suggested arrangements might be extended to specified assistant and support staff⁴ who provide direct care to patients and service users. It also suggested that other support staff (working in areas such as domestic, portering, administration and clerical work which do not involve direct patient or service user care provision) might be less well served by formal regulatory arrangements and that the performance of these groups might be more appropriately managed locally by the employer.
- 1.10 The consultation also sought opinion on the format of regulation, who should regulate these groups, and the appropriateness of statutory or alternative forms of regulation (statutory self-regulation; statutory shared regulation; voluntary regulation led by staff organisations; employer-led regulation linked to employment contracts).
- 1.11 Consultation responses⁵ were received from professional bodies, employers and employees of the health and social care sector. A summary of consultation outputs can be found in Annexe C. The responses indicated very strong (93%)

³ Stakeholders were defined here as individuals or organisations with a particular interest and investment in the subject under consideration.

⁴ health care assistants, assistant practitioners in a wide range of care settings, AHP's assistants, healthcare scientist workforce (but excluding aspirant professions), social services support staff, pathology assistant practitioners

⁵ *Summary report of the consultation on regulation of healthcare and social care support staff in Scotland, 2004* (web only May 24, 2006) <http://sh45inta/Publications/2006/05/HCSW>

support for the extension of regulatory arrangements to cover health and social care assistants and support staff. The majority of respondents felt that support workers should be accountable for their own practice, but that this should be dependent upon their level of training and/or scope of practice. However, it was felt that setting standards should remain the responsibility of the manager/employer. There was also some call (UNISON Scotland) to consider further extending regulation to ancillary staff groups like porters and domestic/house-keeping staff who came into direct contact with patients and who could impact directly on the health and welfare of patients.

- 1.12 The majority (90%) were content that statutory regulation was the most appropriate way to ensure public protection but there was no general consensus over which of the regulatory bodies should regulate these staff. The Council for Healthcare Regulatory Excellence remained to be convinced that statutory regulation was appropriate and encouraged the consideration of employer-led regulation.
- 1.13 There was also significant awareness among respondents to the consultation of the need to avoid multiple registrations and to facilitate transferability of staff between the four UK countries; and that it would make sense for regulators to work together to develop core/common standards.
- 1.14 In parallel to the Scottish consultation the Department of Health issued *Regulation of health care staff in England and Wales: a consultation document*. This consultation had focused on clinical support staff⁶ but excluded consideration of other non-clinical support staff (domestic, portering, administration and clerical work). Again, the consultation responses expressed broad support for statutory regulation of some, but not necessarily all, support staff. Respondents wanted more debate upon who might be included, what body might regulate them and the form any regulation might take.

UK developments in regulation policy

- 1.15 Most health care professional staff are already regulated⁷. The work of the Council for Healthcare Regulatory Excellence (CHRE)⁸, set up in 2003 and working across the UK, focuses upon the importance of patient safety and public protection. Other, currently unregulated healthcare professions (some healthcare scientists, psychologists and psychotherapists) are in the process of, or considering, statutory regulation for their professions. Social care

⁶ Clinical support staff included: health care assistants, assistant practitioners and those undertaking similar roles across a wide range of care settings; therapy assistants; all sectors of the Healthcare Scientist workforce apart from the aspirant professions.

⁷ Regulation exists to ensure standards of practice and to protect the public as far as possible against the risk of poor practice. It works by: setting agreed standards of practice and competence, registering those who are competent to practice, restricting the use of specified titles (if statutory) to those who are registered and applying sanctions such as removing from the register anyone who fails to meet these standards.

⁸ <http://www.chre.org.uk/>

professionals are in the process of being regulated by the four separate social care councils⁹.

- 1.16 The function of these health and social care regulatory bodies is to ensure that professionals have the skills and knowledge needed for practice, that they meet appropriate standards, are registered and act ethically. The bodies also take action to protect the public by investigating complaints and by taking action should there be issues about a professional's fitness to practise because of poor health, misconduct or poor performance¹⁰. They can remove people from the register and prevent them from practising.
- 1.17 Over the past few years, a number of high profile cases have focused attention upon the scope and format of regulation of individuals working within the National Health Service¹¹.
- 1.18 Two key reviews of regulation by the UK Department of Health, published in 2006, have influenced the development of the Scottish pilot. *Good doctors, safer patients*¹² was a broad review of medical regulation. It aimed to create an improved approach to promoting and assuring good medical practice, and protecting patients from bad practice. The review of *The regulation of the non-medical healthcare professions* (2006) was chaired by Andrew Foster (former Director of Workforce at the Department of Health).¹³ One of the six key themes explored through the review was the need for the regulation of healthcare staff with lower levels of qualification. The review decided that the Scottish pilot on healthcare support workers would provide important evidence and could lead to the adoption of a UK-wide approach.
- 1.19 In February 2007, the UK Government White Paper - *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*, (2007)¹⁴ was published. This set out Government proposals for improving public safety by strengthening the system of professional regulation for healthcare professionals. The proposals were based on consultation, in 2006, on the above two reviews. The White Paper was complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, *Safeguarding Patients*, which set out a range of measures to improve and enhance clinical governance in the NHS.

⁹ Social care professionals are regulated by four separate bodies Care Council for Wales, <http://www.ccwales.org.uk/>; General Social Care Council (GSCC), <http://www.gsc.org.uk>; Northern Ireland Social Care Council (NISCC); Scottish Social Care Council (SSSC) <http://www.sssc.uk.com>

¹⁰ *Who regulates health and social care professionals* (July 2006) UK Public and Patient Involvement (PPI) group (http://www.chre.org.uk/_img/pics/Regulators_Leaflet.pdf)

¹¹ The Shipman Inquiry, <http://www.the-shipman-inquiry.org.uk>; *Safeguarding Patients* (2007), Department of Health

¹² *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients* (2006) DOH

¹³ Department of Health (2006) *The regulation of the non-medical healthcare professions – a review by the Department of Health*.

¹⁴ *The White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, (2007) Department of Health.

1.20 Chapter 7 of the White Paper considers plans for extending regulation to 'New roles and emerging professions'. In particular, it drew attention to the role of support workers and said that the Government in England would:

- Evaluate the results of the Scottish pilot and consider the way forward with stakeholders
- Consider whether there is sufficient demand for the introduction of statutory regulation for levels 3 & 4 on the Skills for Health Career Framework – against criteria

1.21 In 2008, the UK Extending Professional Regulation Working Group took this work forward in close liaison with the devolved administrations¹⁵. The Group aims for a common approach across the UK for determining which healthcare and professional groups should be subject to regulation now and in future. Its task is to set out criteria against which the appropriateness of potential regulation for un-regulated groups might be judged. It has commissioned further work to identify the range of potential methods for safeguarding the public (including models of regulation and methods used internationally, voluntary registers, and employer-led models). The Group's work indicates that a proportionate and risk-based approach should underpin any future decisions about regulation (final report anticipated early 2009).

Background to the Scottish pilot

National (Scotland Group) - the 'regulation of healthcare support workers project'

1.22 In order to progress discussions on how the 2004 consultation outcomes should be addressed, the Scottish Executive set up a short-life, National (Scotland) Group for the Regulation of Healthcare Support Workers which met twice (May and June 2005). The group, whose membership consisted of a wide range of key stakeholders¹⁶ (Annexe D), considered a number of options for the regulation of HCSWs including: doing nothing, non-statutory approaches (e.g. the employer-led model) and statutory options (i.e. similar to those in place for the regulated healthcare professions). The group considered both the consultation results and the practicalities of what might be possible to achieve on a Scotland-only basis. Statutory regulation was not considered achievable on a UK wide basis within a timeframe acceptable to the group, given that the other three government health departments were not in a position to progress at that point. The National (Scotland) Group was keen to see public protection measures implemented for the people of Scotland sooner¹⁷ rather than later and expressed a preference to progress on a Scotland-only basis until the other three home countries were in a position to consider their own

¹⁵ In Scotland the Scottish implementation group for Extending Professional Regulation has worked in close liaison with the UK group

¹⁶ 'Stakeholders' are defined here as individuals or organisations with a particular interest and investment in the subject under consideration.

¹⁷ The group's work was conducted in a context of increased focus upon the need for safe recruitment practices and information sharing across all agencies - The Bichard Inquiry into the Soham murders. <http://www.webarchive.org.uk/pan/12841/20060926/www.bichardinquiry.org.uk/index.html>

approaches. The group agreed to progress with the implementation of a model of service-led regulation with the addition of a centralised, mandatory, occupational register¹⁸.

- 1.23 As a result of the work of the National (Scotland) Group, the 'Regulation of Healthcare Support Workers' project was born. The National (Scotland) Group expressed interest in testing the viability of the preferred option on behalf of the four UK countries. Following a request by the secretariat to the Department of Health (DH) *Review of Non-medical Regulation*, a position paper was presented by SGHD to the Advisory Group (July 2005) setting out details of the proposed Scottish model. As a result, it was agreed that Scotland would introduce a set of arrangements and lead the way for the rest of the UK, with input and support from each home nation. The aim¹⁹ was to develop and test, a model of 'employer-led' regulation for HCSWs (with national consistency) built on the premises of patient safety and public protection, and underpinned by nationally agreed standards for safe recruitment and induction, a code of conduct for HCSWs and a code of practice for employers. Compliance with these standards by HCSWs and Employers would underpin regulation.
- 1.24 This work was to be guided by the core principles (transparency, accountability, targeting, consistency, proportionality) set out by the UK Government's Better Regulation Commission²⁰ and additional principles identified by the National (Scotland) Group (Annexe G).
- 1.25 In late 2005, a four-country Steering Group²¹ (Annexe E) was established to steer the pilot project. This had representation that included the Nursing & Midwifery Council, Health Professions Council, Royal College of Nursing, UNISON, Council for Healthcare Regulatory Excellence, Scottish Social Services Council, independent sector and lay reviewers. A Working Group, consisting of stakeholders from a broad range of backgrounds and a wide range of interest in both public protection and the development of healthcare support workers (Annex J) was also established. Its remit was to develop the standards and codes and to prepare for public consultation.

Consultation on standards for healthcare support workers

- 1.26 The Scottish consultation *National Standards relating to Healthcare Support Workers in Scotland* (May-August 2006) sought views in order to further refine the draft standards for HCSWs employed in NHSScotland. The developed codes and standards focus on public protection. The Induction Standards

¹⁸ *National Standards relating to the Healthcare Support Workers in Scotland: Consultation document* (p4). This phrase has in some subsequent documentation been amended to a model of employer-led regulation with the addition of a centralised occupational list

¹⁹ The aim set out in the initial Project Initiation Document, drawn up June-October 2005

²⁰ The wider approach towards the regulation of HCSWs reflects the five principles of good regulation set out by the UK government's Better Regulation Commission (formerly Better Regulation Task Force)

²¹ 4 Country Steering Group first meeting held 19 October 2005, added a context section to the initial PID.

consist of fourteen public protection statements with associated performance criteria (Annexe K).

- 1.27 Prior to consultation, the Working Group had taken into account a number of systems and processes already in place across Scotland. The Group was mindful of the need for compatibility with existing systems and hoped to reduce potential duplication of effort and processes for NHSScotland Boards. Scottish Health Boards were in the process of implementing Agenda for Change, under the UK wide NHS pay modernisation agenda²² along with its development arm The Knowledge and Skills Framework (KSF)²³ (and e-KSF, the supporting on-line tool). The draft induction standards had drawn on applicable and already tested competences²⁴ from the Skills for Health database (the Sector Skills Council (SSC) for the UK health sector). Although not planned as part of the pilot, there was potential over time, for mapping across to the Scottish Credit and Qualifications Framework (using induction standards performance criteria as evidence for achievement). From 2003, the PIN (Partnership Information Network) Guidelines on people management had been mandatory in NHSScotland; in particular, Personal Development Planning and Review, which cross referenced with KSF²⁵. The PIN guidelines are also used voluntarily by independent and voluntary sector services which aspire to provide services for the NHS to the same standards. It was anticipated the pilot would also take into account the NHSScotland core induction programme and local induction schemes.
- 1.28 The consultation response indicated strong support for the principle of public protection and a positive response to the standards. There was some call for the standards to be mandatory. There was some concern expressed regarding 'tone', 'language' in relation to the Code of Conduct and induction standards.
- 1.29 During September and October 2006 responses²⁶ to the consultation were used to refine the standards before they were reviewed by the Plain English Society. During the late summer and autumn of 2006, SGHD held a series of communication events with NHS Chief Executives and other senior representatives²⁷ in healthcare. SGHD found that the principles of the pilot were unanimously signed up to. There was a Scottish Ministerial launch of the final

²² <http://www.paymodernisation.scot.nhs.uk/>

²³ <http://www.paymodernisation.scot.nhs.uk/afc/ksf/index.htm>

²⁴ A "competence" describes the appropriate performance of a single function within the workplace underpinned by the knowledge and understanding required to perform that function to an appropriate standard. Competencies are the building blocks developed and used by Skills for Health in the development of competence frameworks. Individual competencies are described as either National Workforce Competencies (NWCs) or National Occupational Standards (NOSs). Both basically the same but NOS are competencies that have been through an additional approval stage in the UK. Wide basis for use in Scottish Vocational Qualifications or National Vocational Qualifications <http://www.skillsforhealth.org.uk>

²⁵ NHSScotland Staff Governance, Partnership Information Network 12 (PIN) Policies <http://www.staffgovernance.scot.nhs.uk/pages/Pin.htm>

²⁶ *National Standards relating to healthcare support workers in Scotland – Summary of consultation responses*, Scottish Government (2007)

²⁷ Executive Directors of Human Resources and of Nursing; Scottish Workforce and Staff Governance Committee; Trade Unions, Employee Directors etc.

revised standards²⁸ and the pilot in November 2006. The standards have been available for voluntary implementation across NHSScotland since then.

The Pilot

- 1.30 The purpose of the pilot was to explore the effectiveness of regulatory arrangements for healthcare support workers with a view to informing further debate. The proposed employer-led model comprised the set of national minimum standards (Induction standards; Code of Conduct for HCSWs; Code of Practice for employers) and a list of HCSWs who met the standards which would be maintained as part of the pilot. As noted above, the definition of healthcare support worker is particularly important in the Scottish pilot and it includes both clinical and non-clinical support workers.
- 1.31 The national standards were piloted in three NHS Boards and one independent sector hospital. At the outset, the pilot was to be limited to HCSWs working in mental health and children's services; older people's services were added later. The pilot, initially planned to run for one year (January 2007 to January 2008), was extended to two years. HCSW participation in the pilot was to be on a voluntary basis. Frontline managers and workplace supervisors were expected to assess HCSWs against the standards using existing Human Resources practices and supporting guidance from SGHD. Participating HCSWs would also be required to undertake a Disclosure Scotland criminal record check. HCSWs who achieved the standards would have their name entered on the occupational list (to be held on SWISS²⁹). The pilot was supported by a national coordinator and local coordinator in each participating site. It was expected that there would be consistency of approach of operation across all pilot sites. A key objective of the pilot was to develop systems for monitoring compliance with standards in line with existing governance arrangements (such as staff governance and clinical governance frameworks).

Related policy and research developments

- 1.32 Two key areas of policy development have potential to impact upon future arrangements for the pilot. (Further detail is provided in Annexe J). At the outset of the pilot it was envisaged that the 'vetting and barring scheme' for the protection of vulnerable groups and children would have been introduced³⁰ and that the evaluation would have opportunity to explore links between its provisions and the proposed HCSW 'occupational list'. However, progress on implementation of the Protection of Vulnerable Groups Act has been slower than anticipated.
- 1.33 Currently it appears that if an 'occupational list' of HCSWs were to be put in place then this would be complementary to the PVG scheme. The HCSW list would signify safe recruitment of the HCSW and that a basic induction level competence was reached. Further work would need to be done to clarify what

²⁸ www.workinginhealth.com/standards/healthcaresupportworkers

²⁹ SWISS Scottish Workforce Information Standard System, a workforce database for NHSScotland

³⁰ Scottish Government Protection of Vulnerable Groups Act (Scotland) 2007 website
<http://www.scotland.gov.uk/Topics/People/Young-People/children-families/pvglegislation>

communication links would need to be established between a proposed HCSW 'occupational list' and the PVG scheme. A flow chart showing communication lines between the NHS employer, PVG scheme and individual HCSW would need to be drawn up, illustrating decision points and potential actions concerning the 'occupational list'.

- 1.34 Two NHS Education Scotland (NES) lead projects have been developed in parallel with the first year of the HCSW pilot. Firstly NES was in the process of conducting a scoping study of the administrative and support services in Scotland and their support needs³¹. This study has high relevance to the HCSW pilot in terms of understanding the range of literacy levels across support workers and implications for mechanisms to support learning.
- 1.35 Secondly, key staff involved with the HCSW pilot have contributed to NES work on developing educational support for clinical HCSWs, going beyond the induction stage. The three potential parallel assessment practices (HCSW induction standards, KSF, vocational qualifications) all require supervisor assessment skills and the person taking on the role of the pilot Workplace Supervisor (anticipated to be the KSF reviewer) may potentially need to cover all three practices.

Report structure

- 1.36 *Chapter two* sets out the original SGHD aims and objectives for this evaluation study and the methodology followed by the evaluation team. *Chapter three* highlights key findings from the early implementation of the pilot and issues arising during the subsequent operational phase. *Chapter four* describes the development of key pilot processes including the training of workplace supervisors, the learning and assessment toolkit, the Disclosure Scotland application processes and arrangements for the 'occupational list'. *Chapter five* sets out the *numbers* and characteristics of healthcare support workers taking part in the pilot. The following two chapters present stakeholder, supervisor and support worker views on recruitment (*Chapter six*) and learning and assessment processes (*Chapter seven*). *Chapter eight* outlines the NHS QIS devised processes for NHS Board self-assessment and review and the perceptions of those taking part in these activities. *Chapter nine* outlines the additional NHS QIS quality assurance measures for the pilot. The process and outcome of the final consultative workshop is highlighted in *Chapter ten* with a final summary and recommendations in *Chapter eleven*.
- 1.37 The Annexes provide further detail on pilot steering group membership, pilot processes and pilot and evaluation documents. Abbreviations and acronyms common to the pilot are listed in Annexe A.

³¹ NHS Education for Scotland (2008) *Developing an Education Framework for Staff in Administrative Services and Support Services. Scoping Study and Stakeholder Consultation Report*

2 THE EVALUATION

Aims and objectives of the evaluation

- 2.1 This chapter sets out the aims and objectives of the evaluation and summarises the approach, timetable and methods employed.
- 2.2 The Scottish Government Health Directorates set multiple aims and objectives for the evaluation of the pilot. The initial overarching aim of the evaluation was to:

Evaluate the implementation, operation and potential impact of employer-led regulation of HCSWs in Scotland.

- 2.3 In relation to the *implementation* of the pilot, the evaluation was to assess:
- Early communication with pilot sites and the usefulness of initial guidance for participating NHS Boards
 - The need for local/national coordinators
 - The ease with which the standards fitted with existing HR practices
 - The time taken to establish the pilot within local sites
 - The initial training required for Workplace Supervisors
 - The time taken to establish monitoring criteria as part of quality assurance measures
- 2.4 In relation to the *operation* of the pilot the evaluation aimed to:
- Describe the process of recruiting HCSWs into the pilot and identify reasons for non-participation
 - Explore stakeholder views on the definition of 'healthcare support worker' and groups to be included
 - Assess whether Disclosure Scotland was able to meet the pilot demands for 'enhanced' Disclosure Scotland (DS) criminal record checks
 - Identify whether systems are in place for recording and dealing with previously unknown convictions uncovered through DS checks
 - Identify the processes used to assess achievement of the standards and entry to the list
 - Assess whether the process of personal development planning and review (PDPR) is fit for purpose for assessing HCSWs against the standards and entry to the list
 - Assess whether the process used to demonstrate and document the achievement of standards has the potential to be linked to the KSF foundation gateway of Agenda for Change
 - Assess how onerous the process of achieving the standards is on the HCSW and the Workplace Supervisor
 - Investigate the interface between the standards required of HCSWs within this pilot and those for support workers in social services and independent healthcare

- Assess the technical aspects of setting up, operating and maintaining a list of HCSWs
- Assess whether an appeals process is required for HCSWs who disagree with their Workplace Supervisor's assessment of their fitness to practise and whether there should be a process for the reinstatement of names in any future regulatory framework

2.5 In relation to the *potential impact* of employer-led regulation the evaluation aimed to:

- Assess whether rolling out the pilot across Scotland has the potential to enhance public protection
- Assess whether the SWISS database has potential to support future safe recruitment practice through 'flagging up' when a new entrant to the NHSS workforce is already on the SWISS database or has been dismissed by another employer for fitness to practise reasons
- Assess whether rolling out the pilot has potential to improve working practices amongst HCSWs
- Provide an indication of the resources (including staff time) required for potential roll-out of the pilot
- Identify how employer-led regulation could most effectively fit within existing/forthcoming human resource policies and procedures
- Assess whether the regulation of HCSWs needs to be underpinned by legislation/statutory regulation
- Provide recommendations outlining how, and whether, a system of employer-led regulation and listing of HCSWs could most effectively and efficiently be rolled out across Scotland
- Assess the added value that a future list would bring over the implementation of national standards alone
- Outline the measures that will need to be put in place prior to rolling out the pilot across Scotland

Methodology

2.6 The evaluation comprised both formative and summative aspects and adapted to follow pilot developments. A range of methods was used, including:

- Stakeholder and key informant interviews
- Individual HCSW case studies
- Surveys of HCSW volunteers, workplace supervisors, and non-participant HCSWs
- Desk research – pilot documentation and monitoring data
- Consultative Workshop

2.7 The SGHD tendered the evaluation in October 2006 and commissioned it in late 2006. The evaluation, originally planned to run for a full year (2007) in parallel with the pilot was subsequently adapted, in design and timescales, to capture the slower than anticipated pilot implementation. An initial formative stage (December 06 –March 07) explored the early implementation of the pilot and gained key informant perspectives to help scope aspects of the evaluation.

Following a formative report to the 4 Country Steering Group in April 2007 and at the commissioner's request, an additional formative phase was undertaken (into summer 2007). The evaluation, following the extension of the pilot itself was extended to the end of December 2008. The summative stage, obtaining participant and stakeholder feedback ran from June to September 2008, to gather data to inform the consultative Workshop.

- 2.8 Throughout, the evaluation team has liaised closely with the SGHD commissioner and the National and Local Pilot Coordinators to track pilot developments. The lead researcher attended a range of pilot meetings; evaluation observations of these meetings inform this report. Meetings attended included the 4 Country Steering Group, NHS QIS National Project Group, a sample of pilot briefings, meetings and training sessions. Interim evaluation reports were presented to the 4 Country Steering Group (April and October 2007, September 2008) and the Workshop event.
- 2.9 The Scottish Government invited the independent healthcare site taking part in the pilot, Ross Hall Hospital, to take part in the evaluation. However, because of funding issues, Ross Hall declined.
- 2.10 The possibility of including patients' perspectives in the evaluation was considered at the outset, but the commissioners and evaluation team agreed that the pilot would be at too early a stage for this to be either possible or meaningful. However, the lay perspective was included on the 4 Country and NHS QIS National Project Steering groups, and their views are included in the evaluation.

Stakeholder and key informant interviews

- 2.11 Formative stage interviews (December 2006 to summer 2007) and end stage interviews (June to September 2008) were conducted, comprising a total of 54 interviews with 45 participants, with some participants interviewed twice. The planned number of interviews was extended (from 32 to 54) to capture the complexity of the pilot. Around 25 were stakeholder interviews and 29 were with key informants (some respondents held dual roles, being both directly connected to the pilot and also holding a role on a national group or body). Pilot stakeholders were purposively selected to capture pilot experience from a range of roles across the three sites but not all roles were represented at all sites. Pilot stakeholder representation included National and Local Pilot Coordinators, pilot site lead officers, human resources, facilities and partnership representatives (including some from the withdrawn Glasgow site). Key-informant representation included Disclosure Scotland, NHS Quality Improvement Scotland (NHS QIS) professional staff and lay reviewers, NHS Education for Scotland (NES), Ross Hall Hospital, Manager of Scottish Workforce Information Standard System (SWISS), Health Facilities Scotland, Nursing Directors, Scottish Social Services Council (SSSC), 4 Country Steering Group, KSF implementation lead, HCPL, Director Council for Healthcare Regulatory Excellence, UNISON, SWAG/AMICUS/UNITE, the Scottish Government pilot lead officer and the Protection of Vulnerable Groups policy officer.

2.12 The majority of interviews were conducted face-to-face with some additional end stage interviews by telephone. Separate topic guides were developed for the two stages of the pilot and were used flexibly and adapted to the particular area of interest for particular informants to pick up on emerging issues. Topics included:

- Informant role and involvement in pilot
- View on HCSW definition and inclusion in pilot
- View on guidance, approaches taken, processes and materials developed
- Key barriers, facilitators and emerging issues
- View on potential roll-out of pilot

Individual healthcare support worker case studies

2.13 Individual healthcare support worker case studies had two purposes:

- to provide rich data on HCSW and WPS perceptions of pilot processes
- to inform development of questionnaires and topic guides

2.14 Prospective case studies explored individual participants' experiences of recruitment, clearance by Disclosure Scotland, assessment, achievement of the standards and listing, and their perceptions of the pilot's development, timescales and burden. These individuals, tracked over time, helped inform the emerging picture of different experiences across worker groups and pilot sites as the pilot developed.

2.15 The twelve case studies represent a range of participants, from those who completed the process fairly easily to those for whom it went much less smoothly. They include people working in hospital and community mental health service settings, older people and children's services. The case studies include representation from the three sites (Ayrshire & Arran 5; Lothian 3; Lanarkshire 4), and from clinical (6 Nursing assistants; 2 Allied Health support workers) and non-clinical groups (3 Domestic assistants and 1 Medical laboratory assistant).

2.16 The research team briefed the Local Pilot Coordinators on the range of case studies sought and several potential participants were identified. The research team then contacted HCSWs by telephone or letter to request an interview. Each HCSW was interviewed by telephone, initially soon after recruitment and again some months later towards the end stage of the pilot. At first interview, we requested the HCSW's permission to contact their Workplace Supervisor and this was again confirmed at the second interview. The WPS was not contacted by the research team until after the second HCSW interview and 11 were interviewed (1 HCSW could not be contacted for a second interview). Separate topic guides were developed for HCSWs and WPS and topics included HCSW perceptions of information received, assessment, Code of Conduct and listing; WPS perceptions of preparation, training, support and the learning and assessment process.

- 2.17 In this report, case study material is used to illustrate themes. Given the small number of recruits in some categories, complete individual case studies are not presented to preserve confidentiality.

Surveys of HCSW volunteers, WPS and non-participant HCSWs

- 2.18 A questionnaire survey was sent to all HCSWs who had agreed to take part in the pilot and evaluation, to gain an understanding of their perceptions and experience of the process. A questionnaire survey was also sent to Workplace Supervisors to gain understanding of their experience of training and support received during the pilot and their views on supporting HCSWs through the pilot. A brief questionnaire was sent to all eligible HCSWs who had not taken up the invitation to get involved with the pilot.
- 2.19 The three questionnaires were drawn up in consultation with the NHS QIS Project Steering Group. ScotCen provided survey packs to Local Pilot Coordinators who generated name and address labels and mailed the surveys on our behalf (June-August 2008). Very recent HCSW recruits, who would have had little chance to progress, were excluded. The survey went to all WPS involved at the time. Reminders were issued to participating HCSWs and Workplace Supervisors only, two to three weeks later. The timing of the surveys was determined by the requirement to provide early evidence to the consultative workshop³².
- 2.20 The evaluation team was keen to capture the views of healthcare support workers who opted not to get involved with the pilot. Early on, individual letters offering research interviews were sent to non-participants who had given consent to take part in the research (Lothian). However no-one responded. Later, we set up two 'drop-in' sessions to enable reluctant HCSWs to speak to a researcher, but again there was almost no take up (February 2008 Lothian). Therefore in order to maximise the possibility of returns, we extended the scope of the non-participant survey and issued it to all 2101 eligible HCSWs identified at that point.
- 2.21 All healthcare support workers and workplace supervisors were made aware of the evaluation at local site briefings on the pilot and via the evaluation information leaflet in individual information packs. HCSWs gave signed consent to Local Pilot Coordinators for participation in the pilot and/or evaluation. All mail outs were issued by LPCs. Informed consent was again sought at the start of any HCSW or WPS interview.

Survey Response

- 2.22 Participant response rate ranged from 38% for Workplace Supervisors to 43% for HCSW-participants, a reasonable figure for a self complete postal survey (Table 2.1). The HCSW-participant survey response rates were consistent across the three sites, but the responses to the WPS survey were not. Only a 19% return from Lothian was achieved, suggesting that there was possibly less engagement from that site's WPS at that point. The 12% response rate from

³² The HCSW participant survey was issued to 81% (n=380) of the final 470 HCSWs recruited.

non-participant HCSWs was higher than anticipated with over 240 valid returns. The majority of returns came from the much larger pool of Lothian eligible HCSWs 86% (208) with 10% (25) from Ayrshire & Arran and just nine responses, 4% of the total, from Lanarkshire non-participants.

Table 2.1: Survey response HCSW participant & WPS, non-participant HCSW

		<i>Returns from 3 surveys (June-August 2008)</i>								
		HCSW – Participants			Non-Participant HCSWs			Workplace Supervisors		
Pilot site		Sample	%	(No)	Sample	%	(No)	Sample	%	(No)
Ayrshire & Arran		103	43	44	340	7	25	72	42	30
Lothian		87	45	39	1711	12	208	72	19	14
Lanarkshire		190	43	81	50	18	9	97	49	48
Totals		380	43	164	2101	12	242	241	38	92

2.23 The response from all three surveys represented a reasonable spread across services areas (children's, mental health and older people's services); across worksites (hospital and community based) and across working patterns (full and part-time). There was little feedback from new employees. Full details of survey response rates are provided in Annexe O.

Desk research

2.24 The basic requirement for routine monitoring data was clarified at an early meeting between the ScotCen team, national SWISS lead officer, NHS QIS project officers and pilot site lead officers. Data tracked HCSW participants' progress from recruitment to eventual listing upon SWISS. LPCs forwarded an anonymised, agreed dataset to the National Pilot Coordinator who subsequently forwarded an amalgamated national data set (Excel format) to the evaluation team. It refers to the 470 HCSWs who volunteered to take part in the pilot. Data on the pool (2961) of eligible HCSWs, including participant and non-participant HCSWs is taken direct from the local datasets forwarded to the evaluation team. All monitoring data in this final evaluation report is as available at 31/12/2008.

2.25 NHS QIS conducted a number of Quality Assurance activities throughout the project. The NHS QIS Project Report³³ and associated independent consultant reports³⁴ inform this final evaluation report. The ScotCen team and NHS QIS National Pilot Coordinator worked together to try to avoid duplication and to minimise the evaluation burden upon pilot participants.

2.26 The Scottish Government Health Directorates Professional Adviser to the Pilot regularly forwarded updates from relevant Scottish and 4 Country policy and practice developments. The NPC and LPCs forwarded local and national pilot steering group minutes and updates.

³³ Journey to improvement. Piloting a model of regulation for healthcare support workers regulation in Scotland. Draft Management Report. September 2008. NHS Quality Improvement Scotland.

³⁴ *Organisational development report*. Lifetree Consultants. August 2008;
Internal report on learning and assessment process. Frontline Consultants. September 2008

Consultative workshop

2.27 The SGHD and evaluation team initially planned to hold a consultative workshop (October 2008) on pilot and evaluation findings and to debate policy recommendations. As the national regulation agenda developed, this planned pilot event became the focus of the second day of SGHD's first Regulation Event. A wide range of policy and practice representatives, pilot stakeholders and participants, partnership and service user representation and representatives of patients and the public attended (Chapter 10).

Data management and analysis

2.28 All interviews were digitally recorded and transcribed in full. Transcripts were then summarised for analysis using 'Framework'. Framework, developed by the National Centre for Social Research³⁵, provides a consistent method for organising and condensing qualitative information to enable robust analysis. It facilitates both between case (looking at what different people said on the same issue) and within case (looking at how a person's opinions on one topic relate to their views on another) investigation. A charting 'matrix' of key topics was developed following familiarisation with the transcripts. Every transcript was then summarised under these key themes. These summary charts were then investigated to map the range and diversity of peoples' experiences and views and to explore the reasons for particular opinions.

2.29 Quantitative, questionnaire and monitoring data, was entered into and analysed in SPSS statistical package.

2.30 Verbatim quotations, in italics, are anonymised to protect respondent identity, and are used to illustrate, amplify and clarify findings.

Summary

2.31 The two year evaluation (2007-2008) ran parallel to the pilot and aimed to evaluate its implementation, operation and potential impact. The mixed method approach captured both early process issues and early outcomes. A rich range of perspectives was gained via over fifty stakeholder interviews and three surveys to healthcare support workers (participant and non-participant) and their workplace supervisors. Individual support worker and supervisor case studies illustrated key themes. Local site data was collated to monitor support worker progress from recruitment through to assessment and listing. A final national level, consultative workshop, provided an opportunity for key stakeholders and pilot participants to comment upon the pilot and early evaluation findings.

³⁵ ScotCen's parent organisation

3 IMPLEMENTATION OF THE PILOT

Introduction

- 3.1 This chapter outlines the commissioning of pilot sites by SGHD and describes the participating pilot sites. We explore perceptions of initial guidance and early communication with the Scottish Government. Key findings from the formative stage include perceptions of reasons for early delay in implementation and understandings of key concepts on which the pilot was based ('patient safety and public protection' and the definition of and inclusion of healthcare support workers). The second section sets out the roles of NHS QIS and pilot coordinators and stakeholder views on development of processes and level of resource required for the pilot.

The SGHD invitation to tender

- 3.2 In July 2006 the Scottish Government Health Directorates (SGHD³⁶) issued an invitation to Health Boards to bid³⁷ to be a host site for the national pilot project to test out arrangements for employer-led regulation of healthcare support workers in Scotland. The invitation highlighted the high profile, unprecedented nature of the project, its role in informing future decisions about the regulation of HCSWs and its potential to inform the way forward across the UK. The pilot funding for a 12 month period (January 2007 to January 2008) was to cover three main elements of support: a financial contribution to assist *retrospective* Disclosure Scotland for existing employees; funding for one Local Pilot Coordinator per site; the support of the National Pilot Coordinator based at NHS QIS. The pilot and funding were subsequently extended until the end of December 2008.
- 3.3 The invitation detailed criteria to be met by Boards including: Board level support and partnership arrangements; services for inclusion and healthcare support worker sample; workplace supervision and support; arrangements for data entry to the 'list'; internal data collection and for the external evaluation; contribution to the project process including across Board pilot development. The pilot was to focus on mental health and children's services in particular and SGHD indicated that **all** HCSWs in these service areas were eligible to take part in order to achieve an appropriately sized sample.
- 3.4 Initially, six NHS Boards expressed interest in the pilot. Three Boards subsequently withdrew because it was felt that other priorities (such as Agenda for Change) were more pressing. The three NHS Boards submitting successful bids to SGHD (September 2006) were NHS Ayrshire & Arran, NHS Lothian and NHS Greater Glasgow & Clyde. Ross Hall Hospital, Glasgow, represented the independent healthcare sector and took full part in the pilot but not the

³⁶ Known as the Scottish Executive Health Department at that time

³⁷ *Invitation to Bid: National pilot sites for the regulation of healthcare support workers in Scotland*, (issued 17 July 2006 closed 31 August 2006) Paul Martin, Chief Nursing Office of the Scottish Government Health Directorates (SGHD).

independent evaluation³⁸. NHS Glasgow and Clyde subsequently withdrew (early April 2007) and NHS Lanarkshire later joined the pilot to be the third site (July 2007).

- 3.5 There were multiple factors contributing to NHS Glasgow and Clyde's decision to withdraw from the pilot. The bid was completed at a time of local Health Board reorganisation (March 2006) and consequent restructuring of partnership arrangements. It was a challenge to identify and include all potentially interested parties within the short timescale for the bid. The bid was strongly initiated from within children's services and after discussion with SGHD Mental Health was subsequently brought on board. There was some break in continuity later as the mental health lead officer changed post.

The participating pilot sites

- 3.6 The Local Pilot Coordinators were placed within the practice and development teams for unqualified clinical staff. Ayrshire and Arran had a strong team of three lead officers: Head of Practice Development, Head of Organisational Development, and the Vocational Learning Manager. In Lothian, the project was managed by a Senior Nurse Clinical Support Worker and the lead was the Head of Continuing Professional and Practice Development. The Lanarkshire pilot was managed by the Support Workers Development Manager and overseen by the lead, Associate Director of Practice Development for Nursing, Midwifery and Allied Health Professions. Each participating site had an executive sponsor on the NHS Board and support from the Chief Executive.
- 3.7 The model was piloted in areas with vulnerable client groups. Ayrshire and Arran and Lothian began running the pilot within Children's services and Mental Health services. The Lanarkshire site included the Older People's Directorate and Old Age Psychiatry. At a later date, NHS Lothian expanded recruitment to include Older People's services. Bank services were involved at all three sites.
- 3.8 The original site bids varied in specificity of healthcare support workers (HCSWs) to be included. NHS Ayrshire and Arran, was a relatively small site (500+) and expected the majority of recruits to be nursing assistants, with a lesser emphasis on ancillary staff (catering, portering, domestic, laboratory). NHS Lothian, a much larger site, anticipated a large and diverse sample (1500+), but no detailed breakdown was given at outset. The Lanarkshire site planned to initially focus upon clinical support workers and Bankaide but planned to engage support services at a later stage. At this site, children's services were excluded because most services were community based without eligible HCSWs and there were low numbers of ward based eligible HCSWs.
- 3.9 It was anticipated that these three sites would be sufficiently different in terms of the settings' operations to allow the scheme to be tested in both urban settings (with large, dense populations, busy healthcare settings, and large staff groups) and in rural settings (with dispersed or remote healthcare settings covered by smaller staff teams).

³⁸ Details on Ross Hall involvement and progress with the pilot will be presented to SGHD in the full NHS QIS Project Management Report

Perceptions of the early stages of implementation

- 3.10 The bids from the three initial pilot sites were prepared in parallel to the Consultation on Standards but prior to the Guidance being written. The initial bids varied in terms of level of detail presented, and despite the criteria set out (para 3.3) there was a perception by some respondents within the pilot sites that they had been bidding 'blind'. The Glasgow bid was spearheaded from children's services and took longer to draw in mental health than the other sites. Moreover, partnership arrangements were not clearly specified by Boards in the initial bid. It was probably not a coincidence that the two sites with the most complete bids (Ayrshire and Arran and Lothian) were furthest ahead in the first few months, with Glasgow subsequently withdrawing from the pilot.
- 3.11 The initial focus on mental health and children's services was largely driven by the pragmatic need, at that stage to focus on specific cohorts of workers, but also by NHS QIS's concurrent overall strategic focus on these services. Respondents were largely happy with this focus as these services were expected to provide contrasting experiences, and both covered work in the home. HCSWs within children's services were more likely to have more SVQs, and to have high child protection awareness and to have achieved the standards already. In contrast, it was anticipated that within mental health services, the standards would provide a development opportunity for more HCSWs with a lower level of assessment achievement, and there would be opportunity to explore risk assessment and accountability for junior staff in unsupervised areas.

Guidance and early communications

- 3.12 The following nationally developed documents were produced at the intended points:
- Code of Conduct and Induction Standards for HCSWs; Code of Practice for Employers; the Standards consultation response (published on the web November 2006)
 - Guidance for Employers and Employees in participating NHS Boards (December 2006)
 - Four page generic publicity flyer about the pilot and standards
 - Payroll insert distributed to all NHS employees (February 2007)
- 3.13 Pilot site respondents generally felt that early communication between Boards and SGHD had worked well. They felt they had opportunity to comment on draft standards and guidance although there appeared to have been some communication gaps around distribution of the general publicity flyer which arrived somewhat late to pilot sites. They thought it would have been beneficial to have draft documents at the outset (an assessment outline format plus more guidance on minimum standards) to help inform HCSWs and steering groups at the outset.
- 3.14 Whilst those in the pilot sites were realistic about the pressures of compressed timescales for the HCSW project and about how much pre-pilot activity could have been covered, they still felt some very key issues were not sufficiently

addressed pre-pilot and these continued to surface throughout the pilot. In particular the following were not clear at the outset:

- What the level of co-ordination required from the National Pilot Coordinator and the information and training requirements via the Local Coordinator would be; the level of preparatory work if any already carried out by Boards; time required to train WPS and HCSW
- The induction processes already in place differed for each Board; they appeared clearer for some groups (e.g. nursing assistants) than others (e.g. ancillary staff)
- How the new standards might or should be operationalised and measured was not fully understood or shared
- The anticipated Board self-assessment process needed to be robust to gain confidence in employer-led regulation – and there were concerns for some that the format and consistency of employer-led regulation could affect support.

3.15 The evaluation team's perception was that the main early focus was on the HCSW induction standards and that other elements (Code of Practice and Board self-assessment) were of low profile. The wording of the overall term 'Standards' (for all three elements) and specific term 'induction standards' was not helpful and added to lack of clarity at times.

Delay in implementation

3.16 Many factors contributed to early delays including: withdrawal of Greater Glasgow and Clyde from the pilot, recruitment of National and Local Pilot Coordinators, slowness in establishing the national and local steering groups and pilot communication structures.

3.17 The appointment of the National and Local Coordinators was problematic from the start. The first National Coordinator due to commence early October 2006, with a view to getting underpinning processes underway, actually took up post two months late at the end of November (she was subsequently absent from post for some months). A second NPC was seconded on a two day per week basis from May 2007 and took up post four days per week from September 2007.

3.18 There were differing views, between SGHD, Boards and NHS QIS about the appropriate band level for both NPC and LPC posts and between Boards and NHS QIS about the recruitment approach for LPC posts. The original proposal was for central NHS QIS recruitment and management of the LPC posts but there were concerns from Boards about the perceived low banding of the NPC post, by NHS QIS, which in turn had implications for banding of LPC posts. There was also concern that the whole process was too rushed and driven from the centre. The pilot Boards decided to take over recruitment and management responsibilities locally. The initial delay caused by differences about banding and recruitment reflect the need for a shared approach to evaluation of posts for projects with both a national and local dimension.

- 3.19 Dispute over banding delayed local Coordinator appointments by at least four months. The Lothian LPC took up post, one day per week from April 2007 then four days per week from June. The Ayrshire and Arran LPC began late May 2007. The Lanarkshire LPC, recruited late August 2007, began late 2007. (The first Lothian LPC moved post in April 2008, temporary cover was provided over the summer until a replacement LPC could be recruited).
- 3.20 The NHS QIS National Steering Group first met late April 2007 after two postponed meetings. It took some time to achieve full membership, with a Disclosure Scotland representative added after the first meeting and difficulty in securing a Human Resources Director. Considerable focus at initial meetings was on revision and sign off of project management documentation (e.g. the Project Initiation Document, Communication Strategy).
- 3.21 Although the NHS QIS lead officer had met with site lead officers separately, there was minimal cross Board communication until the National Management group (NPC and three LPCs) first met some four months into the pilot. The continued absence of the first NPC led to delay in a number of areas including clarification of what was already available at Boards, completion of the project plan and timescale and direction of the assessment framework. However, once the new NPC and LPC staff were in post, the pilot quickly picked up momentum. The NHS QIS project administrator appointed mid March 2007 worked part-time initially until the second NPC began to drive the project forward.
- 3.22 The first two local site steering groups were in place from late February: Ayrshire and Arran were furthest ahead and put a paper to the local Partnership Group in mid February. All three groups had a bank staff manager; Ayrshire and Arran and Lothian had input from Facilities managers.
- 3.23 It soon became clear that the proposed twelve month timescale was insufficient. There was consensus that a year of fully operational working was required once the Local Coordinators were in post and the first HCSWs were recruited (September 2007 - September 2008). Therefore SGHD extended the pilot by one year to end of December 2008³⁹.
- 3.24 This was in recognition of the delay in NPC and LPC starts. It was also recognised that LPCs faced a huge initial task in negotiating with Partnerships, and the clarification of existing induction and development arrangements. Once in post LPCs required time to engage HCSWs and individually gain consent. More time was required to clarify implications for both existing and new staff, especially in light of variation in Knowledge and Skills Framework implementation. A full year was required to see how HCSWs entered onto the list might be managed longer term; particularly to address any implications about information sharing across Boards. Longer than a year was required to assess whether the standards could be met and whether any changes to standards might be required.

³⁹ This was discussed at the 4 Country Steering Group April 2007 and formalised at the NHS QIS National Project Group 24/04/07.

Early perceptions of core concepts

3.25 The evaluation found that, in the formative stage of the pilot, there was great variation in understanding of and focus on key concepts underpinning the pilot and that these differences had potential to impact upon the way the pilot developed.

‘patient safety’ & ‘public protection’

3.26 The terms ‘patient safety’ and ‘public protection’ were seen as a ‘given’ in documentation but, in fact, were inconsistently described, presented or emphasised by stakeholders and key informants. Focus varied between:

- top-down, possibly heavy-handed focus on protection - “bad” practitioners or individuals & protection from serious injury or death (e.g. Soham, Shipman)
- safety and protection defined in terms of ‘absence of harm’
- more positive focus in terms of overall improvements in the confidence and quality of practitioners and the work they undertake

3.27 This suggested that there may be a need for greater clarity and consistency in any documentation underpinning any future roll-out.

Definition of ‘healthcare support worker’

3.28 There was a wide range of opinions about the healthcare support worker definition. At the outset, there was general consensus about including clinical support workers (nursing assistants & assistants to allied health professionals). There was far less clarity about including categories of worker who might not have direct contact with patients in ways that might overtly affect patient care (laboratory, ancillary staff, unqualified technical staff, catering staff, pharmacy assistants, and mortuary attendants).

3.29 Some advocated that the pilot should take a more focused approach and only include those working in areas where they had a direct involvement in patient care. Others supported a more inclusive approach, to include anyone who:

- supports professionals or assists in the delivery of care
- has direct contact or a direct role with potential impact upon patient
- has prolonged and particularly unsupervised contact with patients
- simply works in a healthcare setting and has potential access to patients

3.30 The early lack of consensus raised questions as to how the pilot might be implemented. The 4 Country Steering Group (April 2007) confirmed that in order to sufficiently explore and test the proposed model, all listed groups were to be included. There were also concerns as to whether specific categories of worker would perceive themselves as HCSWs and if not, whether that would affect whether they registered for the pilot.

Partnership, HCSW and patient/public representation to the pilot

Partnership involvement

- 3.31 Establishing Partnership support has been an integral part of the healthcare support worker project from the start. The evaluation has obtained opinions from partnership representatives at national and local level. UNISON is the main union which represents the largest number and a diverse range of healthcare staff across all disciplines in the health service. It seeks to present a global view on the issues and is represented on area and local Health Board Partnership Forums (management, trade unions and user groups).
- 3.32 Changes in UNISON representation on the 4 Country Steering Group at that time resulted in a lack of UNISON input to the Standards consultation document, although the union was able to issue written comments on the Standards consultation document at the same time as other agencies. A subsequent meeting was held between the SGHD adviser, 4 Country Steering Group lay chair and UNISON Scotland representatives to exchange information and views (February 2007), and after further discussion of key areas UNISON made clear its intention for continued involvement with the pilot. However, it was noted that UNISON Scotland has no jurisdiction over local branch activities.
- 3.33 Since then, UNISON Scotland has had active involvement on the 4 Country Steering Group to the pilot. The NHS QIS National Project Steering Group has two invited UNISON representatives and AMICUS representation.
- 3.34 There has also been active partnership representation and involvement at all local steering groups. Participating sites have provided Partnership groups with regular update reports. In particular, Partnership representatives have had direct input to: development of the pilots' documentation (information pack, assessment papers); examining the standards links with KSF; and the consultative workshop. Local representatives have actively supported the recruitment process and encouraged managers to facilitate HCSW attendance at HCSW information sessions. In Lothian, the Employee Director, joint chair of the partnership forum was a key member of the steering group and the local UNISON representative worked jointly with the LPC to deliver briefing sessions and promoted the pilot at wards where HCSWs had not been able to come to meetings.
- 3.35 Local partnership representatives fully supported the development opportunity. They had received largely positive feedback from support workers taking part. Their feedback also indicated that the learning and assessment burden for the HCSW and WPS was not found to be excessive by participants. Staff had indicated some potential for the induction standards to fit with KSF. It is worth noting that Union representatives had not had any individual cases or concerns concerning the pilot brought to them and this was confirmed by the evaluation surveys.
- 3.36 The key concerns from UNISON have remained constant since the first consultation on regulation: that the burden of any potential cost for future

regulation does not fall upon this relatively low paid group of workers; that the 'employer-led' model does not disadvantage workers in any way via the potential conflict of interest felt to be inherent in the employer taking on a regulator role. Partnership representatives would wish to continue to be involved in considering further options post pilot and in moving towards national implementation.

HCSW and patient/public representation

3.37 A Public Partner (lay representative) sat on the 4 Country and NHS QIS National Project Group and two Public Partners took part in the peer-review site visits (Section 8.30).

3.38 It was agreed (NHS QIS National Project Group, May 07) that local sites should invite HCSW representation onto their local steering groups. However this did not prove so easy in practice and Lothian and Lanarkshire were most successful in getting this representation. There was however HCSW and WPS representation to several NHS QIS National Management Groups and the 4 Country Group, and a good number attended the consultative workshop.

Development of the pilot

NHS QIS and the National and Local Pilot Coordinator roles

3.39 The SGHD commissioned NHS Quality Improvement Scotland (NHS QIS), which has responsibility for clinical governance and patient safety across Scotland, to coordinate and manage the operation of the pilot. NHS QIS aimed to assist implementation of the three elements of the standards within the participating pilot sites and to capture learning from the experience, and the strengths and challenges of putting the standards into practice.

3.40 The key NHS QIS objectives were to:

- demonstrate compliance with all three elements of the national standards
- consider how pilot requirements interact with existing HR and governance arrangements
- develop and test systems for HCSWs achieving the standards to be entered upon an 'occupational list'⁴⁰

3.41 Two tools were developed to achieve these aims:

- An assessment toolkit to demonstrate HCSW achievement of the public protection standards (Chapter 4)
- A self-assessment framework for employers to demonstrate compliance with the Code of Practice for Employers (Chapter 8)

⁴⁰ During the pilot QIS developed processes and tested systems for an HCSW achieving the standards to be entered upon an 'occupational list'; however such a 'list' was only for the purposes of the pilot and only to last for the duration of the pilot

- 3.42 The NPC role was to co-ordinate, support and project manage the pilot through to completion. This included a wide range of tasks including project management; supporting local steering groups and coordinating the three LPCs; developing systems, processes and documentation and the above assessment materials; ensuring internal and external communication about the pilot.
- 3.43 The 4 Country Steering Group, serviced by SGHD, continued to maintain national level oversight of the pilot, and received reports from both NHS QIS and the independent evaluation team throughout the pilot. To support the pilot, NHS QIS developed a full management infrastructure (Annexe L,M). Initially the NHS QIS National Project Steering Group was formed, meeting bi-monthly. The National Management group comprising the National Pilot Coordinator and three Local Pilot Coordinators met monthly. Comprehensive pilot documentation was developed, to steer and control the pilot process and quality, including: a Project Initiation Document (further refined from the initial SGHD draft coming from the National (Scotland) Group); a national project plan; a local project plan for each site; a national communications strategy and a national risk register.
- 3.44 The NPC also set up a number of processes to assure quality and aid in capture of project learning (Chapter 9).
- External quality assurance of the induction standards learning and assessment process
 - External consultant advice re organisational development (OD) issues
 - Internal pilot reporting system
 - Local pilot site monitoring data
- 3.45 The role of the Local Pilot Coordinators was to manage the pilot locally on a day to day basis, to be in close communication with the NPC, and to facilitate achievement of pilot objectives. In the early months, the LPCs at the first two sites worked with the NPC to develop recruitment processes (Chapter 6, Annexe I) and other underpinning pilot processes (Chapter 4, Annexe I):
- Training and support of workplace supervisors
 - Development of learning and assessment materials
 - Exploring the fit with the Knowledge and Skills Framework
 - Disclosure Scotland arrangements
 - Setting up the occupational list on SWISS

Stakeholder views on pilot processes

- 3.46 The NHS QIS role was both to implement the standards and to devise ways of testing compliance with them. This role was a difficult one, requiring a fine balance between 'governance' and 'support' roles and as the central agency they endeavoured to ensure consistency of messages between Boards, NHS QIS and SGHD. Sometimes communication was more difficult as there were three Boards with different cultures and ways of working, and at times particular Boards had strong views about how they wished to approach certain aspects

(e.g. obtaining consent for Disclosure Scotland checks, considering mapping to SVQs).

- 3.47 NHS Board stakeholders welcomed the placement of the NPC within NHS QIS as it was seen to promote messages of quality, patient safety and clinical governance. On the whole Boards found the NHS QIS role very beneficial but found some NHS QIS demands (QA processes, self-assessment, level of internal reporting) to be more burdensome than anticipated. Boards felt some pilot requirements were added as the pilot progressed (inclusion of bank staff at Ayrshire and Arran, refocus on ancillary staff at Lanarkshire, precise testing against KSF outlines).
- 3.48 The pilot work was aided by the high level of enthusiasm and motivation of all pilot implementation staff involved and the effort put into achieving their objectives. The overall structure largely worked well. The teams of site lead officers provided key support to Local Pilot Coordinators. On the whole the National Pilot Coordinator and three Local Pilot Coordinators worked well together as a team with complementary skills and experience. Early pilot sites sometimes took the lead on developing approaches and materials. Lead officers from Ayrshire and Arran also contributed substantial time to the development of learning and assessment materials. Site lead officers were particularly keen to have a Certificate to present to participating HCSWs and Workplace Supervisors (section 7.34).
- 3.49 NHS QIS provided specialist knowledge in project planning and development of documentation; other NHS QIS staff also gave considerable input to development of assessment tools. NHS QIS faced a number of challenges. The timescale was short and processes were in fact being developed and piloted simultaneously, the more usual method, for NHS QIS, would be to fully develop then implement and test. The assessment toolkit in particular, may have been more successful, had there been further development time to streamline it, remove duplication and inconsistencies. NHS QIS was charged with working with the standards as developed and already published by SGHD. There was, therefore, no scope to amend any wording or format of the induction standards and Codes. These documents had been designed, by SGHD, to stand alone and to serve different purposes. NHS QIS found the differences between the induction standards, Code of Conduct and Code of Practice, which had not been developed with specific measurement formats in mind, then made it difficult to develop approaches for measuring compliance. The first approach to developing a Board self-assessment tool, in line with Clinical Governance and Risk management as stated in Guidance, had to be abandoned as the standards did not lend themselves to being measured with a detailed tool.
- 3.50 From August 2007, the primary and continuing focus was on the identification and recruitment of HCSWs to the pilot (Chapter 6). Implementation of the pilot required a high level of marketing and negotiation skills because of its voluntary nature. In comparison with the implementation of mandatory frameworks it required a different approach to encouraging staff to take part; neither managers nor HCSWs could be 'press-ganged' to be involved. This took up the majority of LPC time and in hindsight, the LPCs felt they should have refocused attention sooner towards ensuring HCSWs got through the stages of

assessment (Chapter 7). The coordination of the Board self-assessment document and the peer review visit process also demanded a lot of their time (Chapter 8). Facilitating the external consultant meetings with HCSWs and WPS was an additional and unanticipated task (section 9.3).

- 3.51 All LPCs felt their role was seriously hampered by lack of adequate administrative support⁴¹. On the whole, LPCs had to manage all administrative tasks themselves, including all mail outs, organisation of briefings, preparation of all materials, and assessment papers, collation into packs, all photocopying etc. Very limited support was provided from the base teams in Lothian and Ayrshire and Arran but none was available in Lanarkshire. Had administrative resource been available then more LPC time could have been spent upon progress chasing of individual HCSWs to ensure completion of the process.

Pilot sites future plans

- 3.52 All three pilot Boards already strongly supported the clinical support worker role with training and development opportunities and they found that the pilot complemented this. The three sites varied in plans for continuation of the pilot processes. Ayrshire & Arran and Lothian intended to support the final recruits into January 2008 to complete assessment. However Lanarkshire faced resource issues concerning the 100 who had yet to begin the observation stage.
- 3.53 All three sites planned to continue development of HCSWs. In Lothian the new LPC post had been extended by a year to facilitate this, but there were no future decisions on incorporating the pilot standards. There were considerable resource implications for supporting the pilot components. Ayrshire and Arran had presented options for adopting elements of the standards to senior clinical managers and had strong expectation the standards would be used to some degree alongside other initiatives to develop HCSWs. Lanarkshire hoped to continue using the induction standards as a tool for induction (and specifically with Bankaide staff) but this required further work, and they hoped to use the standards to inform PDP and KSF reviews.
- 3.54 The pilot sites intended to consider the final NHS QIS Code of Practice compliance monitoring report but did not have any specific plans to take forward any of the issues raised until the pilot outcomes were published.

Stakeholder views on resources to support implementation

- 3.55 Many respondents expressed concern as to how well the model might work once it went beyond being a pilot. There were concerns that Boards' efforts might be less focused and that the whole process might take more time across a wider range of HCSWs, and across all services and new and existing employees. It was felt that the current HCSW pilot volunteers were long serving employees, probably the most enthusiastic and motivated, able and better

⁴¹ The original SGHD invitation to bid offered funding for the LPC post only and retrospective Disclosure Scotland checks only; it was implicit that Boards would provide any administrative support required.

qualified (many with SVQs). The current Workplace Supervisors were also likely to be the most motivated. It could be anticipated that newer staff and less motivated existing staff might take longer to achieve the standards. A variety of implementation approaches might be required to suit different groups of workers (e.g. new or existing staff; with or without SVQs). Lothian's experience, where it was a challenge to attract and support existing staff through the process, suggests that the resource implications may be more significant for larger Health Boards across multiple service areas with large numbers of new staff.

- 3.56 Boards felt they faced significant additional costs not covered by the SGHD pilot funding. The overall level of human resource entailed by the pilot was not apparent at the outset. Sites felt they contributed at least 20% of the site lead officer's time for day to day pilot business and one site funded the Local Pilot Coordinator at a higher band. All sites relied on the great flexibility and commitment of individual Local Pilot Coordinators to cover night and weekend staff and administrative tasks. Sites also resourced time for Workplace Supervisor training and assessment (particularly costly in relation to bank and night staff); staff side representation at meetings and briefings; steering group membership attendance. There were also substantial materials and communications costs: photocopying all paperwork, preparing packs, provision of folders, postage, and the cost of any administrative support provided by host teams. However it should be noted that an SGHD offer of funding allocated for DS checks, but not spent due to slow recruitment, was not taken up by Boards.

Summary

- 3.57 The SGHD July 2006 'invitation to bid' set out criteria to be met by Health Boards interested in hosting the pilot to test out arrangements for the employer-led regulation of healthcare support workers in Scotland. Three Boards were successful, NHS Ayrshire and Arran, NHS Lothian, NHS Glasgow and Clyde (withdrawn April 2007) and NHS Lanarkshire joined later (July 2007). The pilot was run across Mental Health, Children's and Older People's services and across a wide variety of settings. There was early shared consensus on including clinical support workers in the pilot but less clarity about non-clinical support workers.
- 3.58 The pilot was extended by one year in recognition of the size of the pilot task and following early delay caused by multiple factors. The National and Local Pilot Coordinators worked well together to devise, implement and test a range of tools and processes to monitor individual HCSW and NHS Board compliance with the standards. All three pilot sites supported the principle of continued development of HCSWs but felt additional resource may be required to support full implementation of the tested standards in future. Partnership representatives were involved throughout and fully supported the aims of the pilot.

4 DEVELOPMENT OF PILOT PROCESSES

Introduction

- 4.1 This chapter outlines how key pilot processes and underpinning structures were put in place by NHS QIS and the pilot sites including: the preparation of Workplace Supervisors; the learning and assessment materials and process; the fit with KSF and local induction and training initiatives; the Disclosure Scotland application process; arrangements for the occupational list. We present the views of workplace supervisors on training and support received plus the perspectives of key stakeholders on development of all process. Further detailed description of processes can be found in Annexe I.

WPS training and support

- 4.2 The evaluation aimed to assess the initial training required for workplace supervisors (WPS) and how onerous the process of supervising HCSWs through the process was for them.
- 4.3 The centrality of the Workplace Supervisor role became more apparent as the pilot progressed. Sites felt pre-pilot planning had failed to fully address issues relating to the WPS role, particularly resource implications and what might motivate them to be involved. The role is set out in the Guidance⁴² but implications not fully addressed included: was participation 'voluntary' for WPS, what were the motivators; would the WPS role fit with their existing role, how much of their time was required and what was required to support them through the pilot?
- 4.4 The identification and engagement of workplace supervisors proved far more difficult for the first two sites than anticipated and flexibility in training approach and delivery proved essential. Stakeholders and WPS felt supervising HCSWs through the process was not particularly onerous, but there were sometimes great difficulties in WPS and HCSW successfully linking up to start and complete assessment.
- 4.5 Pilot stakeholders reported that in practice, there were many potential barriers to identifying and securing WPS engagement with the pilot. For a WPS to take an active part in the pilot they had to be both released to take part and motivated to be involved. Managers were not always willing to release WPS from busy wards for an unspecified amount of time for training and to undertake assessment of HCSWs. The timing of HCSW consent, WPS identification and training varied in practice across sites and over time and this would appear to be related both to the size of the pool of eligible HCSWs and to the local pilot style. Focused recruitment of HCSWs at Lanarkshire (Chapter 6) aided engagement of WPS and their release by managers and a large group training approach worked. The other two sites found there was no simple system in place for identification of WPS and training had to be very flexible, and resource intensive, to accommodate diverse WPS work patterns.

⁴² The Guidance for Participating NHS Boards (Annexe F)

- 4.6 The Guidance intended that an individual's KSF reviewer would also be the pilot WPS; but during the time of the pilot, KSF was not yet fully implemented (section 4.57). Although the WPS role could be seen as integral to a supervisor's normal role, including induction and monitoring staff, some already very busy staff (or their managers) were not keen that they take on what was an additional and, in some cases, very substantial extra task.

Table 4.1 Number of Workplace Supervisors

<i>Source: LPCs (as at 30/09/08)</i>	
Pilot site	Number of Workplace Supervisors Trained
	No.
NHS Ayrshire & Arran	76
NHS Lothian	51
NHS Lanarkshire	100
<i>Totals</i>	<i>227</i>

- 4.7 By the end of September 2008 a total 227 WPS were trained (Table 4.1) an approximate ratio of 1 WPS: 2 HCSW for the final 470 HCSW volunteers, (or approximately 1 WPS: 1 HCSW for those HCSWs attending an initial meeting with their supervisor).
- 4.8 At the outset pilot management and the pilot sites agreed that the SQA⁴³ model of approximately 1 WPS to 3 HCSWs would be about right. In places, with some clinical staff groups this looked like it might be possible. However for non-clinical groups this was much more problematic. At one site the low ratio of supervisors to domestic support staff proved to be a serious obstacle (5 managers for 99 domestic staff). Only 3 managers were available to assess the 21 recruited domestics. It was agreed to tackle this on a phased basis but this would mean that it would take a long time to progress all the domestic recruits. Other non-clinical groups (catering, portering and laboratory services) also faced this same low WPS: high HCSW ratio issue.
- 4.9 Once the WPS had been enabled to undertake the task their level of enthusiasm was very important to securing recruitment of HCSWs. Local Pilot Coordinators reported that a really motivated charge nurse could bring in a whole ward of HCSWs and ensure the process was followed through (e.g. one Lothian hospital sent 17 WPS for 34 HCSWs over 3 training sessions).
- 4.10 There was a wide range of WPS experience of regulation culture and experience of formal assessment, using and recording of evidence. As anticipated at the outset, clinical supervisors/assessors were more familiar with the mentoring/supervisory role than some support services supervisors. Within some ancillary staff groups (catering, domestic service, portering) the supervisors themselves are not regulated and stakeholders felt they may be less likely to see the potential benefits for their HCSWs. For some it was entirely new and for others there was considerable overlap with work already done (e.g. SVQ or Domestic Workbook assessment). Some support services

⁴³ Scottish Qualifications Authority <http://www.sqa.org.uk>

staff took longer to get to grips with the handbooks and the concepts of assessment and evidence.

- 4.11 It was initially envisaged that a half-day training session would be sufficient to inform the WPS role. In practice there was considerable variation in content and delivery across sites, over time and across groups of staff. The training package appeared to develop over the life of the pilot, and simpler training materials were found to make the pilot more accessible for support staff. Within all sites, there was a view that it was not efficient to train too many managers in advance of HCSWs being recruited as there would be too long a gap before they could start assessment work.
- 4.12 From evaluation observation of training sessions the WPS attendees appeared generally in favour of the pilot but raised a number of questions. These, for example, related to what to write for assessment evidence, queries about paperwork, fears about potential HCSW fees, how HCSW circumstances might change (pay, conditions, further training opportunities), what the ratio of WPS to HCSW would be, what was the SWISS database. One group of WPS supported HCSW development but were sceptical because they found that in practice their own training requirements, as identified in Personal Development Planning, were not actioned.
- 4.13 There was clear pilot stakeholder feeling that further work needed to be done to assist supervisors who did not normally do that kind of assessment (e.g. some support services staff) to develop the required skills. Lead officers from at least one participating pilot Health Board were clear that their Workplace Supervisors should have at least a basic level of assessment experience and preferably a relevant SVQ before undertaking the WPS role. From evaluation observation, the WPS training pack included handouts as memory aides on assessment skills, but this element was only very briefly touched on during training.
- 4.14 The evaluation case studies, questionnaires and the NHS QIS review of completed assessment materials all indicated that more needed to be done to ensure that Workplace Supervisors were clear about what might constitute evidence for a standard and what needed to be recorded.
- 4.15 The evaluation's WPS survey results below indicate that the majority of WPS were willing volunteers. They were motivated by aiding HCSWs and patients and by career development. They were very supportive of the pilot aims but felt the induction standards were best aimed at new starts. However they had concerns about the time commitment required of them, fitting the task into already busy jobs was an issue and only half felt sufficiently supported with this. Half felt 1 to 2 HCSWs to supervise was the right level and this suggested that the envisaged 1 WPS to 3 HCSW ratio was overly optimistic.
- 4.16 The evaluation found that in future the WPS role would require much further development and considerably more resource to cover WPS training and assessment time. The use of 'own time' for preparation found in pilot needs to be acknowledged. The support of middle managers is essential and consideration needs to be given to how best to meet the needs of low WPS: high HCSW ratio groups. Stakeholder suggestions include using peripatetic

assessors or additional supervisors or a 'mentor' similar to those in place for student nurses. A 'mentor' would take overall responsibility for the HCSW but not necessarily assess every element (this might assist in situations where ward qualified nursing staff did not take responsibility for bank staff).

4.17 Areas to be further explored include:

- flexible approaches to meet diverse work groups and work patterns
- motivators for WPS across a more diverse range of staff groups
- preparatory work on the principles of regulation, evidence and assessment for workgroups where this is not already part of the culture
- Disclosure Scotland clearance for potential supervisors without this already
- review of WPS training materials to develop a consistent and comprehensive package; materials need to be fully accessible and delivery needs to meet needs of all work patterns
- the potential for e-KSF to make explicit the WPS/HCSW link

The views of Workplace Supervisors

Table 4.2 Workplace Supervisor survey response

		<i>WPS survey (July-August 2008)</i>				
		Survey sample and response rate by pilot site			Percentage of WPS returns by pilot site	
Pilot site		Sample	%	(No)	%	(No)
Ayrshire & Arran		72	42	30	33	30
Lothian		72	19	14	15	14
Lanarkshire		97	49	48	52	48
Totals		241	38	92	100	92

4.18 Workplace Supervisors' (WPS) views were gathered by the evaluation team via the WPS survey and the case studies. The WPS survey had a 38% (92) response rate⁴⁴. Ayrshire and Arran (42%) and Lanarkshire (49%) had similar response rates, but the relatively smaller response from Lothian (19%) suggests possibly less engagement from WPS at this site (Table 4.2). The returns were biased towards those working in older people's services and these came mostly from Lanarkshire (Table 0.10). There were responses from both hospital and community settings, including those working in patients' homes. Over half the responses were from nursing (57%, 51) and allied health (38%, 34) plus 4 domestic and 1 laboratory staff (Table 0.8). Most supervisors were on bands 5-7 and already carried out a formal assessment role (79%, 68).

4.19 Most supervisors first heard of the pilot from their line manager (84%, 77) and this was true for 90% (43) from Lanarkshire (Table 0.16).

4.20 Two-thirds (67%, 60) felt that it was their own decision or a shared decision with their line manager to take part in the pilot and the remaining third (33%, 30) thought it was a decision made more by their line manager or a senior

⁴⁴ The survey was issued to more HCSWs in June-August than were in place at the end of September 2008. The discrepancy appears to lie at the Lothian site, it may be that potential WPS did not actually become engaged with the pilot; alternatively it was an administrative error.

manager. A larger proportion felt it was their own decision in Ayrshire & Arran (79%, 23) than Lanarkshire (62%, 29). Overall most supervisors (63%, 56) were clear they wanted to take part.

- 4.21 A quarter (26%, 24) had no concerns before starting the pilot (Table 0.17). The main concerns were that there 'might be too much work' (48%), too busy at work' (47%) or 'might get too many HCSWs to supervise at one time' (16%) or personal commitments (9%) (Table 0.18).
- 4.22 The main motivator for taking part in the pilot was 'to help the HCSWs in my ward/unit' (71%) followed by 'to improve patient safety and public protection' (50%); 'learning new things' or 'a development /career opportunity' were equally important (29%) and 'having my say' a reason for fewer people (16%) (Table 0.19).
- 4.23 The survey confirmed the variety of training formats delivered. In Ayrshire & Arran more had attended a small group session of 3-6 participants (60%) and 5 had had an individual or paired session. In Lanarkshire more (58%) attended a larger group session of 7 or more participants. Training sessions were generally a half day but some Lothian (10) and some Ayrshire supervisors (14) noted shorter 2 hour sessions (including at least 2 night shift and 3 weekend workers).
- 4.24 Most supervisors (89%, 81) found the training about the right length and that it gave them all the information they needed (63%, 57). However half (52%, 48) felt they needed to do further preparation after training, and more felt this at Ayrshire and Arran (69%, 20). One in five supervisors undertook further background reading. Preparation included: discussing with a colleague/other WPS (33%, 30); thinking of oral and observation assessment examples (32%, 29). Of those doing further preparation, just 7 supervisors had done all the preparation in their own time, half (53%, 35) did some in their own time and the remainder (37%, 25) did it all in work time. Quite a variety of 'own time' was cited, from a couple of hours to three days. The most common was commonly cited was 1-2 or 3-4 hours, but also 5 hours or one day, several evenings or sessions over the six month period. Just nine supervisors noted that they felt using their own time was 'unreasonable'.
- 4.25 Around half (46%, 42) of the supervisors contacted the LPC for further clarification after initial training. This indicates the need to build in additional supervisor preparation time after the basic training and confirms the need for LPC support. A fifth wanted a three way meeting with their LPC and HCSW to clarify issues to do with evidence of prior achievement (22%, 20) and assessment (29%, 27). In 10 cases LPCs had arranged a three way meeting to clarify assessment issues and in 6 cases this had involved a difference of opinion between the WPS and HCSW. No WPS had found it necessary to contact a Union representative to clarify anything.
- 4.26 Over half of the supervisors (58%) were supervising just one HCSW and a further 37% were supervising 2-3 HCSWs. In their current post, most WPS (82%) felt they could supervise 1 (39%) or 2 (43%) HCSWs through the standards at one time. Just 16% felt they could supervise 3 at one time.

- 4.27 Although most WPS felt supported by their department, line manager and LPC (73-79%) a smaller number felt the Board provided all required support (39%, 36). Only half 50% (46) felt supported to take the time required in their role as WPS and 20% (18) definitely did not feel supported to take the time required (this included representatives from bank, weekend and night shift staff).
- 4.28 Two thirds (57%, 51) did not find it easy to fit the WPS role with their other work and there was some indication that nursing assistants (73%, 37) found it harder to fit and that allied health support staff found it “very” or “fairly easy” (66%, 21). Some (10) wrote comments on the great difficulty in getting the time to complete assessment and paperwork or being able to meet their HCSW (6).

The most difficult part of the pilot was finding the time to carry out the assessments due to differing shifts, sick leave and annual leave. It was difficult to set aside time due to restraints within the ward and ever changing clients.

(Staff Nurse band 5, acute hospital, mental health services, working 12 hour shifts, weekend and nights)

- 4.29 Three-quarters (77%, 69) found the Workplace Supervisor Handbook easy to use or about right but one in five (21%, 19) found it hard to use and felt the paperwork could be amended. The main issues with the materials overall were that there was: too much paperwork, too long, too much duplication, too ‘wordy’, poor correlation between HCSW and WPS handbook, poor signposting to sections and duplication across elements.

- ~ *The handbook is enormous and therefore quite daunting*
- ~ *Far too long and repetitive, difficulty particularly with oral questions*
- ~ *I felt there was a lot of writing to be done*
- ~ *Needs to be simpler*

- 4.30 On the whole supervisors felt the assessment documents would be better for new staff at induction and most (20) written comments related to the HCSWs already working at or above these standards.

Our work is predominantly in schools. Many of the questions appeared to be more relevant to ward settings. Our Healthcare Support Workers have NNEB qualifications and some have degrees. I found the questions too easy and we found ourselves looking at the questions in too much depth.

(Speech and language therapist, band 7, working 9-5 with children in schools)

- 4.31 The survey responses indicated that WPS supported what the pilot was trying to do. Around 84% thought the standards should be in place both for their own HCSWs and for HCSWs in different jobs. Most (92%) thought the standards should be in place across all Health Boards and slightly fewer (83%) also thought the list should be in place (Table 0.21).

Domestics like doing the course. They forgot how much they do day by day, about the standards and how high standards are achieved, how much nurse and domestic work together for all clients needs.

(Hotel services supervisor, mental health services, community based working 8 hour shifts)

The assessment process and materials

- 4.32 The evaluation aimed to identify the processes used to assess achievement of the standards and entry to the list. The pilot developed an assessment toolkit to aid the HCSW in working towards and evidencing achievement of the basic induction standards. A checklist was developed to ensure all required evidence and Disclosure Scotland outcome was in place before the successful HCSW was entered upon the list (section 4.91).

Format of final process and materials

- 4.33 The assessment toolkit developed for the pilot consisted of two handbooks, a Healthcare Support Worker handbook and a parallel Workplace Supervisor Handbook. The two handbooks varied slightly in content (Annexe I). The final HCSW assessment tool had two parts: an observation assessment and an oral assessment. The process was intended to take the following steps. Firstly an initial meeting between HCSW and WPS would be held. This would map out an approach towards achieving the standards and identify any development/learning needs. Evidence of previous achievement would be considered if appropriate. A date for the Observation and Oral assessment elements would be arranged. On completion of the assessment the HCSW would sign the Code of Conduct Declaration and commit to working to the Code at all times in future. Once the Disclosure Scotland outcome was known the HCSW could be entered upon the occupational list and could receive a Certificate of Completion.
- 4.34 The Guidance suggested that the HCSW should achieve the standards within three months and the Handbooks said as many reassessments as required could be undertaken up to six months. If the HCSW still failed to meet the standards, a three way meeting between HCSW and WPS and LPC would be convened to identify any obstacles and/or further learning opportunities. If the standards were still not met then, as stated in the Guidance for Employers and outside the pilot arrangements, the NHS Board would follow existing capability procedures.

Experience of the development process

- 4.35 The pilot management team faced many challenges in developing the assessment materials and process. Assessment was intended to ensure that the HCSW understood the purpose of the public protection standards and had achieved this basic induction level. The formative stage of the evaluation found that there was no shared view as to how the new standards might be operationalised or measured. It was not known what induction processes already in place at each NHS Board might provide evidence of prior achievement. Site lead officers were however quite confident that much

induction material would very likely be useful and that many HCSWs already held SVQs.

- 4.36 The timescale for development was very tight; this was exacerbated by the absence of the first NPC. In addition to the lack of pre-pilot development there were early mixed stakeholder views about the way to approach devising an assessment approach. Using the Home Care Practice Licence Tool (HCPL)⁴⁵ as a starter model both aided and hampered the process. Despite these difficulties, the process moved forward quickly on appointment of the second NPC and was aided by the commitment and contribution of skills from the LPCs and lead officers at the first two pilot sites. The pilot team managed to develop a comprehensive set of working materials, test them with a wide range of staff (Chapter 7) and facilitate a quality assurance exercise (Chapter 9).
- 4.37 Partnership representation to the 4 Country Steering Group (April 2007) underlined the need for a nationally agreed assessment tool to be consistently applied across sites and worker groups. The NHS QIS Project Steering Group confirmed that the assessment process and guidance must be in place prior to recruitment of HCSWs. Members of the assessment working group then felt that there was considerable pressure from SGHD to have the tool developed by the end of May 2007, in order to facilitate a full operational year once HCSWs had been recruited. The finalised first drafts of materials were tabled at the July 2007 meeting, more than six months into the project, and subsequently approved by local steering groups. The handbooks were finally approved and disseminated to pilot sites in August 2007.
- 4.38 The Guidance was clear that NHS QIS had a role in quality assuring processes at participating NHS Boards but was not specific about the development of such processes. Initially there was some expression of tension between the first two participating Boards' desire to approach development of the assessment tool on a local basis and the intended NHS QIS centrally-led approach. SGHD and NHS QIS had already commissioned initial work from Stirling University to undertake a preliminary mapping of the HCPL against the pilot's assessment requirements.
- 4.39 The Home care Practice Licence Tool developed by the Dementia Services Development Centre (DSDC) of Stirling University, is a tool for validating the knowledge, skills and competence of home care workers. The pilot management considered the model to be of potential value for three key reasons. It had already been fully piloted in 2003-2005 across seven different organisations⁴⁶. The HCPL was based upon the Driving Standards Agency model of the UK driving test, consisting of three components: a theory test, a practice observation and oral questions. It was aimed at a comparable worker group, home care workers without a recognised qualification in care, and it was

⁴⁵ Home Care Practice Licence Tool (HCPL), Dementia Service Development Trust, University of Stirling

⁴⁶ *Home Care Practice Licence Tool*. Dementia Service Development Trust, University of Stirling
Cobban, N and Dincarslan, O (2005) *Home Care Practice Licence (HCPL): A pilot project to explore the potential of a test to validate the practice of home care workers in the UK: Report of Pilot Study Findings*, Stirling: .

relevant for both staff who had completed induction and preliminary training and experienced workers. The test could determine the effectiveness of induction training, skills gaps and training needs, and in addition to validating competence, would encourage workers towards further development. It had also been proved suitable across a variety of work patterns, validating the practice of those not able to participate in higher level qualifications for a variety of reasons (e.g. working short part-time hours, approaching retirement).

- 4.40 A working group⁴⁷ was set up (LPCs and some site lead officers, NPC, NHS QIS, the KSF national lead and the HCPL team) to progress development. The initial mapping indicated some key issues. The HCPL model differed in cultural tone and style from the standards and applied to a single rather than diverse group of workers. Importantly it focused more on service user outcomes rather than organisational and employee responsibilities. There were also questions about using all three elements of the HCPL model. Whilst there was support for the practice observation and oral assessment elements, there were very varied views about the applicability of using a written test.
- 4.41 Members of the working group felt the work was hampered by several factors. The absence of the first NPC hampered early communication and planning with DSDC and slowed progress. The group had to await appointment of the LPCs and their contribution of a more detailed health perspective. The new NPC, with authority to steer decisions then quickly moved the process along. Energy was spent in attempting to adapt the HCPL multiple choice test element with its associated handbook (i.e. generating test questions and example right and wrong answers for HCSWs). Time was also lost in the exercise of mapping the existing HCPL questions to the HCSW induction standards for the observation and oral assessment elements (i.e. adapting the HCPL tool rather than focussing upon what was required to measure the HCSW induction standards as already published). Early drafts of materials failed to capture all the information required in the standards.
- 4.42 There were differing views about the appropriateness of a written test for HCSWs, given the wide range of literacy levels across groups (Annexe J). The SGHD view that it had always been clear that a written test was not to be included was not apparent to the assessment working group and this was confirmed at the May NHS QIS National Project Group. However there were some remaining differences of opinion about the removal of the written test element from the assessment. There was a general understanding that a written 'test' might have been off putting for some HCSWs with relatively low literacy skills. The NHS QIS Project Group decision was that a test, with a pass/fail mark, was inappropriate for the very wide range of HCSWs and out of step with the more usual NHS model focusing upon workplace learning and development. However others felt that HCSWs would have easily been able to undertake the simple test of straightforward common sense questions just as thousands are able to undertake the theory element of the driving test. One

⁴⁷ The assessment working group held several meetings (2 May, 22 May, 13 June, 20 June). Ayrshire & Arran Ayrshire contributed LPC and Vocational Manager time, Lothian contributed LPC time. The KSF lead officer attended the first meeting only. The new NPC participated from the third meeting and Ross Hall from the fourth.

view was that, had an objective electronic test been used, there might have been opportunity to obtain easily comparable measures across Health Boards, but such a system would carry resource implications.

- 4.43 The working group found that varied possible interpretations of the standards caused difficulties when creating assessment materials. It was not always clear what standards meant, why there was repetition across standards and performance criteria and what might be expected or appropriate in terms of evidence. As the purpose of the pilot was to test the standards as published; there was no scope for reformatting or rewording the standards, which had already been consulted upon.
- 4.44 The working group developed oral and assessment materials to fit the HCSW standards and criteria. It became clear that certain observation criteria would be difficult to evidence in practice and these would be better covered by the oral assessment (Standard (S)5: reporting incidents at work; (S)6: working within confidentiality guidelines; (S)14 whistle blowing in cases of harm and abuse). The oral assessment paper was generated from a database of 105 questions designed to cover all the standards performance assessment criteria. The working group confirmed that all 25 observation criteria and 30 oral questions were to be satisfactorily met to indicate the HCSW had a minimum threshold of knowledge and could carry out a particular role safely.
- 4.45 Finally, the National Management Group considered the Code of Conduct and decided that assessment of the HCSW's understanding of the Code was not appropriate; any testing would necessarily be subjective as the Code provides guidance on appropriate behaviour. A mapping of the code to the induction standards indicated that if the latter were achieved then the HCSW would be working to standard *and* the Code of Conduct. Therefore a Code of Conduct Declaration form was developed for the HCSW to sign on completion of the observation and oral assessment, and to agree to work to at all time throughout their working career.
- 4.46 NHS Education for Scotland (NES) reviewed the final handbook drafts for their appropriateness for learning. A small number of minor amendments were subsequently made to improve print layout and accessibility, to use Plain English; to make a few oral questions more explicit and the wording of observation criteria more consistent. NES suggestions towards a more elaborate professional print job were not followed at this stage due to pilot budget constraints but might be appropriate if further roll-out is pursued.
- 4.47 A complaints and appeals procedure (available in the HCSW handbook and separate from any already in place at pilot sites) was designed by NHS QIS to ensure all HCSWs being assessed during the pilot had opportunity to raise any concerns connected with the process and appeal any assessment decision. As no complaints have been made this has not been tested during the pilot.

Stakeholder views of the final materials

- 4.48 At the end of the pilot there was general consensus that a single approach across sites provided greater consistency within an employer-led model, but

there was some expression that having used a single approach did not allow the testing of whether this was the right assessment approach or whether other approaches might have worked better.

- 4.49 Pilot site stakeholders felt that HCSWs were generally positive about the process and that it had been well received by participating HCSWs, that it had given them opportunity to consider their own development and had boosted their confidence.
- 4.50 All those involved in developing the tool kit were largely happy with the end result given the short amount of time to develop it. However, by the end of the pilot it was clear that there was still a lot of work to be done. The two handbook format had been based upon the HCPL guidance model. After testing it in practice it was apparent that stakeholders felt there was much duplication across the handbooks and across guidance and assessment papers within the handbooks. The ring binder formats were helpful, offering HCSWs a chance to take ownership and add their own supporting materials and evidence. However it all needed to be streamlined and repackaged, probably to one single simpler set of materials so that it appeared less cumbersome and off-putting to both HCSWs and WPS. There were many reports from stakeholders and the evaluation surveys and case studies about difficulties of repetition, 'wordiness' and difficult and not easily understood language.
- 4.51 The working group explored drafting lists of key points or sample answers as examples for the oral questions. There was lack of time to develop appropriate examples across a wide spectrum of disciplines and services and respondents were concerned about the potential for examples to be misinterpreted as 'correct answers'. Therefore it was decided this would be better considered in future development.

Fit with other induction and training processes

- 4.52 The assessment development working group and pilot stakeholders had much discussion about how the WPS would assess the accreditation of previous qualification as evidence for the standards, its relevance to the current role and currency of application. No formal mapping of the standards to induction, SVQs or induction was in place at the start of the pilot. Therefore the WPS, in assessing the achievement of standards would be making individual judgements about which elements of previous qualifications might provide evidence for any individual HCSW role.
- 4.53 As anticipated there were multiple induction processes in place at each Board and various combinations of core and more localised induction by area of work. The evaluation found that although some preliminary work had been conducted at sites towards mapping local induction processes against the standards this had yet to be completed. For example, Lothian was originally a national pilot area for an induction programme with online induction modules completed for all staff and initial mapping against the standards indicated some fit but also quite a lot of gaps. The role of induction was examined more formally during the Board self-assessment exercise.

4.54 The 4 Country Steering Group had agreed at an earlier stage that any qualification credit negotiations would come following completion of the pilot (the performance criteria included against each standard statement would enable an SCQF rating to be considered at a later date). Lothian initially used the potential for the standards to contribute to SVQ accreditation as a major selling point to its staff. They had preliminary discussion with Care Scotland and SQA about the potential for the HCSW assessment process to provide credits for VQs but the assessment papers had not been put forward for any formal process of consideration. No formal mapping was undertaken by other sites.

Fit with Knowledge and Skills Framework and Personal Development Planning and Review (PDPR)

4.55 A key aim of the evaluation was to explore whether the process used to demonstrate and document HCSW achievement of the induction standards had potential to be linked to the Knowledge and Skills Framework (KSF)⁴⁸ foundation gateway of Agenda for Change. We also aimed to explore whether there would be any additional burdens entailed by the standards on top of the KSF requirements and whether KSF outlines for HCSW roles could accommodate the national standards being tested.

4.56 The Guidance sets out the intended relationship between the standards and the KSF procedures. The standards are achieved through induction and can be used to support ongoing development within KSF; processes used for collection of evidence should be the same as that used for KSF review; evidence should be gained and documented through the personal development planning and review process (PDPR)⁴⁹; different systems for carrying out PDPR are in place, including KSF. The Code of Practice notes that trained supervisors should provide formal assessments as well as plan for personal development to meet KSF, and employers should consider using e-KSF⁵⁰.

4.57 The evaluation found that the potential burden of the induction standards over and above KSF requirements had not been tested during the pilot. The Guidance pre-supposed that KSF would have been implemented⁵¹ in participating sites and that a KSF outline and PDPR process would be in place for each HCSW. Pilot site stakeholders indicated that KSF roll-out was still at an early stage and was implemented to different degrees across sites, services and groups of workers. Roll-out appeared further ahead at Ayrshire and Arran (but with mainly paper based KSF) than in Lothian; Lanarkshire was reported to be further ahead in training reviewers⁵².

⁴⁸ Knowledge and Skills Framework (KSF) (www.paymodernisation.scot.nhs.uk/afc/ksf/index.htm)

⁴⁹ Personal Development Planning and Review Partnership Information Network (PIN) guideline

⁵⁰ The e-KSF is a web-based toolkit developed to help implement and run the KSF. It is also seen as an important tool for monitoring

⁵¹ The Knowledge and Skills Framework became mandatory in each NHS Board in October 2004

⁵² At pilot sites organisational effort had been focused on assimilation under Agenda for Change; also NHS Ayrshire & Arran's Review of Services and NHS Lanarkshire's Picture of Health review were to

- 4.58 NHS QIS and the KSF lead encouraged pilot sites to try to identify a sample of WPS/HCSW who could illustrate how the two processes might fit together. Stakeholders reported that the local KSF officers' clear priority was on implementation of KSF rather than on the requirement to consider fit with the pilot standards. Pilot sites found it was not easy to identify HCSWs who were doing both processes. Two sites did identify a sample of HCSW volunteers who were new in post or who had recently had a KSF outline assigned, with the aim of exploring whether evidence collection could inform both processes. LPCs also hoped for feedback from other HCSWs, who were further along the KSF process, on if and how evidence collection for induction standards had informed the KSF development review. Neither set of feedback was available to the evaluation team by the end of the pilot. There was some limited anecdotal evidence from WPS feedback forms to suggest that the standards might complement the KSF process.
- 4.59 Local Pilot Coordinators were concerned about the potential burden of organisational effort in running the two processes together, and that WPS might be put off by the potential burden of doing both processes at once. It was felt that already drafted training materials might need to be adjusted to include more specific reference as to how HCSW standards might provide KSF evidence.
- 4.60 Pilot stakeholders found that there were potential difficulties in the 'KSF outlines' accommodating the induction standards as there were some differences in scope. The original KSF lead officer was involved in the review of the standards, post consultation and pre their final publication. Further work did not take place until August 2007 when the KSF lead, NPC and LPCs and a UNISON representative met. They undertook a paper based exercise to map the two together (a detailed report of which will be available in the NHS QIS project report⁵³).
- 4.61 KSF deals with development and application of skills and knowledge within the post. There were concerns as to whether the fourteen public protection statements were accurately cross-referenced to KSF dimensions (Annexe K) and there was some concern about ambiguity in interpretation and duplication across the standards. The induction standards and Employee Code of Conduct also address capability and performance areas – these would need to be dealt with outside the KSF process. Such aspects would definitely not be recorded on e-KSF currently and would therefore need to be recorded separately. These behavioural aspects concern not what an HCSW knows but how they are expected to undertake the task (e.g. safely, maintaining patient dignity, with the correct attitudes and behaviours).
- 4.62 A task for the pilot was to explore how the WPS could differentiate these elements and be clear about what would be recorded for induction and what for

be re-presented following the new administration's decision to review decisions on accident and emergency services 06/06/07

⁵³ This is fully reported in the QIS Project Report

KSF in practice. As we have seen it was not possible to test this with any HCSW and WPS undertaking the assessment process for the pilot.

- 4.63 There were also some issues to do with terminology. KSF refers to 'reviewers' rather than 'workplace supervisors'. Some stakeholders felt that the term 'induction' itself could be problematic to some extent as it is used in many different ways (it could encompass a self-contained two day workshop or continuous assessment over a period of time).
- 4.64 The relative timing of the two processes was also an issue. The first KSF gateway is to be met at twelve months and if the induction standards are to be met at 3-6 months then signing off of this process will need to stand independently. At the consultative workshop questions surfaced about whether the length of time for achievement of the standards should apply to full completion of all the standards only or whether a more differentiated approach was required (e.g. particular standards should be achieved within days or weeks rather than months).
- 4.65 By the end of the pilot NHS QIS anticipated that evidence from achievement of the induction standards would help to inform the interim and final foundation KSF reviews and that the completed documentation could be loaded onto e-KSF when it is rolled out across Scotland⁵⁴. The requirements of both the induction standards and KSF were felt to be open to interpretation. Some of the induction standards performance assessment criteria did not easily map across to KSF. Some standards requirements would not be included in all HCSW KSF outlines. Rather than progressing further work on clarifying links between standards and KSF outlines it was felt a more useful way forward would be to use the same skills assessment and evidence collection process to inform both processes. Once the induction standards had been achieved and the evidence had informed a successful foundation gateway review, maintenance of the standards could be evidenced via further KSF reviews.
- 4.66 The potential relationship between the Employee Code of Conduct and the KSF review was still not entirely clear. NHS QIS were suggesting that working to the Code of Conduct should inform the HCSW's KSF personal development plan. However, as we have seen, the Code includes behavioural aspects which cannot easily be monitored under KSF. For example, should an HCSW breach the standard 'Confidentiality' by inappropriately giving out information about patients or treatment this might be a conduct error but not necessarily an illegal act. Such an act would need to be considered under staff governance procedures and may or may not result in dismissal. (The employer may choose to take into account factors such as training received by HCSW, scope of the breach, intentionality, harm caused etc).
- 4.67 During the pilot NHS Boards were working upon developing Gateway/Review policies to outline when issues coming up at a review no longer fell under KSF but needed to move into a management process. Organisations faced a learning curve, there was no national level document but it was anticipated that good practice would be shared via the KSF Leads Network and the Human

⁵⁴ NHS QIS Draft Management Report

Resource Directors Group. It is also not clear at present how such practice will be affected by forthcoming arrangements under vetting and barring procedures under the Protection of Vulnerable Groups (Scotland) Act.

- 4.68 In summary it appeared that the way the induction standards and KSF might work together had not as yet been fully explored. Stakeholders felt there needed to be further exploration of KSF core standards to see if anything in addition to this was required for clinical groups
- 4.69 It was clear that any future adjustment to KSF would need to be undertaken under 4 country KSF and partnership agreement. E-KSF has the facility to upload files of supporting evidence (word documents, scanned certificates); it would be hoped to avoid duplication and any material outside the KSF remit would need to be excluded.

The Disclosure Scotland Application process

- 4.70 The evaluation aimed to assess SCRO capacity to meet pilot demand for 'enhanced' DS criminal record checks and also whether systems were in place to record and deal with previously unknown convictions uncovered through DS checks.
- 4.71 The SGHD Guidance to participating Boards indicated that, before an HCSW could be entered upon the occupational list, the employer must evidence that the HCSW had been safely recruited against the standards set out in the Code of Practice for Employers⁵⁵ including the PIN guidelines. The PIN guideline Safer Pre and Post Employer Checks was published during the course of the pilot (December 2007). It describes the procedure for entry of staff into NHSScotland which must be followed in addition to general recruitment policy.
- 4.72 There are three levels of Disclosure Scotland checks: basic, standard and enhanced. The Guidance indicated that an enhanced check would be required for each HCSW participant, both new and existing employees (whether or not they already had one). However, following advice on the legal requirements governing the disclosure process, this had to be reviewed.
- 4.73 Clarification of the Disclosure Scotland application procedures took up a lot of NPC and LPC time. It became necessary for the SGHD adviser to clarify the situation with Disclosure Scotland in May-June 2007 with a final formal meeting at SGHD (16 August 2007) and it was unfortunate given Disclosure Scotland's long standing involvement with the pilot planning, that such action was required so late on in the pilot. A further meeting between the National Management Group and a representative from Disclosure Scotland (August 2007) further clarified the necessary requirements⁵⁶ and an annotated minute was produced. No other written documentation was produced for the pilot; rather LPCs were referred to the specific sections of the standard DS guidance on the website.

⁵⁵ The Guidance draws attention to the Partnership Information Network (PIN) policies, and also states 'You must have strict recruitment and selection procedures in place and carefully follow Disclosure Scotland www.disclosurescotland.co.uk and other vetting procedures'. (p22)

⁵⁶ An annotated minute of the National Management Group meeting was drawn up

- 4.74 It was now clear that it would not be possible within the law to apply for 'enhanced' for all the kinds of post to be involved in the pilot. Each application should be by individual post and its associated tasks, not by job-group. If the role requires 'direct contact' it would probably require 'enhanced' disclosure, otherwise standard or even basic would be appropriate. A risk assessment was required for each HCSW role to determine the level of contact different types of HCSW have with patients, which then, in turn, determines the level of check to be applied for. The LPCs were advised to check carefully with their own HR department and also with Disclosure Scotland if they were unsure of the appropriate level to apply for.
- 4.75 LPCs had to make several revisions to the pilot documentation and processes: change all document references from 'enhanced disclosure' to 'appropriate level of disclosure' (especially on consent forms); and post out the DS application form separately rather than include it in the standard information pack, as planned.
- 4.76 In order to facilitate tracking of applications, pilot sites assigned two new counter-signatories, whose codes were to be used exclusively for the pilot. These were human resources staff, already knowledgeable about DS processes, but this was time consuming as they had to be reregistered for the pilot.
- 4.77 Each pilot site had an established disclosure process which adhered to local policies for carrying out pre-employment checks. The following process was agreed on for the pilot. A specific part of the pilot consent form was designed to obtain consent to the DS check. On receipt of consent for disclosure the LPC forwarded the DS application form (marked with the correct Disclosure level if possible) and explanatory booklet to the HCSW and the HCSW's manager was required to check the HCSW's identification documents. The completed forms were to be forwarded to the LPC for accuracy checking (normal HR practice to reduce application errors) before forwarding to the HR department where they would be processed and sent to DS. On receipt of the form back from DS the HR department would log the Disclosure outcome and share this with the HCSW.
- 4.78 LPCs were therefore undertaking some aspects of application processing and checking which would ordinarily fall on HR departments. This was very time consuming, with much chasing up and reissuing of forms and delay due to HCSW errors or failure to return forms.

Numbers of DS applications made by pilot sites

- 4.79 The numbers going forward to Disclosure Scotland were small, much lower than anticipated at initiation of the pilot, and easily processed by the agency. However, Disclosure Scotland noted that should there be a planned large influx

if applications, they might well have to put in more resources (recruit and train staff⁵⁷, computers).

- 4.80 The monitoring data confirms that all but three of the 470 recruits to the pilot had given consent for the DS application. 155 forms had not been returned to the LPC. Where forms had been returned the amount of time taken varied widely from 3 days to more than 350 days (where an individual had an initial meeting with a WPS but then observation assessment did not take place for over a year); half the cases took more than 40 days to be returned. There was then great variation across pilot sites in how quickly forms were forwarded to the HR department. In Ayrshire & Arran almost all forms (97%) were forwarded by the LPC mostly within two days and mostly on the same day. For the other two sites only around a fifth were turned round this quickly. 60% of cases were then forwarded by HR to Disclosure Scotland within five days (Ayrshire & Arran 84%, Lothian 79%, Lanarkshire 33%).
- 4.81 Of the 470 recruits, 70% (331) had application forms forwarded to Disclosure Scotland for the pilot. Disclosure Scotland provided detail⁵⁸ on the 200 applications (43% of recruits) forwarded to DS between January to September 2008 (Ayrshire & Arran 77; Lothian 35; Lanarkshire 88). This was an average of 22 per month but in practice sites tended to send off applications in batches from HR departments. Ayrshire & Arran submitted the first applications from October 2007 and the other two sites from late February 2008. The average by pilot site, for the application to be turned round at Disclosure Scotland (case input to system (case created) to disclosure certificate issued (case completed)) varied from 6 - 8 days.
- 4.82 More than one in ten (12%, 23) of the 200 applications were returned with errors. Most of the returned forms had one or two errors. The majority of errors were items that the employer would have been responsible for completing (Invoice and Payment methods and CSG errors). Relatively few were HCSW errors (missing names 7, maiden names or where other documentation suggests other names; and Address History errors, 2). This suggests that the systems put in place were correcting most HCSW errors prior to submission to Disclosure Scotland and perhaps further work was needed to ensure LPC/internal HR staff were checking information which was the responsibility of the employer to record.
- 4.83 Most applications were for 'enhanced' Disclosure and were granted. Just three applying for 'enhanced' came back as 'standard' and these included two Clinical Support Workers working with older people in acute and primary care hospital settings and one physiotherapy assistant in children's services. Disclosure Scotland advised that one hospital based medical laboratory assistant did not come into contact with patients so basic disclosure was applied for and granted. Nine HCSWs were shown as entered on SWISS but monitoring data did not record Disclosure level received.

⁵⁷ Disclosure Scotland already has experience of bringing in additional staff to meet peak periods i.e. the influx of temporary Christmas postal workers

⁵⁸ Report from Disclosure Scotland as at 03/10/2008.

Dealing with previously undisclosed material

- 4.84 All pilot sites felt DS checks were important and for some years all had carried out DS checks on new employees and at post changes. Checks on existing employees, for the purposes of the pilot, was a new feature. At the outset, site lead officers were unclear about the number of HCSWs who had not already been subject to Disclosure, or whether some particular categories of worker had routinely been subject to 'Enhanced Disclosure'. They were clear any issues raised by Disclosure checks would go through HR directors who would evaluate the issue but did in fact struggle to recall any specific incidents, concerning HCSWs, where Disclosure checks had raised problems in the past.
- 4.85 All three pilot sites are satisfied that systems are in place to deal with previously undisclosed material. Lanarkshire has a points based initial 'risk assessment' procedure in place and also felt it important to enhance the initial information given to HCSWs to ensure they fully understood the potential implications of signing up to the pilot and making an application. Lothian held back Disclosure forms while making a decision about the Disclosure process for the pilot; there was a feeling that retrospective checking was having to be addressed in advance of procedures drawn up for the implementation of the Protection of Vulnerable Groups Act. Across the sites, a handful of minor previous convictions have come to light and have been dealt with by Boards. One case illustrated HCSW lack of knowledge about how far back the check might go.
- 4.86 Initially it was not clear to pilot sites whether HCSWs, who did not sign up to Disclosure Scotland checks, could take part in the pilot. SGHD clarified that HCSWs could take part in testing the achievement of the induction standards, without contributing to the separate pilot aim of testing the burden on Disclosure Scotland. By the end of the pilot there were 41 cases where the Code of Conduct was signed and all assessment completed but the Disclosure Application was not recorded as sent on to Disclosure Scotland as yet. At least two staff had discussed their wish not to forward an application to DS with a manager who advised them they could not be entered onto the occupational list.
- 4.87 From the surveys, HCSW participants (97%) and non-participants (95%) had no concerns about having a Disclosure Scotland check. Most participants had previously had a Disclosure Scotland check (73%, 114) but a quarter (25%, 39) had not.

The occupational list

- 4.88 The evaluation aimed to assess the technical aspects of setting up, operating and maintaining a list of HCSWs. It also aimed to assess whether a future list would add value over the implementation of the national standards alone.

Technical aspects of the 'occupational list'

- 4.89 For the purposes of the pilot, the occupational list is held on the Scottish Workforce Information System (SWISS), a workforce database for

NHSScotland⁵⁹. The SWISS project lead officer was an active member of the 4 Country Steering Group and National Pilot Project Group and continued to advise the pilot.

- 4.90 It was clarified that the individual Health Board is the data controller for all its own Health Board information and has responsibility for verification pre data entry, entering data, ensuring accuracy and completeness. Each Board would also need to decide processes for keeping information up to date and for any potential removal of names. Boards would need to decide who might access the list locally, what reports might be made and how employee or employer queries about list information might be answered.
- 4.91 The evaluation found that the first set of these requirements, the practical arrangements, had been tested by the pilot. A drop down list facility has been set up to record successful achievement of the standards (Annexe I). Local Pilot Coordinators had access permission and guidance to enter data onto SWISS for the purpose of the pilot. Local Boards have facility to generate their own report and SWISS have provided sample reports on the successful 193 HCSWs entered onto the list (Table 5.8). LPCs developed a checklist to ensure all criteria set out in the Guidance are met before an HCSW name is entered.
- 4.92 In considering potential roll-out of the occupational list it is clear that the physical update and maintenance of the occupational list upon SWISS would be straightforward. In addition, other existing fields could be added to increase the functionality of the list (date of validation, reason and date for end of listing). However a number of key issues would require consideration before any potential roll-out of this pilot list.
- 4.93 SWISS can only be used for NHS employees and should non-NHS healthcare support workers be included in future then another system would have to be used. SWISS could produce an export file for electronic transfer or re-keying to another system but, as the pilot is voluntary, permission would need to be sought from the already listed HCSWs to do this.
- 4.94 SWISS currently records achievement of the standards only. In order to facilitate monitoring on a national level it would also be necessary to record the start date of the assessment process (currently recorded on local pilot site monitoring databases only). Without this it would be possible for individuals to keep restarting, but not completing the process, at different Boards.
- 4.95 For national roll-out a standard format for unique ID would be required (for the pilot each Board took its own approach). A national view would also be required on recording Disclosure Scotland checks (SWISS currently has a facility to record the level and date of Disclosure check (not the result), but Health Boards have different policies on using this and this field was not updated by participating Health Boards during the pilot).

⁵⁹ As SWISS is an NHSScotland workforce database, the participants from the participating independent hospital could not be entered onto the occupational list.

- 4.96 For any further development work on the SWISS system a requirements specification would need to be drawn up as soon as possible to allow inclusion into the March 09 or October 09 development plan. Any requirement to add to the existing arrangements for transfer of data to e-KSF would also need to go into the development specification.

Stakeholder views on 'added value' of the list

- 4.97 The evaluation found that pilot sites had been focused on the earlier stages of the pilot: recruitment, assessment and entering onto their own Board list. At the outset, pilot stakeholders were clear that a full operational year or more was required to see how HCSWs entered onto the list might be managed longer term; particularly to address any implications about information sharing across Boards. There had been insufficient time for any of these issues to arise in practice.
- 4.98 By the end of the pilot there was still a great deal of uncertainty, and a wide range of opinion from local pilot stakeholders and national key informants as to the added value of having an 'occupational list' once the employer responsibilities (Code of Practice) and healthcare support worker responsibilities (induction standards and the Code of Conduct) were in place. Pilot site stakeholders felt the next step, 'the central list', was for the Scottish Government to consider. During the course of the pilot a number of potential advantages and disadvantages have been aired but in the evaluation's opinion, considerably more detailed work is required before a final decision might be reached.
- 4.99 A key purpose of the 'occupational list' would be to improve safe recruitment of workers moving across Health Boards or healthcare sectors. Currently we do not have detailed evidence about the number of healthcare support workers who: change jobs within Health Boards; move across Health Boards; move across country boundaries or cross healthcare sectors. Anecdotal evidence is of a largely locally bound workforce with relatively little movement. The SWISS database has the facility to provide reports on numbers crossing these boundaries, but, as yet, this data is largely unpopulated; SWISS was set up in 2004 and the employment starts of the vast majority of long serving HCSWs involved in the pilot will pre-date this⁶⁰.
- 4.100 Respondents were very keen that the successful HCSW's effort and stage of development was externally recognised. A certificate was seen as providing an external sign, '*a badge of honour*'. A certificate could be used to an HCSW's own advantage; it would be easily portable and transferable across Boards if assessment was *nationally* implemented to the same level of consistency. The question was then how to ensure the level, as signified by the certificate, was

⁶⁰ Preliminary figures from SWISS indicated that 5 of the then 185 HCSWs listed currently had another NHSScotland post.

(Annex N) The HCSW participant survey returns suggest some mobility across care sectors but little across NHS Boards. 19% (n=31) currently held another post at the same Health Board and 7 staff currently held either a private health or social care post elsewhere. 12% (n=19) had previously held a social care post and 7% (n=11) a private health care post but only 4 individuals from Lanarkshire, all Clinical Support Workers had been employed via another Health Board in the past.

maintained. As seen above (section 4.65) it is suggested that achievement of the standards and Code of Conduct be reviewed annually. A list would provide a further 'audit trail' of competence and positive achievement. It would also allow local Boards to audit the proportion of their workforce at this level.

- 4.101 However by the end of the pilot the balance of opinion appeared to be weighing towards the greater disadvantages of an 'occupational list' and the real possibility of lack of proportionality of effort expended to outcome achieved. It was felt a list might give an illusion of public protection but that this would only be maintained in reality if the employer follows their own regulations and manages their own staff, to follow safe recruitment practices, including Disclosure Scotland applications and the giving and receiving of proper references. The PIN policy for safe recruitment practice was implemented during the pilot and needed to be followed.
- 4.102 If an HCSW has met the standards and has a Certificate of achievement, then maintaining the standards would rest upon the Code of Conduct. If it is found that the HCSW does not have the competence then the employer needs to take action to assist the HCSW to make improvements. If a conduct issue arises then the employer needs to follow the standard disciplinary procedures. Stakeholders felt there was a need to ensure that the employer has mechanisms to ensure the HCSW maintains the standards and that possibly this could be under the PDPR. However there was also a perception that if there was no 'strike-off' capability then this would not be regulation.
- 4.103 The data on the current database, SWISS, legally belongs to each individual Health Board (twenty-two separate NHSScotland employers) and it cannot be shared across Boards.
- 4.104 The Scottish Social Services Council experience indicates the huge cost and manpower involved in maintaining a registration list. There is a requirement for human rights compliant adjudication and complaints procedures. If there was to be a national HCSW 'occupational list' then there would be a need to be clear on decisions about the level of resource required and who would staff it.
- 4.105 The currently unanswered question is what proportion of the HCSW workforce will fall under the Protection of Vulnerable Groups (Scotland) Act vetting and barring scheme and to what extent this would fulfil some of the original intentions behind the proposal for an 'occupational list'.

Summary

- 4.106 It emerged that the WPS role and their enthusiasm was key to the pilot success. Over two hundred WPS were trained, but greater flexibility than envisaged was required to overcome multiple barriers to their engagement with the pilot. More needed to be done in future to provide further support for the role, particularly to prepare those without experience of regulation culture to undertake assessment. WPS (92%) supported the pilot aims but wanted the paperwork streamlined.

- 4.107 NHS QIS and pilot sites developed a learning and assessment toolkit. Stakeholders were largely supportive of the materials but they required some repackaging and removal of duplication.
- 4.108 It was not possible to test the potential burden of the induction standards over and above KSF requirements as KSF roll-out was still at an early stage at pilot sites. The pilot found some potential for fit between the induction standards and KSF processes but further more detailed work needed to be carried out.
- 4.109 The pilot had tested arrangements for Disclosure Scotland applications for HCSW participants in the pilot. The pilot clarified that each application should be by individual post and its associated tasks and not by job-group and also confirmed that procedures for dealing with previously undisclosed material were in place.
- 4.110 The practical arrangements for a simple list, of HCSWs who have achieved the standards, have been tested on the Scottish Workforce Information System (SWISS). However further issues would required to be addressed before any potential roll-out of the pilot. Stakeholders continued to maintain widely varying opinions on the added value of a potential 'occupational list'.

5 NUMBERS & PROGRESS OF HCSWS

Introduction

5.1 This chapter outlines the final numbers of healthcare support workers recruited and progressed through the learning and assessment process from the initial meeting with their workplace supervisor to being entered upon the occupational list. The following chapters present stakeholder and HCSW perceptions of the recruitment and learning and assessment processes.

5.2 The original bids from NHS Boards outlined their estimates of their potential sample to be included in the pilot. This figure was adjusted as criteria for eligibility were clarified and LPCs identified roles and job titles more closely. .

Number of healthcare support workers recruited and progress⁶¹

Table 5.1 Number recruited HCSWs by pilot site

Pilot Site	Eligible HCSWs	Recruits to pilot	
		No.	%
Ayrshire & Arran	519	169	33
Lothian	2024	97	5
Lanarkshire	418	204	49
Totals	2961	470	16

Table 5.2 Volunteers by stages of the process

Pilot Site	Recruits to pilot	Initial meeting with WPS		Observation assessment completed		Oral assessment completed		Declaration of Code of Conduct signed		Entered on SWISS	
		No	%	No	%	No	%	No	%	No	%
Ayrshire & Arran	169	74	125	64	109	64	109	51	86	43	73
Lothian ⁶²	97	73	71	68	66	64	62	61	59	35	34
Lanarkshire	204	68	139	54	111	48	97	43	88	42	86
Totals	470	71	335	61	286	57	268	50	233	41	193

5.3 By the end of December 2008, a total of 2961 healthcare support workers had been identified as eligible for the pilot (Table 5.1). Sixteen percent (470) were recruited to the pilot and 71% (335) of these volunteers went on to have an initial meeting with their Workplace Supervisor to discuss arrangements for learning and assessment (Table 5.2). Of these volunteers, 61% had completed the observation assessment, 57% the oral assessment and 56% (263) had completed all assessment. Half the volunteers (233) had signed the Code of

⁶¹ All figures in this chapter are from the monitoring data as at 31/12/2008

⁶² By the final pilot implementation group meeting 45 Lothian HCSWs had been entered upon SWISS

Conduct Declaration and 41% (193) had completed the whole process and their names had been formally entered on SWISS.

- 5.4 The proportion of recruits (470) across pilot sites was: Ayrshire and Arran 36%, Lothian 21%, Lanarkshire 43%. Both NHS Ayrshire & Arran and NHS Lanarkshire began with a smaller pool of eligible support workers but recruited a higher proportion (Ayrshire & Arran 33%; Lanarkshire 50%⁶³) whereas NHS Lothian only recruited 5% (Table 5.1).
- 5.5 There was also variation in success in progressing HCSWs from recruitment through each stage of the process (Table 5.2). Ayrshire & Arran had run the longest and progressed the highest proportion through from the initial meeting with the WPS to being entered upon SWISS (43%, 73). Lanarkshire, having started much later, by the end of the pilot had more recruits and a similar percentage entered on SWISS (42%, 86). Lothian had 30% (34) entered on SWISS.
- 5.6 Almost one third of recruits did not even get to the first stage of having an initial meeting with their WPS and for the majority of these no reasons were available. 15% (20) formally opted out and some reasons given were: redeployment after ward closure, feeling too old for the course, feeling that the course was not relevant, being involved with other studies. Personal reasons were a factor for 19%: long term sick leave (12), maternity leave (2), relocation/left post/retired (11).
- 5.7 For 19% (26) organisational issues were given for delay: 22 domestic staff were to be assessed on a phased basis due to shortage of available supervisors, the WPS was on sick leave, unable to attend training sessions or had left the post, or it was not clear who would be the WPS. Five paediatric nursing assistants, who delivered packages of care in the community and worked entire shifts in clients' homes, signed up early in 2008 but were delayed from starting the pilot. The LPC subsequently met with the service manager to clarify that it would be the District Nursing Sister who would be their WPS.
- 5.8 Reasons given for lack of progress after the initial meeting were similar but there were more issues noted (14) to do with work pressures, 'Clinical demands, difficult arranging meetings', and conflicting WPS/HCSW shift patterns. A further 6 staff formally opted out after the initial meeting and reasons included: 'aged 60+ only working 15 hours per week', 'lost interest' and concentrating on 'doing cleanliness champions'.

⁶³ If looking at Lanarkshire's original target of Cohort 1 and Cohort 2 the recruitment rate would be even higher 68%, (n=198 recruited of 292 invited to take part).

Table 5.3 HCSW recruits by pilot site and job grouping

Pilot Site	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Nursing Assistant/CSW	54	91	77	75	86	175	73	341
Allied Health	19	32	12	12	11	22	14	66
Facilities	22	37	10	10	3	7	11	54
Laboratory	5	9		0		0	2	9
<i>Totals</i>	100	169	100	97	100	204	100	470

Table 5.4 HCSW recruits by pilot site and job title

Job title	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Nursing/HCSW Assistant	54	91	65	63	3	7	34	161
CSW		0	12	12	82	168	38	180
OT/Speech&Language	8	13	3	3	10	20	8	36
Other therapies	11	19	9	9	1	2	6	30
Catering Assistant		0	1	1	1	2	1	3
Domestic	21	36	8	8	2	4	10	48
Portering	1	1	1	1	0	1	1	3
Laboratory Assistant	5	9		0		0	2	9
<i>Totals</i>	100	169	100	97	100	204	100	470

5.9 The Guidance⁶⁴ sets out the staff groups to be included in the pilot. The pilot successfully recruited a good number of clinical staff. The majority (73%, 341) of recruits were nursing assistants (the post title is Clinical Support Worker in Lanarkshire)⁶⁵. Fourteen percent (66) of recruits were unqualified allied health staff. The largest group was occupational therapy/speech and language therapy (8%, 36). Most of the groups listed by the Guidance were included but in small numbers (audiology=1, music therapy=1; podiatry=8 radiography=12, physiotherapy=2). Others on the Guidance list (dietetic, orthotist and prosthetist assistants and play staff) appear not to have been recruited.

5.10 Very few non-clinical staff were attracted at the recruitment stage. These included a small group of laboratory assistants (9) in Ayrshire and Arran. Some 11% (54) of recruits were from support services, including 48 domestic assistants, 3 catering assistants and 3 portering staff.

⁶⁴ *Guidance for employers and employees in participating NHS Boards* (December 2006) Scottish Government.

⁶⁵ Annex B sets out the Numbers of Healthcare Support Workers in NHSScotland. Bands 1-4 represent the unqualified healthcare support workers of relevance to the pilot

Table 5.5 HCSW recruits by service group

Service group	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Adult - mental health	22	38	22	21	1	3	13	62
Older people – mental health	28	48	9	9	3	7	14	64
Older people's services	7	11	37	36	73	148	41	195
Children's services	5	8	31	30	0	0	8	38
Not specified	38	64	1	1	23	46	24	111
Totals	100	169	100	97	100	204	100	470

5.11 Recruits came from all the target service area groups (Table 5.5). At least 27% came from mental health services for older people or adults and 8% came from children's services. A quarter were staff who might work across more than one service area (Bankaide staff - Lanarkshire, some allied health assistant staff, facilities staff).

5.12 Both hospital and community sites were represented (hospital 74%, 347; community/primary care hospital 19%, 88, community base 7%, 35).

Numbers completing the observation and oral assessment process

5.13 As noted above (Table 5.2) 71% of recruits had an initial meeting with their Workplace Supervisor to decide an action plan for assessment. At least 20% (67) of those having an initial meeting had already met some or all of the standards prior to the pilot, and most of these were nursing assistants/CSW (55). We know from the LPCs and the HCSW volunteer survey that a good number already had an SVQ2 or above (Chapter 7). The monitoring data confirms that at least 16% (53) of those having an initial meeting met six-to-ten standards or more and a further 4% (14) met up to five standards prior to commencing assessment.

Table 5.6 Assessment completed after initial meeting with WPS

Pilot Site	Initial meeting with WPS	Assessment elements completed							
		Observation OR Oral		Observation AND Oral		Observation		Oral	
	No	%	No	%	No	%	No	%	No
Ayrshire & Arran	125	88	110	86	108	87	109	87	109
Lothian	71	96	68	85	60	93	66	87	62
Lanarkshire	139	81	113	68	95	80	111	70	97
Totals	335	87	291	79	263	85	286	80	168

5.14 By the end of the pilot, 79% (263) of recruits, who had an initial meeting with their Workplace Supervisor, had completed both the observation and oral elements of the assessment (Table 5.6). There was some variation in this

pattern across the three sites. 70% had signed the Code of Conduct Declaration and 58% were entered upon the SWISS database.

Table 5.7 Assessment completed by job grouping

Assessment completed	Nursing/CSW	Unqualified allied health assistants	Facilities	Laboratories	Total
	No.	No.	No.	No.	No.
Observation or Oral	206	57	24	4	291
Both	181	54	24	4	263
<i>Totals</i>	239	61	26	9	335
	%	%	%	%	%
Observation or Oral	86	93	92	44	87
Both	76	89	92	44	79
<i>Bases</i>	239	61	9	26	335

5.15 The majority 86% (206) of nursing assistants/CSWs had completed some assessment after the initial meeting and 76% (181) had completed both elements. An even higher proportion of allied health assistants had completed all assessment 89% (54) (Table 5.7).

Table 5.8 Assessment completed by job title

	Assessment completed							
Job title	Observation OR Oral		Observation AND Oral		Code of Conduct Declaration signed		Entered on SWISS	
	%	No.	%	No.	%	No.	%	No.
Nursing/CSW	71	206	69	181	67	157	63	122
Allied health assistants	20	57	21	54	22	52	26	51
Occupational therapy	8	23	8	22	9	22	11	21
Speech & language	3	9	3	8	3	6	3	6
Radiology	3	10	3	9	4	9	5	9
Physiotherapy	2	6	2	6	3	6	3	6
Podiatry	3	8	3	8	3	8	4	8
Art therapy	<1	1	<1	1	<1	1	1	1
Facilities	8	24	9	24	9	21	9	18
Domestic	7	20	8	20	7	17	8	15
Catering	1	2	1	2	1	2	1	1
Portering	1	2	1	2	1	2	1	2
Other								
Laboratory	1	4	2	4	1	3	1	2
Totals	100	291	100	263	100	233	100	193

5.16 Of those signing the Code of Conduct Declaration 67% (154) were Nursing assistants/CSWs and 22% (52) allied health assistants, and just 9% (21) were facilities staff. Smaller numbers but similar proportions were entered on

SWISS. The numbers within sub-groups of allied health assistants and non-clinical staff were small.

- 5.17 By the end of December 2008 193 HCSWs had been entered upon the list, including 122 nursing assistants/CSWs, 51 allied health support staff, 18 facilities staff and 2 laboratory assistants.

Summary

- 5.18 Of almost 3000 eligible HCSWs (2961), around one in six (16%, 470) were recruited, more than half completed assessment (54%, 263) and 41% (193) were entered upon the 'occupational list'. Recruits came from all target area service groups but the largest group was Clinical Support Workers working in Lanarkshire. The majority (73%, 341) of recruits were nursing assistants/Clinical Support Workers or allied health unqualified support assistants (14%, 66). The few non-clinical support staff recruited included laboratory assistants (9), domestic assistants (48) and catering assistants (3) and portering staff (3).
- 5.19 By the end of the pilot more than half (57%, 263) had completed both observation and oral assessment elements and 41% (193) were entered on SWISS as having achieved the HCSW standards.

6 PILOT OPERATION – VIEWS ON RECRUITMENT

Introduction

- 6.1 In this chapter we outline stakeholder perceptions of the identification and recruitment of eligible HCSWs; the views of participating healthcare support workers on getting involved with the pilot and views from support workers who chose not to volunteer.
- 6.2 The final recruits represented a broad cross section of clinical support workers (Table 5.4) across the three service areas and hospital and community sites (Table 5.5) and across urban and rural bases. However the pilot largely failed to attract non-clinical staff and therefore the model was tested with only a small number of ancillary and laboratory staff (Table 5.4).

The recruitment process in operation

Targeting and identification of eligible HCSWs

- 6.3 All HCSW participation was voluntary as there was no legislative underpinning the pilot to require mandatory participation. The approach to engaging HCSWs or 'marketing' the pilot was therefore critical to its success. The Local and National Pilot Coordinators collaborated to design an approach and to develop a range of recruitment materials. The basic approach consisted of advance publicity specifying all staff to be included (posters, leaflets, newsletter articles); identification of eligible HCSWs via managers and human resources listings; briefing sessions; an invitation letter plus consent sheet; information pack and Disclosure Scotland application. The approach and materials (Annexe I) were adapted to some degree by pilot sites to suit local needs and differing cultures as the pilot progressed.
- 6.4 The three sites varied in their approach to identification and targeting of eligible HCSWs. As the pilot was voluntary, marketing it to HCSWs entailed a fine balance between 'invitation' and stronger 'encouragement' to take part. The voluntary aspect was clearly maintained at all sites but the strength of marketing at each site appears to have led to different results. The overall level of Board support for the pilot appeared more consistent at Ayrshire and Arran and Lanarkshire, which both achieved a greater number of recruits, than at Lothian (Table 5.1).
- 6.5 The first two pilot sites, Ayrshire and Arran and Lothian, began with an open, broadcast information-giving approach, relying upon HCSWs to come forward, and this was followed at a later stage with more targeted action. These sites recruited using a multi-pronged approach to identify all eligible HCSWs including: comprehensive identification and widespread engagement with senior and middle managers; attendance at standing meetings; email to middle managers; plus cross checking of lists from HR systems. Lothian issued an individual letter in one batch (August 2007) and Ayrshire and Arran issued invitations in batches by occupational grouping, offering briefings by occupational group or one-to-one sessions.

- 6.6 Ayrshire and Arran lead officers had, in the first two months of the pilot, conducted a series of five promotional briefings attracting more than sixty HCSWs. The LPC, building upon this activity, found it easier to identify the smaller number of HCSWs involved (500+ excluding bank staff). The much larger NHS Lothian site (1400+ at the outset) faced a much more complicated task due to the diverse range of locations and the local reorganisation legacy of changed structures, multiple job titles following Agenda for Change assimilation, multiple data systems and unaligned data. The ease of identification of HCSWs also varied across services and locations. For example, children's services were relatively contained in one hospital in Lothian but across two large general hospitals in Ayrshire and Arran.
- 6.7 Lanarkshire, starting later, was able to learn from the slower recruitment at the first two sites. This site took a defined cohort approach from the outset and began by targeting middle managers, getting them to identify and sign up briefing times for their HCSWs, as opposed to waiting for HCSWs to 'volunteer' to attend briefings. This approach resulted in an almost 100% sign up at various Lanarkshire locations. However the Lanarkshire approach, although most successful in terms of recruitment, was thought to be unrealistic for much larger sites with much larger numbers of eligible HCSWs, where it would have taken too long for the LPC to visit each individual manager at the outset.
- 6.8 All sites included bank staff but this was a later addition for Ayrshire and Arran (September 2007). Lanarkshire hoped to include some 10 new Bankaide starts per month, presenting a further potential challenge as these clinical support staff could be placed anywhere across the Board. Lothian had a potential 330 Nurse Bank staff and planned for the coordinator to undertake the oral assessment element.
- 6.9 The process of 'follow through' also varied across sites. All stakeholders felt it was essential to try to keep up the recruitment momentum to ensure engagement. Ideally this would be by quickly following up initial invitation letters, identifying a WPS once the HCSW volunteered and if possible by organising the first HCSW/WPS meeting within two weeks of the WPS being trained.
- 6.10 However the LPCs had to balance their time between recruitment into the pilot and ensuring completion of the process for the individual. The Ayrshire and Arran LPC continued to be very flexible – working evenings and weekends to capture different shifts and different types of workers. The LPC also paid close attention to developing follow-up tracking systems. The Lothian pilot started very well, with a huge effort going into recruitment, but this lapsed somewhat over the summer of 2008. The first LPC left the post in April 2008 and although temporary cover was put in place, recruitment momentum was lost. In hindsight the site felt more attention could have been put into ensuring the link-up of HCSW with the supervisor once HCSW consent had been received. The Lanarkshire LPC had a very strong focus on recruitment but the site felt there was further work to do at acute sites to ensure facilitation of HCSW engagement.

Engaging HCSWs with the pilot

- 6.11 Initially the NPC/LPC team decided that recruitment would run August 2007-January 2008 (once pilot materials were in place) but as recruitment was slow in late summer the period was extended to April/May 2008, which would still allow a three month window for late recruits to complete assessment.
- 6.12 All sites held multiple HCSW briefing/awareness sessions lasting around one hour (e.g. Lothian ran some 8 initial HCSW briefing days, a total of 32 sessions, held at multiple sites, followed later by more tailored one-off sessions). The numbers of HCSWs attending varied from none to one, two, twelve and nineteen. The format varied from open to all (Lothian), grouped by occupation (Ayrshire & Arran), specific invitees (Lanarkshire). In Lothian it appeared more first line managers attended, sometimes in place of HCSWs. LPCs were very flexible, holding sessions in ward meeting rooms, at regular team meetings, going direct to wards when it was difficult to get staff released (e.g. children's hospital, where there were small teams or low staffing levels).
- 6.13 In Lothian partnership support was underlined as sessions were run by both the LPC and a UNISON steward. As the pilot progressed it appeared that there was some shift away from messages about 'protection' (para 3.26) and more towards an emphasis on messages about improvement of HCSW 'competencies' and moving towards more recognition of their work. The message about opening up career pathways, meeting KSF objectives and the potential for attaining other SQA credits was particularly strong in early Lothian recruitment. The message about 'having your say' and a chance to influence potential regulation was strong at all three sites. LPCs used PowerPoint presentations or adopted a more informal style as required, with plenty of time for questions.
- 6.14 In the formative stage stakeholders anticipated a range of uptake by HCSWs. It was expected that the pilot would "make sense" for nursing and allied health assistants, working within an area where there was already strong professional ownership by registered professions. The UNISON Scotland survey of nursing assistants (2005) had already found a keenness to be accredited. It was expected many workers would see the standards as a route back into learning and career development opportunities. Some workers would already have awareness of patient and employee vulnerability issues.
- 6.15 Stakeholders also anticipated a number of potential challenges to recruitment including HCSW personal fears (of intimidation and potential failure, individual 'attitude', Disclosure Scotland checks, they might have to pay for regulation, feeling 'untrusted' if already working some time in post); past experiences (aftermath of Agenda for Change; previous inadequately resourced SVQ programmes); fear of assessment (literacy issues, potential multiple assessment and lack of integration); resource issues (freeing up WPS and HCSW staff) or some HCSWs might be looking for financial incentives.
- 6.16 It was anticipated that engaging ancillary staff would present the greatest challenge for several reasons. They were seen as a group with little history of a public protection approach and were a relatively un-empowered workgroup who

might be less familiar with 'volunteering' for projects. Many were on short hours contracts and some groups of workers had a more transient population.

- 6.17 In practice the timing and method of identifying and contacting non-clinical support workers varied by site. Lothian and Ayrshire and Arran aimed to recruit the full range of workers from the outset whereas Lanarkshire tackled this group at a much later stage.
- 6.18 Lothian had more success in establishing earlier contact with the Board Facilities Group (May 2007) and managers who were supportive of the pilot; however few catering or domestic staff attended briefings. By October 2007 Ayrshire & Arran had yet to make firm arrangements with some hospital Hotel Services. It was hard to identify which of the large (600+) generic hospital hotel/catering staff group had direct contact or influence on patients or public within children's services, including those who might provide sickness absence cover to children's wards. It was most difficult for Ayrshire & Arran to engage with hotel services staff (catering, porters, domestics) for a variety of reasons: no regular staff group meetings to easily access; short shifts (e.g. cleaner 4-7pm on ward); unfamiliarity with volunteering; staff taken away from post already by Agenda for Change and KSF. There was small turnout to briefing sessions but the LPC found some individual sessions successful. However by the end of the pilot Ayrshire & Arran had been the most successful in recruiting non-clinical staff (Table 5.3)
- 6.19 Lanarkshire had been clear from the initial bid that it would recruit on a phased basis, initially focussing on four distinct cohorts of clinical support workers with a view to recruiting ancillary workers later. In June 2008 recruitment of the first two cohorts was only just complete. Lanarkshire was then disappointed to find its own plans disrupted by the 'centre's' request to reprioritise Lanarkshire's project plan towards recruitment of ancillary staff. SGHD however were clear that including ancillary staff was a requirement of the initial bid. Lanarkshire then began to make arrangements for recruitment of ancillary staff. After delay because of re-arranged meetings with senior non-clinical managers, arrangements were finally made for an additional exercise (late October 2008). During a recruitment/assessment day a total of six HCSWs (4 domestics, 1 catering assistant and 1 porter) worked through and completed the assessment process and signed the Code of Conduct declaration. One WPS (a project manager from property support services) attended and therefore the pilot LPC and the site lead officer acted as additional supervisors.

Views of participating Healthcare Support Workers

- 6.20 There was a 43% (164) response rate from the HCSW-participant survey with similar proportions from the three pilot sites (Table 0.1). Almost half the HCSW survey returns came from Lanarkshire. Returns were weighted towards clinical support workers, older people's services and longer serving staff. (Table 0.2). The returns were mainly from clinical support workers (nursing assistants 70% (115); allied health assistants 21% (35) with just 8 from non-clinical staff (7 facilities; 1 laboratory assistant) (Table 0.3). The largest group was from older people's services (47% (77) mostly from Lanarkshire (64). Just 11% (18) were from children's services and 38% (62) from mental health services (Table 0.5).

There was feedback from 21 bank staff (Lanarkshire) but just 12 returns from workers new to the Health Board or in post less than one year.

- 6.21 Evaluation questionnaires were received from 4 of the 6 late recruited Lanarkshire non-clinical HCSWs, all long-serving and hospital-based. These returns are not included in the evaluation numbers but some quotations have been included in the report.
- 6.22 All HCSWs were sent an introductory letter but face-to face communication registered most (from their line manager (57%); a briefing (30%) Table 0.16). Local publications registered with very few. Some HCSWs commented it would have been good if HCSWs and WPS could have been briefed together.
- 6.23 At the outset of the pilot stakeholders expressed concern that the pilot might not appear truly voluntary or that HCSWs might feel pressured to participate lest they be excluded from other development opportunities. The evaluation observed that all LPCs were very careful to make it clear that the pilot was voluntary.
- 6.24 The majority of participating HCSWs clearly felt that sign-up to the pilot was voluntary (94%) (own decision (76%); shared decision with the line manager (18%)). However 8 felt the decision was made for them by a line or senior manager. Most (68%) felt they received enough information before starting (Table 0.17).
- 6.25 The main reasons HCSWs got involved in the pilot were altruistic (“help my patients/improve patient safety” (56%, 92); “do my job better” (54%, 88) followed by the attraction of learning and development (“I like learning new things” (45%, 73); “To develop job and career opportunities” (41%, 67); “time to think about what I do in my job” (37%, 61). There was some influence by senior staff “Strong direction from senior staff” (21%, 34) or colleagues “Other staff I knew were doing it” (13%, 22), some wanted to “Have my say” (30%, 50); or for their patients to know they were doing a good job (26%, 42). Table 0.17).

I was only asked to attend the pilot one day prior to the meeting and went into it with an open mind. I feel that this scheme will be of great benefit to all involved.

(Domestic Supervisor)

- 6.26 A smaller proportion of HCSWs noted concerns before sign-up to the pilot: a third were concerned about having time to do the pilot “Might be too much work” (33%); “Too busy at work” (28%); and a fifth (21%) were concerned it “Might be too difficult for me”. Around a third (30%, 50) had no concerns before sign-up.
- 6.27 The evaluation team attended several HCSW briefings. Some reasons put forward by HCSWs for being supportive of the pilot were:
- ~ *we already do this anyway*
 - ~ *everyone should have the chance for a PDP*

~ carers of children in hospital need to know standards are in place; a HCSW does not want to appear ignorant in front of patients

- 6.28 Questions raised by HCSWs at sessions included wanting clarification about: the WPS (how many WPS and ratio to HCSW, will it always be the line manager what training will they receive, will they do the DS application); assessment (will it be adapted for older, slower learners, approaching retirement; staff on nights, backlog of non-disclosed staff); time required (is it like SVQs, will we be released if we are short staffed); and how flexible it was (how fit with the Domestic Workbook, can standards be changed).
- 6.29 Attendees, both some HCSWs and some supervisors, suggested that groups of staff might like to go through the process together and approaches to group learning could be explored. However, a potential staffing shortage was identified by one supervisor of a small team of four, where she already supervised a student and someone already undertaking an SVQ.

Views of Non-participant HCSWs

- 6.30 The non-participant HCSW survey had a 12% (242) return and the majority came from Lothian (86%, 208) of which 104 came from older people's services, the service area added to the pilot to try to increase numbers of recruits (Table 0.2, Table 0.14). Half the participants felt they had not heard about the pilot (56%, 132) and 5% (13) were not sure what it was. Only around a third felt they had actually heard of the pilot (39%, 92) or been given information about it (32%, 64). The majority (59%, 119) had not and the remainder (18) were not sure. Where information had been received, almost half (47%, 43) said that it was all the information they needed, while almost one in five (18%, 16) did not feel that they got the information they needed. There was also an evident untapped pool of potential volunteers as 8% (14) thought they would definitely take part in the next few months and 13% (24) thought they might; two in five (39%, 71) were unsure. Forty percent (74) of the non-participants were, however, definite that they would not take part.
- 6.31 Half (54%, 132) of the non-participant respondents gave reasons for not taking part in the pilot. The main reasons put forward were either: personal - "I had other personal commitments" (20%, 48), "I am soon due to retire" 14%, 35) or work-related - "I am too busy at work" (21%, 51) "we are short staffed at work" (19%, 46) and already having an SVQ or above (20%, 48); or about the pilot "it might be too much work" (15%, 36) and "I did not see any value in taking part" (14%, 33). Written comments confirmed and added detail to the above. Most concerned not knowing enough about the pilot (39 of the 40 who said this were from Lothian) or being about to retire or change job soon. Some (12) were already doing or about to start another training/course or had other personal commitments (11). Ten said that they did not have enough time to take part and some found it not relevant to their job.
- 6.32 A small number of responses were angry: one talked of feeling pressure to participate in something supposed to be voluntary, one wanting a definition of healthcare support worker, two felt resentful about feeling unfairly treated by

Agenda for Change, and two felt there had been unclear instructions and support.

Summary

- 6.33 As the pilot was entirely voluntary the method of marketing the pilot was critical to its success. NHS Lanarkshire's phased cohort approach, targeting line managers was most effective but considered to be potentially unrealistic for larger sites. The successful engagement and tracking of recruits depended upon a greater level of flexibility and input from LPCs than anticipated. Planned group HCSW briefing sessions had to be enhanced with multiple individual sessions in order to attract recruits.
- 6.34 43% (164) of participating HCSWs replied to the survey and most (94%) confirmed they took part voluntarily. They were motivated by improving patient safety and improving their own performance but expressed some concern that the pilot might be too hard or they might not have time to do it. The non-participant HCSW survey attracted a 12% (242) response, mostly from NHS Lothian (86%). It appeared there was an untapped pool of volunteers as many had not heard of the pilot and some (21%) indicated that they might wish to take part in future. The main reasons for non-participation included having other personal commitments, being about to leave post or feeling they did not have time at work.

7 PILOT OPERATION – VIEWS ON LEARNING AND ASSESSMENT

Introduction

- 7.1 This chapter explores stakeholder, healthcare support worker and workplace supervisor experiences and perceptions of the learning and assessment process. We follow the process through from setting up the initial meeting between HCSW and WPS, use of evidence of prior achievement, through the observation and oral assessments to being entered upon the occupational list.
- 7.2 In Chapter 5 we saw 71% (335) HCSW volunteers went on to have an initial meeting with a workplace supervisor and 61% (286) had completed at least the first observation element of assessment (Table 5.2). The large majority of HCSWs completing assessment were: clinical support staff, nursing assistants/CSWs (71%, 206), allied health support staff (20%, 57) (Table 5.8).

Pilot site stakeholder perceptions

- 7.3 The monitoring data indicated that the large majority of assessments were, as expected, completed within two to three months. Delays appeared to be more about logistical issues than capability of the HCSW. Local Pilot Coordinators attributed slippage in the process to the combination of multiple reasons:
- Late and lost consent forms; issues with internal mail
 - HCSWs starting other jobs, courses or opting out for personal reasons (e.g. maternity leave)
 - Service re-design causing relocation of staff and difficulties in linking HCSWs and WPS
 - WPS prioritising other work responsibilities; not able to attend or missing arranged training sessions
 - Difficulties in identifying an appropriate WPS
 - WPS assessing HCSWs on a phased basis to cope with larger numbers of HCSWs
 - Difficulties in getting meetings arranged between HCSW and WPS e.g. on opposite shifts; both being absent consecutively or sequentially (sickness, holiday); staff shortages
- 7.4 Stakeholders reported that the assessment burden was generally not excessive for HCSWs and that those undertaking the process had found it valuable and enjoyable. Partnership representatives had largely received positive feedback about the learning and assessment process – some HCSWs said they could see how the standards relate to the KSF outline for their post. However it must be noted that these comments applied largely to clinical support staff.
- 7.5 A small number of medical laboratory staff worked through the standards. The Workplace Supervisor tried to find ways of making some of the standards and criteria applicable. However it currently appears that for standards 1, 10, 13 and 14 it is not possible to provide evidence for these posts. It has also been found that it is possible to generate an oral assessment paper with criteria not of relevance to these posts.

- 7.6 Stakeholders considered the assessment paperwork sufficient but there needed to be some adjustments to consistency across documents and preferably a reduction in the amount of paperwork.
- 7.7 The Local Pilot Coordinators found that again at this stage there was a much higher amount of time-consuming administrative work than anticipated. On receipt of completed assessment papers the LPCs checked for completeness of data and might find they had to telephone the WPS for completion of missing dates or even missing questions and the form might need to be returned to the WPS. One LPC reported the WPS as saying they missed things because the assessment papers were wordy and repetitive.
- 7.8 Local Pilot Coordinators found that going back to the HCSW, once all the assessment paperwork was signed, to get the Code of Conduct Declaration form signed was yet another unanticipated time-consuming task. It could take a half-hour per HCSW to ensure the form was read, understood and signed, then photocopied and returned to the HCSW.

Healthcare Support Worker views on learning and assessment

Learning

- 7.9 At the time of the participant HCSW survey 90% (146) had a Workplace Supervisor in place (in Lothian at this point 26% did not). For over two thirds (68%, 111) the WPS was another member of staff in the HCSW's work section and this was true for 83% of Lanarkshire HCSWs. For a fifth (20%, 32) the WPS was their usual line manager. For 4% the supervisor came from outside the work section. In the majority of cases (80%, 132) there was no difficulty in arranging a Workplace Supervisor, but for nine staff there was some or a lot of difficulty. Most (81%, 133) felt their WPS, at the first meeting explained what was required very or fairly well.

Table 7.1 Evidence of previous achievement

Working towards the standards	Prior achievements			
	Already held		Used as evidence	
	%	No	%	No
SVQ2	35	58	24	39
SVQ3	8	13	5	9
Certificate/Diploma/Degree	13	21	9	14
Short Course	16	26	11	18
Other training	32	53	21	35
None/Can't say	6	10	4	7
Totals*		164		164

* Percentages may sum to more than 100% as some HCSWs hold more than one qualification

- 7.10 Two thirds (66%, 109) had discussed taking prior achievements into account with their WPS. For most (65%, 106) there had been no difficulty in deciding which to take into account as evidence but for 7%, (12) there had been some or a lot of difficulty. Table 7.1 shows that inclusion of the range of prior evidence

was certainly not automatic (some 11% had an SVQ2 which was not included). 40% (65) had discussed personal development needed to meet the standards. 34% (56) had this already planned or had carried it out.

- 7.11 The majority (62%, 102) thought they needed to do preparatory work before assessment (Table 0.20). There was a consistent pattern across the three sites in terms of perceptions of the balance between work time and own time required to prepare for the standards: less than one in five (15%, 24) reported doing the work all in their own time, a third (34%, 55) spent some of their own time, and less than a third (28%, 46) prepared all in work time but a quarter did not comment (24%, 39). The amount of the volunteers' own time spent preparing for the standards ranged from none to 10 - 15 hours over a several days or weeks. Around a fifth spent 2 hours and a third 3-4 hours on preparation but a tenth said they spent more than a day. Of those using their own time, most felt this was reasonable and only 11 individuals felt it to be unreasonable.
- 7.12 41% (67) felt they needed some help with the preparation process. Half (54%, 88) received this from their WPS plus some (8%, 13) from a senior manager; others (21%, 35) turned to another HCSW.

Assessment

- 7.13 The plans for approaching assessment varied: 28% did all the Observation assessment first as recommended; 16% did all the Observation and Oral together in one go; 32% did a few standards at a time, Observation and Oral together, (this perception came from facilities staff); a handful did all the Oral assessment first. Only two fifths had completed assessment elements when the survey was taken (40%, Observation; 33%, Oral) and a further 25% felt they were just getting started.
- 7.14 When asked about how easy or difficult they thought the standards were, two-thirds (64%, 105) thought they were about right, more than a quarter (29%, 47) were unsure. Few (11) felt they were too easy and only one person thought they were too difficult.
- 7.15 Half (52%, 86) thought that the standards were mostly applicable to them, while just under a quarter (24%, 39) thought they were only applicable in parts.
- 7.16 Most HCSWs found the time required to work towards the standards about right (63%, 103); a few thought it was too much (7%, 11) or too little (4%, 6); but a quarter did not know (27%, 44). Around half the HCSWs (49%, 80) expected it to take up to three months to achieve the standards; less than one month (23%, 37), two to three months (26%, 43). A few (8%, 13) thought it would take longer than three months but 43% (71) did not know how long it would take.
- 7.17 At briefing sessions HCSW's appeared appreciative of the overall presentation of materials (e.g. plastic ring binders).

Table 7.2 The standards potential to affect HCSW's work

Working towards the standards	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
I feel more confident at work	70	31	31	12	41	33	46	76
I know more about my job	50	22	31	12	38	31	40	65
I know more about patient safety	55	24	38	15	41	33	44	72
I feel more able to take action to keep patients safe	59	26	38	15	43	35	46	76
My career/job opportunities will be improved	43	19	13	5	35	28	32	52
It will be easier for me to move to another Health Board	34	15	10	4	43	35	33	54
Totals	100	5	100	39	100	81	100	164

7.18 Over half (59%, 96) felt the standards had potential to affect the way they did their job but a quarter (25%) did not. Table 7.2 indicates that almost half felt undertaking the standards had the potential to improve their confidence (46%) and their knowledge (40%). Most importantly they felt they knew more about patient safety (44%) and felt more able to take action to keep patients safe (46%). Slightly less felt it might help their career or transferability to another Board. Overall the perceived gains appeared strongest in Ayrshire and Arran and weaker in Lothian. Some 10-15% in Lanarkshire disagreed with these statements but that is most likely because more were already qualified to a higher level before the pilot.

I enjoyed taking part in the pilot project. It was an exercise that certainly makes you more aware of your day to day work activities and how you carry out certain tasks to ensure patient safety.

(Radiography assistant, grade 3, hospital based working weekends, nights and 9-5 hours)

Fit with KSF and PDP

7.19 The evaluation surveys of HCSWs and WPS confirmed that there was a wide variety of experience of both PDPR and KSF across the three pilot Boards. The majority of HCSWs had heard of KSF (70%, 115) but interestingly a fifth (21%, 35) had not and the rest did not know. Half the HCSWs and three quarters of WPS had a KSF outline in place by summer 2008. At least two thirds had had a PDP in the last year. Just half the pilot WPS were also KSF reviewers. Three quarters (78%) of WPS saw potential for fit with KSF but far fewer HCSWs did at this stage (40%).

As a porter I have not yet started my PDP, which I have been told is to be soon. I have never had a one-to one with my line manager about any aspect of my job. But most of the porters think nobody cares how we get on with our job, even though we need to learn certain skills to do our job.

(Porter, 8 hour shifts and weekends).

7.20 Awareness of KSF and PDP varied across the sites. In Ayrshire & Arran 95% had heard of KSF, 78% had a KSF outline in place, 52% felt the standards would contribute to the KSF foundation gateway and 77% had had a PDPR in the last year. In Lanarkshire only 59% had heard of KSF and 46% had an outline in place. In Lothian 80% had heard of KSF but only 40% had an outline in place and only 54% reported a PDPR in the last year.

Table 7.3 KSF and PDPR

Working Pattern	HCSW & WPS survey (2008)			
	HCSW Participant		Workplace Supervisor	
	%		%	
Heard of KSF	70	115		
KSF outline in place own post	49	80	78	72
PDP in last year	66	109	73	67
KSF reviewer			48	44
Potential for fit with KSF	40	66	78	72
Totals*		164		92

* Percentages may sum to more than 100% as they relate to different questions

7.21 The case studies confirmed the wide variation in knowledge of and experience of KSF processes. Some clinical supervisors clearly felt there was potential for the standards to fit together.

It should probably run side by side I should think.

(WPS, Senior OT)

With what we've done in the work and with what I've seen in the KSF, I can'nae see there being any problems. I don't know because I have'nae done it yet so I would need to wait till we've actually done it and then I can tell you.

(WPS, Charge Nurse)

7.22 One WPS and HCSW had found going through the pilot very helpful in preparing for the KSF review

I thought the course [pilot] would help and it did, we just sort of went through it, you know how you do it for Grade 3, I didn't have to do anything to get to the Grade 3, I was there and above.[...]we discussed all the KSF and what it meant and to go through the gateways, because we had already gone through this healthcare thing [WPS] was satisfied that I was at it sort of thing.

(Community nursing assistant)

I think it was [helpful]. I think because you know how you sit down, you obviously agree with the person [HCSW] what you're doing.. what their standards should be. If it's a, you know if its communication, then you should be looking at a '1'. Then you can sit down and say, "Well, you should be able to record things on FACE records or whatever. So the fact we'd already used it in the pilot study meant you were almost.. It

was fresh in your mind, and you were always using the same examples.

(WPS, Charge Nurse)

- 7.23 At first interviews some HCSWs had not heard of KSF or were not sure what it was.

We did do something about this but I really cannot remember – is it to do with the mandatory courses we did, like Food Hygiene, Fire, and Handling courses?

(Domestic assistant)

- 7.24 Where roll-out was slowest one mental health nursing assistant had not heard of KSF at all. The WPS confirmed no one in the ward had a KSF outline as yet but she could see the pilot fitting in with '*the ten essential shared capabilities*'. On occasion HCSWs and WPS had different understandings about whether an outline was in place – this might be because of unfamiliar terminology.

- 7.25 Where the WPS did not yet have a KSF outline in place for their own post or had not yet had the first KSF meeting they were not in a position to be KSF reviewers or to comment on how the induction standards might fit with KSF (e.g. Domestic supervisor Band 2).

- 7.26 There were examples of the KSF reviewer being a different person from the allocated WPS for the pilot (possibly the WPS' own line manager). Any potential implications from this did not appear to have been discussed with the relevant line manager/KSF reviewer.

- 7.27 Technical issues with the e-KSF computer system had slowed down the KSF process at some units

She [HCSW] will have [KSF outline in place] and sorry, I shouldn't laugh, everything is on line with this e-KSF, however for some reason anything to do with my e-KSF went pear shaped and they're trying to work it out why. The technology. I think if I actually know what the standards were for the Clinical Support Workers against you know, for the e-KSF, I could make a comment on that [how they fit together] but as I say I can't get in to get standards just now because of a technical hitch.

(WPS, Staff Nurse)

- 7.28 Many (37%, 61) of the participant returns had written general comments at the end (Ayrshire & Arran 20, Lothian 20, Lanarkshire 21). Seventeen HCSWs took the opportunity to comment on a positive and worthwhile experience and a handful of them praised their supervisors' efforts.

I feel it has been a worthwhile and positive experience. My Workplace Supervisor put in a lot of the time and effort for the pilot scheme.

*(Nursing assistant, full time,
working weekends and 9-5, hospital based)*

- 7.29 Eleven staff commented that they were already operating at this standard and most of these felt the standards would be better for new staff at induction.

Felt the pilot scheme is excellent for new members of staff coming into post but not for staff that has worked for years in present post. Observation, excellent. Oral, felt the questions were duplicated quite a few times.

(Rehabilitation support worker, older people's services, working in community setting, part time (30 hours), ten years with Health Board)

- 7.30 An issue within Lothian was lack of support to know how to progress the pilot and - in some cases - get support from supervisors. Difficulty arranging the same shifts as the WPS was an issue for a few in Lanarkshire. The case studies confirmed this sense of frustration with not knowing what they should be doing or whose responsibility it was. They also indicated how some HCSWs felt relatively powerless to get things moved along and were waiting for someone to come back to them.

This is my first correspondence since completing the Disclosure Scotland form in February for this pilot. In completing this form I had/have no information on the questions and what they mean.

(Nursing assistant, mental health, works weekends)

- 7.31 This quotation confirmed pilot staff views that bank staff may not be supported by ward based supervisors.

I haven't started pilot, I feel that the Staff Nurses on the wards don't want to help or don't have the time because I am Bankaide staff. Maybe if I was in a permanent position on a ward things might be different.

(Clinical support worker, mental health services, Hospital based, full time, band 2)

- 7.32 Other issues - mentioned by a handful only - were the need to make the standards applicable to particular staff, to improve the paperwork, being too busy at work. Interestingly, there was one description of a minor past offence (unlikely to have impacted upon the post) and one protest at the pilot not being voluntary.

- 7.33 At the time of the survey 61% (100) had already signed the Code of Conduct Declaration. Most (96%, 147) thought the Code of Conduct was very (84%, 129) or somewhat (12%, 18) important for people in their job. Only 2 thought it was not important. Just half (52%, 84) were aware of the Complaints and Appeals procedure.

Certificate Presentations

- 7.34 Senior Board level staff presented certificates at special ceremonies thereby endorsing the HCSW participation in the pilot, and the role of the HCSW in the healthcare team. Ayrshire and Arran, being furthest ahead at an earlier stage, held multiple ceremonies in 2008 for smaller groups whereas the Lanarkshire

and Lothian ceremonies were in early 2009 for larger groups of around forty-five HCSWs. Lothian planned a prize draw. Workplace supervisors also attended. The HCSWs appreciated the ceremony and the fact that presentations were by senior staff. They commented upon the catering, photographs and publicity in local newsletters. In some cases HCSWs brought partners along to the event.

7.35 There were three certificates⁶⁶

- Certificate of participation (HCSW volunteers partial completion)
- Certificate of achievement (HCSW volunteers who completed all assessment)
- Certificate of acknowledgement (WPS taking part in pilot)

7.36 Most HCSWs (85%, 140) thought it was very or fairly important to receive a Certificate. They saw it as proof of effort and something to show a future employer. Supervisors felt less need of a certificate for themselves as they mostly already had other qualifications or certificates.

Very important, to recognise, can go into the professional development like the rest of it [but] Its very difficult to keep using up time, you have got patients to see, takes time to get people to come at certain times, don't want to cancel things.

(Technical instructor, allied health)

It's proof that you have done the course, if you did move to another employer you've got that certificate to say you have done it.

(Community nursing assistant, mental health)

Well, I think that's a good thing because you've got proof that you know what you're doing, you know what you're talking about.

(Hotel services operative)

Oh yes, because it gives them something to work for and they have got something to show that they have done it.

(Domestic supervisor, band 2)

I think its important, in nursing, Clinical support workers, I feel under valued, because if there's any training that goes on within the ward it tends to be for staff nurses and senior staff, and they go away and they get their training courses and they get their nice shiny certificates and quite often I feel the clinical support workers look and feel left out, feel unvalued so I think giving them a certificate is a good thing, I think everybody likes that wee bit of paper.

(Staff nurse, band 5, hospital physical disability)

⁶⁶ Lothian decided that where the Disclosure Scotland application was not yet finalised, a Certificate of Participation would be presented in the first instance and a Certificate of Completion would be awarded on receipt of the DS response

Well I don't know, the girls get certificates for everything these days and just probably put them in their domestic room and forget about them.

(Domestic supervisor, band 3)

Entry onto the occupational list

- 7.37 The questionnaire asked a general question 'Do you understand what the occupational list is?' Replies indicated that 'understanding' of the occupational list is patchy with a third (32%, 53) having only some understanding and rather fewer (29%, 47) feeling that they have a good understanding. Perhaps of concern, one in five (19%, 31) reported that they had no understanding, and a further (15%, 24) reported that they had little understanding. The majority 71% (117) were happy for their name to be entered on the list with the remaining respondents either not happy (8%, 13) or unsure (15%, 25) with nine choosing not to answer. However it should be noted that the question itself did not allow any differentiation between 'understanding the reasons' for listing and 'understanding the process' of listing. It is clear from the case studies that HCSWs had little understanding of the 'occupational list'.

Support for the aims of the pilot

- 7.38 The vast majority of HCSW participants supported the aims of the pilot and regarded it as important for HCSWs doing their job (82%, 135) and for different healthcare support jobs (79%, 129) to undertake the standards. Most (87%, 142) said that it was important that all Health Boards have the standards in place, and that it was important that all Health Boards have an occupational list in place (64%, 105).

The pilot scheme should become mandatory to your place of work and not optional as it is at the moment, as everyone connected with the same post as I'm in, but in a different Health Board, will receive the same training and support that they need.

(Mental health care assistant, hospital based full time, 12 hour shifts, weekends and nights)

I think this is a worthwhile course for all NHS Assistants. It can only lead to better patient care and more job satisfaction.

(Podiatry assistant, full time working across hospital and community bases)

Stakeholder views on the definition of 'healthcare support worker'

- 7.39 The pilot has attempted to test the employer-led model with both clinical and non-clinical groups and the local implementation experiences have helped to inform stakeholder and key informant opinion about the current definition of 'healthcare support worker', and thereby the definition of groups to be included in undertaking the standards.

7.40 Discussion has circled around three elements. Firstly, the principle of whether inclusion should be determined by the amount of direct contact and nature of risk presented by the role or whether every health worker should meet these basic threshold induction standards. Secondly, should inclusion be determined by the 'applicability' of certain standards or criteria to particular roles, the scope for workers to evidence criteria and whether different criteria should be generated. Thirdly, should inclusion depend upon the practicality of managing supervision and assessment.

7.41 There was consensus around the principle, applicability and practicality of applying the standards to nursing assistants and allied health professionals. There continued to be very varied views about non-clinical support workers for whom the standards were as yet untested. There was some support for inclusion of some non-clinical staff in particular roles in particular environments (e.g. porters with unsupervised direct access), but a great deal of uncertainty about the inclusion of staff in other support roles (e.g. domestics, catering, laboratory assistants).

- ~ *'A lot of domestics clean wards and have patient contact, catering don't. Still got a huge group where it (the standards) might not be fine'*
- ~ *'some domestics only go into a theatre in the evening to clean it, only work two hours per evening, the supervisor covers the whole of (X hospital unit) and if someone was off sick or a crisis then she wouldn't be able to meet them'*
- ~ *'My view is all of them, admin and clerical as well'*
- ~ *'a lot of staff don't have the same potential to get close to patients and so should not have the same responsibility placed on them'*
- ~ *Porters are in and out of the wards all day, they don't have a lot of dealings with the patients but they will come into contact, particularly the care of the elderly wards... delivering mail, linen, patient's personal clothing*

7.42 The medical laboratory assistants who took part in the pilot did not have direct patient contact. The NHS QIS learning and assessment quality assurance exercise and evaluation case studies found that some standards (1, 10, 13 and 14) may not be applicable to this group where there was no direct patient contact or delivery of direct care. If these latter groups are to be included, it was deemed crucial that the standards be made relevant and attainable. If this could not be done, then those groups should not be included in this model of regulation. Phlebotomists were not included in the pilot (due to an ongoing Agenda for Change related dispute); this skill, requiring direct patient contact, is provided by a range of staff. One job title from the prescribed list 'mortuary attendants' did not appear to have been sufficiently addressed by any site during the pilot.

7.43 There was a strong view from some respondents that many administrative and secretarial staff have as much (or more) direct contact with patients and the public as support staff and that they would like to see them included in the definition of healthcare support worker. The evaluation has discovered that a

number of support workers hold both administrative and support worker roles, perhaps two part-time jobs or a split role (e.g. ward clerk/support worker). The role of administrative staff is being covered by an NHS Education Scotland workstream (Annexe J).

- 7.44 By the end of the pilot, Ayrshire and Arran considered the outcome with the sample of domestics to be disappointing but their focus was on NES funded work with the local college. In hindsight, Lanarkshire expressed some regret that non-clinical support staff had not been approached earlier as some staff had since expressed interest in the pilot.

Views on non-clinical groups

- 7.45 The evaluation team contacted Facilities staff at a national and local level and obtained views from non-clinical support workers via the case studies and surveys. Several potential reasons for the pilot's lack of success in engaging with non-clinical staff emerged.
- 7.46 There were clearly issues of communication at all levels. At a national level, there were very varied perceptions of communication between Health Facilities Scotland, SGHD and NHS QIS. At a local level the pilot was seen as not being 'sold' to these groups (para 6.17). Recognition of the title 'healthcare support worker' was an issue (it is noteworthy that the evaluators received calls from staff, asking why they had been sent the questionnaire as they were not healthcare support workers). The very fact of being 'voluntary' was reason enough for catering staff, in and out of site on short shifts to cover mealtimes, to not take it up. For those on short shifts, perhaps juggling with caring responsibilities at home, further (unpaid, development) obligations would take up too much time. These support workers may also have been put off the pilot because of fears concerning literacy requirements and assessment (Para 12.41).
- 7.47 Existing commitments also took priority (e.g. mandatory training for fire safety, moving and handling, and hygiene⁶⁷). Health Facilities Scotland was in the process of implementing a number of National Education and Training Frameworks for facilities staff across Scotland and consideration had already been given to how these mapped to KSF. The Framework for Domestic Services (2007)⁶⁸ and the mandatory Domestic Assistants/ Housekeepers Workbook was already in place. In Ayrshire and Arran facilities managers were developing arrangements for the Workbook requirements to run alongside an SVQ with the local college.
- 7.48 A major problem in progressing assessment in domestic services was the low Workplace Supervisor to high support worker ratio and difficulties in freeing up

⁶⁷ Royal Society of Health Hygiene Certificate for staff classed as food handlers in the ward area where they were working

⁶⁸ Health Facilities Scotland, NHS Education for Scotland. (2007) *The National Education and Training Framework for Domestic Services. Domestic Assistants/Housekeepers: A Workbook to record your training and personal development.*

sufficient supervisors to undertake assessment, particularly weekend staff (para 4.7).

Monday to Friday is not a problem as we have backfill, some domestics work in department offices only, so they can be pulled out to cover an hour for the questions and answers, for a domestic on the wards to do supervision. But at weekends we don't cover departments at all. All the people we have cover the wards, the patient services so that is going to be a slower process.

(Hotel services manager)

- 7.49 Management prioritised the completion of the Domestic Assistants Workbook which might require a couple of hours per week for experienced staff over four to five months.

If two hours for the domestic every week you are looking at three, three and a half per week for the supervisor because they have to prepare exercises.

(Hotel services manager)

- 7.50 Ayrshire and Arran was able to begin to explore, with a small number of domestic staff, how the standards fitted alongside the Workbook. Managers said that supervisors found the extra task to be a chore and that also only some supervisors, familiar with or interested in assessment, would wish to undertake it or be able to undertake it with sufficient confidence to be able to instil confidence in the support worker. There was duplication with the Workbook but a perception that they could link together.

- 7.51 The standards strengthened some areas not particularly covered by the Workbook

It take a very strong person to put forward a complaint and that standard in particular when its highlighted that everybody has a responsibility, it might give them that bit more confidence...I think the fact that you are going through the statements, about verbal and physical abuse, even just talking about it, there's more awareness to it.

(Hotel services manager)

- 7.52 However these domestic assistants from different pilot sites did not feel the standards applied to them

It is more for the auxiliaries and clinical support workers. It was talking about looking out for violent situations starting up and patients and relatives relaying information to me, and how you should tell a colleague, or whoever is in charge of the ward. That's not anything I'd come up against. I just get on with cleaning.

(Domestic assistant)

We're involved with the patients like as domestics on the ward. We speak to the patients but to me a lot is like for personal care with the patients and that doesn't involve me.

(Domestic assistant)

- 7.53 It confirmed the competence of domestics who undertook the standards, but for some there were concerns about paperwork and potential written work:

Staff themselves quite enjoyed it, they didn't realise that they were actually quite up to speed with the standards, I think they got a pleasant surprise, they didn't realise they were doing it on a day to day basis.

(Hotel services manager)

- 7.54 There were also concerns that ancillary services are often recruiting from a flexible or transient pool of staff. Such staff might find additional requirements off-putting (e.g. Disclosure Scotland applications, induction preparation, potential payment for regulation) and may prefer to take up less demanding employment (e.g. local supermarket).

Summary

- 7.55 Participating HCSWs (82%) supported the pilot aims. Undertaking the standards improved confidence, knowledge about patient safety (44%) and ability to take action to keep patients safe (46%). The certificates and presentation ceremonies made them feel valued.
- 7.56 HCSWs found that supervision arrangements and decisions about the relevance of previous achievements were mostly decided without difficulty, but for some these were both problematic. Half the HCSWs prepared for assessment partially or wholly within their own time (on average around two to four hours). Mostly (64%) the level of difficulty of the standards was 'about right'. Most (71%) were happy to be entered upon the 'occupational list' but many had little understanding of what this might mean. Half the HCSWs and three quarters of WPS already had a KSF outline but this varied across sites and posts; more WPS than HCSWs were aware of potential for the standards to fit with KSF.
- 7.57 As originally anticipated, assessment was usually completed within two to three months; slippage concerned logistical rather than HCSW capability issues. The level of assessment effort required was generally acceptable but paperwork needed to be reduced. It was not possible for non-clinical groups, who did not have direct patient contact, to evidence four of the standards.
- 7.58 Stakeholders expressed consensus about the principle, applicability and practicality of applying the standards to nursing assistants and allied health assistants, but there remained very varied views in relation to non-clinical groups. The lack of engagement of non-clinical groups with the pilot was attributed to: gaps in communication nationally and locally, other priorities in training, the high HCSW to low WPS ratio, lack of identification of this group of workers with the term 'healthcare support worker'.

8 NHS BOARD SELF-ASSESSMENT & PEER REVIEW

Introduction

8.1 The SGHD Guidance to participating NHS Boards included the Code of Practice for Employers, which states at criterion 3.1 that:

NHS Quality Improvement Scotland (NHS QIS) will check the quality of the systems and processes for self-monitoring put in place by NHS Boards taking part in the national pilot. These systems and process will be designed to:

- Help Boards to achieve the standards and
- Make sure that Boards are meeting these standards and report on how they are doing this.

To help Boards prepare for this self-monitoring, NHS QIS will develop a self-assessment document so Boards can show how they are meeting the standards. Self-monitoring carried out by Boards, and the external quality assurance NHS QIS carries out, will be consistent with monitoring processes which relate to the NHS QIS clinical governance and risk management standards⁶⁹.

8.2 To do this NHS QIS developed a self-assessment framework for participating organisations to measure compliance with the code of practice, and verified the evidence submitted in this framework through a process of peer review. The Guidance intention was that this quality assurance approach was to be consistent with monitoring processes which relate to the NHS QIS clinical governance and risk management standards.

8.3 This chapter outlines the development and outcomes of the NHS QIS Board self-assessment and peer review process (summarised from the NHS QIS report). Pilot site stakeholders and the NHS QIS National Project Steering group were fully involved in these development processes. It was agreed with SGHD that the evaluation role was to capture stakeholder perceptions of the process of developing the approach, the experience of self-assessment and review visits and their views on the outcome.

Development of the materials and processes

8.4 The code of practice sets out standards based upon good employer practice and the Boards must be working to this code in order for HCSWs to successfully complete the induction standards and sign the Code of Conduct.

8.5 An NHS QIS working group was set up to develop an assessment model for employers and aimed if possible to use a tried and tested model, already well received by Boards. Initially the working group drew up a framework based upon an established self-assessment and peer review process⁷⁰ commonly used for assessment of NHS QIS clinical or topic related standards. This would follow four Stages:

⁶⁹ NHS Quality Improvement Scotland (2005) *Clinical Governance and Risk Management: Achieving safe, effective, patient-focused care and services*. NHS QIS. October 2005

⁷⁰ This is described fully in the NHS QIS project report.

Stage 1	Design and disseminate a self-assessment to gather evidence from the NHS Boards on how they are meeting the criteria within the code of practice
Stage 2	Identify and train peer review team members
Stage 3	Receive and analyse NHS Boards' submissions (completed self-assessment and supporting evidence)
Stage 4	Produce a report of the findings which identifies strengths and challenges and makes recommendations for improvement

- 8.6 The proposed approach was put to the NHS QIS National Project Steering Group (September 2007).
- 8.7 Three points were discussed at length. The resource implications for pilot NHS Boards and the NHS QIS as facilitator; the sustainability of the approach should the piloted model of regulation be rolled-out; the possibility for using evidence already submitted under NHS QIS Clinical Governance and Risk Management (CGRM) reviews.
- 8.8 Site leads in particular were concerned about the potential burden upon NHS Boards and were keen to avoid duplication of effort. The NHS QIS working group had already noted that just two pieces of core evidence used for CGRM reviews were listed as core evidence for the code of practice. However, there was a major difficulty in that this core evidence would no longer be current for pilot purposes (evidence for reviews might have been gathered up to two years previously, May 2006).
- 8.9 Subsequently the working group investigated possibilities for a less resource intensive and more proportionate model, in recognition that the code of practice had a different function and was less wide ranging than a set of NHS QIS clinical standards. The code specifically highlights five key areas that employers should focus upon in the intended employer-led model of regulation (making sure staff are well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently and provided with an improved and safe working environment). These are underpinned by existing systems of health-care governance and staff governance (the Staff Governance Standard, PIN guidelines) and existing good employment practice.
- 8.10 The working group then considered an approach used to evaluate the Primary Medical Services Quality & Outcomes Framework review (NHS QIS 2006)⁷¹. This external quality assurance exercise seemed closer to the pilot requirement to assure employer compliance with the code of practice. The self-assessment element and report back format was more concise and there was a reduced level of work required from Boards themselves in analysis of submissions. Each Board would complete a pre-set format, referencing the relevant policies and procedures in place. They would also rate themselves on the quality improvement scale below :

⁷¹The Primary Medical Services (Scotland) Act 2004 introduced the concept of the Quality and Outcomes Framework (QOF) as a voluntary contractual requirement for participating GP practices. NHS QIS was commissioned to design a self-assessment framework for NHS Boards to monitor their performance and deliver an external quality assessment (QOF EQA) programme.

0	Nothing in place, system or process has not yet been developed
1	Under development or developed but not fully implemented
2	Fully developed and implemented throughout the service
3	Fully developed, implemented and regularly monitored

- 8.11 The revised assessment model plus six options for the review process were put to the NHS QIS National Project Steering Group (November 2007). The options put forward various combinations of professional adviser/reviewer, review teams and visits. The model agreed on was two or more review teams (depending upon availability) comprised of members from the National Steering Group and aimed to include a NHS QIS manager, Public partner, Staff side representative and a Pilot project lead from a participating NHS Board (not the one under review).
- 8.12 The NHS QIS National Project Steering Group approved the revised approach in December 2007. The self-assessment and guidance for completion was issued to Boards early January 2008 for return with supporting evidence by end of March 2008.
- 8.13 Each pilot Board completed the self-assessment framework, assessing its own performance against the standards within the code of practice, using the associated guidance on the type of evidence (policies and reports) to be provided. NHS QIS analysed the self-assessment submissions and supporting evidence. The review team received the analysis and samples of supporting evidence one week in advance of the visit. All evidence was available on request and on the day of the visit to inform their deliberations.
- 8.14 The peer review team visited the pilot site, met with staff implementing the code of practice and with HCSWs and WPS. Afterwards the review team assessed performance against the standards, based upon the self-assessment exercise plus the visit. NHS QIS drafted a local report of findings which was forwarded to the review team for comment, then shared with the employer to check for factual accuracy.
- 8.15 It was agreed that the aim of piloting the assessment model was to test whether it was an effective method of quality assuring employer's self-monitoring of achievement of the standards within the code of practice. As such, local findings were not to be published but would be available for the local employer to inform future improvements, be shared with the external evaluation team and be used to inform final pilot outcomes.

The outcome of the quality assurance process

- 8.16 As the code of practice sets out standards based on existing good employer practice, NHS QIS expected the participating organisations to achieve the second level on the quality improvement scale and this was achieved for most performance assessment criteria. The exceptions were for those criteria relating to KSF which scored level one (this was anticipated as it was acknowledged that KSF was not yet fully implemented in some places).

- 8.17 NHS QIS acknowledged that it would be difficult for pilot sites to achieve the third level of the scale, within the timescale of the pilot, as they would have to demonstrate that they are *regularly monitoring the implementation of the standard to make continuous improvements in achieving safe and effective patient care*.
- 8.18 The review teams on the whole agreed with the Boards' self-rating on the scale. Two kinds of challenge arose. The first was around evidencing 'monitoring'. The NHS QIS report highlights the reasons for difficulty in evidencing monitoring
- evidence of monitoring some of the standards criteria would be challenging to provide during the piloting of the learning and assessment process;
 - the self-assessment framework did not clearly indicate the evidence of monitoring required to achieve the third level on the quality improvement scale; and
 - two criteria describe how to manage particular outcomes which an employer may not have experienced, and therefore cannot yet monitor and review
- 8.19 The second challenge was around applying a consistent approach to submitting and reviewing evidence for some criteria. For example Criterion 2.1.1.1 of the Code of Practice states
- You must have strict recruitment and selection procedures in place and carefully follow Disclosure Scotland and other vetting procedures
- 8.20 Reviewers highlighted that there was no prescription on how the requirement should be achieved; no single organisational recruitment policy is prescribed; where more than one recruitment policy was in place (inherited post re-organisations) it was difficult for reviewers to ascertain whether procedures were being closely followed in relation to particular healthcare support workers to ensure all are suitable to enter the workforce. Reviewers suggested that in order to meet this criterion, organisations should be implementing a single organisation wide recruitment policy.
- 8.21 NHS QIS also obtained feedback from reviewers (an evaluation form), participating organisations and HCSWs and WPS taking part in review visits. There appeared to be some differences in feedback reported to the evaluation team.

Participating stakeholder perceptions of the Board self-assessment and review process

- 8.22 Pilot site staff expressed some strong feeling that the full requirement for self-assessment, with its potential burden upon a range of staff, had not been fully considered pre-pilot and was not fully apparent at the time of the bid. They also acknowledged the tension between the need to develop a sufficiently robust process to underpin confidence in the model of employer-led regulation against the desire that the model should not place a large paperwork burden on NHS Boards.

- 8.23 The evaluation found some foundation to the first point. At the time of the original SGHD invitation to bid (July 2006), the standards were still out for consultation (closed 31 August 2006) and were not actually published until November 2006. However the invitation was clear about the three elements of the standards (the induction standards, Code for HCSWs, Code for Employers) and it was explicit that the pilot would test: the balance between individual and employer responsibilities in relation to the regulatory standards; what compliance monitoring activities are effective; how the requirements of the pilot interact with routine human resource processes and existing governance arrangements and to identify any gaps. The Guidance (in draft from July 2006) received input from the Human Resources Directors group and was issued to local site officers in the autumn. However sites felt that it was not until the final Guidance⁷² (December 2006) became available that the role of NHS QIS in quality assurance and the process for developing the NHS Board self-assessment was finally clear.
- 8.24 Pilot sites continued to express surprise at the scope of the NHS QIS exercises despite the fact that they had been discussed and agreed at the NHS QIS National Steering Group. Pilot sites felt the exercises, particularly the Board self-assessment and peer review process, were in excess of what they had signed up for. There was a strong sense of frustration about the pilot growing unanticipated '*arms and legs*' and at having additional requirements to meet above the evaluation, which they had engaged with from the start. Sites also expressed concern that HCSWs had not signed up to the QA processes. Some stakeholder and case study interviews indicate confusion between the two processes.
- 8.25 NHS QIS made clear that the end report would not be published as the exercise was intended to test the 'review process' within the pilot rather than testing the achievements of the pilot sites. Nevertheless, sites took the process and self scoring seriously. Several issues arose as a consequence of the limitations of a 'pilot' which it was felt compressed the whole process. The self-assessment document was seen as being formalised late in the day, giving relatively little advanced warning of content. The actual time for preparation of the document was short at six weeks. Stakeholders felt that the review visit was occurring too early in the pilot and this was expressed within both the longest running pilot and the newest. It was felt that recruitment of HCSWs, learning and assessment had not really got far enough along. Also, normally after such NHS QIS reviews, within 6-8 weeks of the report being published, internal clinical effectiveness would work towards drawing up an action plan towards improvement, but the short timescale pre-empted this.
- 8.26 Stakeholders seemed happy with the format for the self-assessment submission. However the whole process was resource intensive. Some external members of review teams expressed astonishment at the huge amount of material generated. Time to properly read all the paperwork before the review visits was an issue.

⁷² Healthcare support workers in Scotland – improving standards: a national pilot of standards and listing in three NHS Boards December 2006

- 8.27 Some site managers felt the process of drawing up the self-assessment was very beneficial in re-familiarising themselves with policies and underlining their confidence in procedures already in place. NHS QIS noted that this was the standard kind of review format and some site lead officers were familiar with the process but it was a steep learning curve for LPCs at two sites. There did not seem to be any surprises for sites in the reports back from the NHS QIS review visits.
- 8.28 There was clear support for a peer review visit and all felt the format chosen was appropriate and that other options were insufficiently testing.

If it wasn't done properly, what was the point?

- 8.29 The membership of the peer review panel was considered appropriate, but there was a weakness (because of the limitations of it being a pilot) in that no one person attended all sites and all non-NHS QIS members only saw two sites. Different panels could therefore end up having quite a different balance of skills and interest within the group which might lead them to focus on particular issues. It was raised that should this format be rolled out the role of the central, in this case NHS QIS, representative would be a powerful one. Members were, however, happy that they had had opportunity to comment upon the reports back to Boards.
- 8.30 Stakeholders liked the format and overall style of the peer review day and were not seeking any structural changes. The meeting with managers was described as '*relaxed*', '*non-confrontational*', '*encouraging*' and not just a paper exercise. However Board representatives and panel members described each day as being very different in style, with different areas of focus and a perception of different levels of 'pressure'.
- 8.31 Pilot sites felt it appropriate that they were not advised in advance of panel questions and largely found the questioning appropriate and sufficiently probing. However, it was suggested that questions relating to non-clinical HCSWs were considered inappropriate in Lanarkshire which had not engaged with this group; at another site, it was raised that questions were insufficiently probing to uncover just why non-clinical staff recruitment was slow. Several review panel members felt that the pilot had been intended to cover the full list of staff groups in the Guidance and that the review had only really been able to test progress for clinical groups.
- 8.32 Pilot site stakeholders felt that no serious gaps in human resource or clinical governance arrangements had been brought to light in the review, but there was some work to do. Some issues were: stage of roll-out of KSF; unclear guidance from NHS QIS on how to evidence 'monitoring' of policies; monitoring of policies such as on harassment and bullying is made difficult by confidentiality constraints; multiple policies and practice in operation following re-organisations.
- 8.33 It was noted that the NHS QIS review process was designed to test whether individual Boards had mechanisms and particular policies in place. It was not designed to test whether it was the same mechanism/policy at each Board. To

ensure consistency, a cross-Board review of policies highlighted in the self-assessment and review process might need to be considered before progressing with an employer-led model. It was suggested that procedures based upon NHS PIN (Partnership Information Network) policies were likely to be consistent across Boards as this is their intention, but any areas lying outwith these policies could potentially show more variation (however they did not specify what these areas might be).

- 8.34 There was considerable variation in review team members' views on the HCSW meeting section of the day. At one site, it seemed there was a perception of HCSWs having been told to come and, at another, HCSWs were very animated and engaged. At another, some HCSWs had not got far into the process and did not seem clear why they were there. It was suggested that should the pilot be rolled out, there would need to be a mechanism for a more robust review of HCSW engagement – for example, auditing paperwork for a random 5-10% sample, meeting a sample selected by the review team not selected by the site and, possibly, multiple meetings to speak with different staff groups across hospital and community sites. There appeared to be variation across sites in the extent to which relevant Board policies were easily accessible for HCSWs via paper copies or computer.
- 8.35 In summary, stakeholders were broadly happy with the format of the self-assessment document, the membership of the peer review panel and the format of the review day. They felt no serious gaps in human resource or staff governance arrangements were uncovered. However the whole process was very resource intensive.

Views on the Employer Code of Practice and compliance monitoring

- 8.36 By the end of the pilot there was general support for the Employer Code of Practice in its current format. It did not appear that there was anything within the Employer Code of Practice which was not already supported by a PIN guideline. There was some view that the Code of Practice's standards themselves were not prescriptive enough and that there was still room for interpretation (see para 8.19 re recruitment policies).
- 8.37 There were more mixed views about the format of compliance monitoring and calls for a review of the entire approach. It was perceived to have placed a very substantial and disproportionate burden on Boards and reviewing staff. It had been carried out too early. It could not be tested against non-clinical support workers as the pilot had failed to recruit them at the time of the exercise. It was largely not possible for pilot sites to meet the 'monitoring' criteria. It really should have been addressed once employers had got much further with recruitment and assessment, but this was outwith the timescale of the pilot.
- 8.38 There were also some apparent limitations or omissions in the compliance monitoring format devised. The Code of Practice for Employers only covers the 5 standards in the Code of Practice (it does not directly cover the induction standards or the Code of Conduct). NHS QIS had also developed a complaints and appeals process, referenced in the Healthcare Support Worker Handbook, but this was not covered in the Board self-assessment. Nor had there been any

appeals arising during the short time of the pilot so the mechanism could not be tested in practice.

- 8.39 It was also felt that monitoring of policies alone was insufficient; a Board may have a consistent policy but it may not be consistently implemented. An impact assessment was required to address whether the policies were indeed contributing to patient safety and public protection (this would require establishment of a baseline and measures to detect change).
- 8.40 There was continued debate throughout the pilot as to whether there was a need for compliance monitoring at all. During the middle stages of the pilot there had been quite strong expression of a preference for a central, external 'governance or review' role but no clear idea as to where this should sit. Later in the pilot the NHS Board self-assessment and peer review had confirmed just how much was already in place at Boards and there was strong feeling that should the Employer Code of Practice need to be evidenced this should be done in a proportionate way without creating an extra burden upon Boards and attending healthcare support workers and supervisors. The setting up of a new scrutiny body or alternatively using an existing scrutiny body was seen as potentially adding yet another cumbersome step and that the responsibility should be left with the employer.
- 8.41 Several suggestions were made as to where compliance monitoring might best fit. An early suggestion was to place it within the NHS QIS Clinical Governance and Risk Management (CGRM) self-assessment and peer review. NHS QIS felt it might be possible to add some high level questions relating to healthcare support workers but that there would not be scope to pay sufficient attention to the support of 'healthcare support workers' to achieve the standards. Timing was also an issue⁷³.
- 8.42 There was support for placing compliance monitoring within the remit of PIN guidelines and the Staff Governance Review (and HEAT targets) to assure employer accountability. There was some expression that the fact that the national pilot had not been included within the Staff Governance Review (of employer policies and clinical risk) was an accident of timing – at another time its existing processes (NHS QIS visits and audit tools) might have been utilised. Further detailed work would be required to identify any gaps and investigate possibilities for an integrated approach.
- 8.43 It was noted that NHSScotland, as a single very large employer can implement policies (PIN guidelines) across the whole of Scotland with a very real possibility of gaining consistency. In contrast the social care sector covers multiple employers, of varying sizes, and an external body is required to manage scrutiny across such a diverse range.

⁷³ While the code of practice quality assurance model was being piloted the Clinical Governance and Risk Management (CGRM) self-assessment was under review. The final self-assessment will be disseminated to NHS Boards ahead of the peer review cycle commencing in May 2009. It is anticipated that the CGRM standards and self-assessment framework will be revised in 2011; this would represent the first opportunity for any revisions relating to the code of practice to be fully considered. (source: QIS draft management report)

8.44 There were also remaining questions about the implications if Scotland chose to go it alone with an employer-led model. UNISON national level representatives continue to express concerns about the potential for conflict of interest in employers having the two roles of 'employer' and 'regulator'. However respondents were aware of the two NMC conferences (February 2008⁷⁴ and June 2008) where following much debate about the traditional statutory model of regulation as widely known and other alternative models there had been a shift "in the level of support for 'hybrid' or 'mixed' models of regulation utilising different components of each broad approach".

Summary

8.45 The Employer Code of Practice was generally supported in its current format. NHS QIS, in consultation with pilot sites, devised and tested a robust format for compliance monitoring of the Code which included a Board self-assessment exercise and peer review visit. In practice no serious gaps in current human resource or clinical governance arrangements were found. However the whole process was perceived to have placed a disproportionate burden on Boards and reviewing staff and stakeholders wished to see the compliance monitoring approach reviewed.

⁷⁴ *Key Outcomes of the NMC hosted Summit Meeting "Health Care Support Workers: exploring developments: a UK debate"* (26 February 2008).

9 QUALITY ASSURANCE OF INDUCTION STANDARDS AND PILOT PROCESSES

Introduction

- 9.1 NHS QIS instigated two additional measures to assure quality and aid in capture of project learning: a quality assurance process for the implementation of the HCSW induction standards; and organisational development (OD) input to the pilot from external consultants. The NPC also coordinated robust internal pilot monitoring systems and the collation of pilot site monitoring data.

HCSW Induction standards – quality assurance

Initial proposal

- 9.2 Initially NHS QIS designed a quality assurance process for reviewing the implementation of the induction standards and the systems put in place to enable the HCSWs to achieve them. It was suggested that LPCs observe and review the progress of a sample of HCSWs (1 in 10) at defined stages of the process (initial meetings with supervisor, assessment meetings). In addition it was suggested that a quality review of completed assessment paperwork (looking at variance in how individual sections were completed) might be undertaken by management representatives from the local sites. The pilot sites were not at all enthusiastic about these suggestions. Firstly, they felt that the LPC role was already stretched and that carrying out the proposed reviewing task would seriously compromise time available for the LPC to continue the recruitment process. Secondly, pilot sites felt that the task of examining assessment materials required a level of resource, staff time and particular knowledge that they could not supply.

Consultant report

- 9.3 Given the lack of support for the first proposal, NHS QIS commissioned external consultants⁷⁵ to evaluate the implementation of the learning and assessment process for HCSWs. This work took place April-August 2008 and consisted of face-to-face participant interviews (55 HCSW, 32 WPS), over 9 separate days, in three pilot sites. Questions, based on Part 3 of the HCSW handbook, elicited HCSW expectations and experience of the pilot, view on standards and assessment, support for learning and suggestions for improvements. Additionally WPS were asked their opinion of the local WPS: HCSW ratio and the potential fit of the process with KSF.
- 9.4 The consultants considered the use of a questionnaire but this was rejected because of the potential to interfere, or cause confusion, with the SGHD commissioned evaluation of the pilot.
- 9.5 The findings from this element mirrored the external evaluation findings from HCSW and WPS surveys and case studies e.g. supervisor views on ratios and fit with KSF. Therefore they are not reproduced here.

⁷⁵ Frontline Consultants, draft report, September 2008.

9.6 The consultancy also reviewed completed Oral (76) and Observation (93) assessment papers, looking at consistency across recorded evidence of previous achievement and current evidence and decisions made. This aspect was not covered by the external evaluation and therefore some very key findings are reproduced here.

- There were no 'not satisfied' decisions recorded for Observation or Oral Assessments
- There was huge variation in evidence recorded by WPS, from single word, to lengthy text to verbatim; evidence recorded for 72% Oral and 45% Observation assessments were considered of adequate quality to demonstrate meeting the particular criteria
- There was no note of further action required on Oral or Observation assessments

9.7 The report concluded that: there needs to be absolute clarity in the guidance given to WPS about describing whether and how HCSWs are meeting assessment criteria.

Organisational Development (OD) exercise

9.8 NHS QIS commissioned an organisational development (OD) consultancy⁷⁶ to provide input to the project management of the pilot and to evaluate the main OD issues as they emerged. The consultancy conducted a workshop with LPCs (April 2008) and a telephone survey with pilot site lead officers in August 2008. The report drew out potential OD issues to be addressed for any future potential roll-out. The report essentially confirmed findings elicited by the evaluation from stakeholder interviews and observations.

Internal pilot reporting systems

9.9 The National Pilot Coordinator set up a system of monthly update reports (increased to fortnightly from October 2007) from pilot sites, which were collated into national pilot reports and forwarded to participating sites, SGHD, the National Project Steering Group, and the evaluation team.

9.10 Local data sets were developed and agreed between the NPC, LPCs and the evaluation team. The data included information on pilot progress for each HCSW from the date of invitation to take part to sign up to the pilot to progress through assessment and eventual entry upon the occupational list. The Disclosure process (dates only) but not outcome was also recorded. As the pilot developed, data fields were refined and some were added to ensure the capture of all relevant information. Anonymised data was forwarded fortnightly to NHS QIS and shared with the evaluation team as required.

9.11 The ability of the pilot sites to set up and resource the set-up of databases to record local monitoring data varied widely. The three Local Pilot Coordinators had widely varying levels of skill and experience in the creation and maintenance of simple databases, with only one site able to fully facilitate all

⁷⁶ Ashleigh Dunn – LifeTree.

the monitoring tasks required in the course of the pilot. Lack of administrative staff support exacerbated this. Pilot sites found the requirement to service update reports and monitoring data (with later format changes for the evaluation) to be a burden.

9.12 NHS QIS was unable to provide sufficient IT support to facilitate direct electronic transfer from the pilot site monitoring data sources to the NHS QIS database, consequently data had to be re-keyed with the consequent risk of inaccuracy and inefficiency. The evaluation team and NHS QIS cross-check of the local site data highlighted errors and these were addressed before final analysis.

9.13 For the future the evaluation team would recommend the development of a national format of monitoring database or spreadsheet or alternatively an appropriately skilled level of administrative support at a central body to advise local sites on the format and content of data collection.

Summary

9.14 Pilot sites felt there was neither funding nor sufficient local capacity to conduct additional quality assurance exercises. NHS QIS commissioned external consultants to evaluate the implementation of the learning and assessment process for HCSWs and to provide additional organisational development input to the project. The findings confirmed findings elicited by the pilot evaluation and in addition highlighted the need for absolute clarity in the guidance given to WPS concerning assessment practice. Pilot monitoring databases were successfully organised but monitoring was hampered by lack of administrative support at sites and by lack of technical support at NHS QIS; additional resource would be required in future.

10 CONSULTATIVE WORKSHOP

Introduction

- 10.1 The Scottish Government Health Directorates held the first annual Regulation event, in Edinburgh in October 2008⁷⁷. Day one provided an update on regulation of existing professions and extension of regulation to emergent healthcare professions. The second day, a world café style event⁷⁸, focused on the regulation of healthcare support workers project in Scotland. There were some 200 delegates listed for day two including ten support worker staff and a range of workplace supervisors from clinical and non-clinical backgrounds plus senior and middle management representatives from healthcare professions, Health Boards and related agencies. Many delegates had also attended the first day of the regulation event.
- 10.2 Opening presentations⁷⁹ set the context for the day with high level outcomes from earlier consultation on regulation and the standards, working definitions for Healthcare Support Worker and Regulation and also brief descriptions of different regulation models. The NHS QIS National Pilot Coordinator and ScotCen provided updates on the pilot project in action and the evaluation study emergent findings.
- 10.3 In facilitated⁸⁰ table discussions, delegates worked in groups, mixed by interest and skill, to get to grips with examples of the standards, assessment materials and Code of Conduct for HCSWs and Code of Practice for Employers. Each table was asked to consider one standard and to look at issues around preparation, assessment and follow on for a new support worker. At each table a facilitator supported discussion and a scribe recorded discussion points on paper tablecloths with questions noted to go forward to the plenary group. All participants at tables were invited to jot down their own thoughts and issues on to the paper table cloths for later collation.
- 10.4 This was followed by an informal plenary panel⁸¹ discussing questions emerging from the floor. Delegates then voted electronically on a series of questions, posed by SGHD and the 4 Country Steering Group, designed to

⁷⁷ Scottish Government Health Directorate, in partnership with the UK health professions' regulators, first annual event, Edinburgh 28 & 29 October 2008

⁷⁸ The World Cafe is a method which makes use of an informal cafe for participants to explore an issue by discussing in small table groups. Discussion is held in multiple rounds of 20-30 minutes. The event is concluded with a plenary. <http://www.theworldcafe.com/>.

⁷⁹ Audrey Cowie, Professional Adviser, SGHD; Bridget Hunter, Unison; Paul Martin, Chief Nursing Officer, Scotland; Frances Dow, lay chair 4-country steering group; Anna Wimberley, NHS Quality Improvement Scotland; Anne Birch, Scottish Centre for Social Research

⁸⁰ Facilitators were drawn from officers familiar with the pilot: the membership of the QIS National Project Steering Group, pilot sites' lead officers and SGHD officials

⁸¹ Frances Dow (Lay chair 4 country steering group), Paul Martin (Chief Nursing Officer), Hazel MacDonald & Diana McLarty (Speech and language assistant and therapist), Anna Wimberley (QIS), Anne Birch (ScotCen)

elicit delegate views and help inform future policy options. The day was recorded in full for SGHD by a professional report writer⁸².

Issues arising during the workshop

- 10.5 The discussions were very lively with delegates taking an active interest in their table's standard and the process for a new worker, although some tables appeared to have focused more upon the particular standard set whereas others looked more at wider issues related to the standards⁸³. Discussion centred upon: national level requirements, Board level requirements, the standards, the process and assessment.
- 10.6 Delegates noted that national rather than Board level consideration and decision-making was required in several areas to promote consistency. These included:
- Promotion of consistent principles and standards across all care sectors
 - Consideration of the independent sector and links across all sectors
 - Decision re voluntary/mandatory status of standards
 - Timescale and resource to bring existing employees into the model
 - Implications of not meeting the standards, at Board and individual HCSW level
- 10.7 At NHS Board level the comments focused around two key topics: resources and fit with existing key processes. Firstly, in order to implement the standards Boards felt they required resource for: backfill for HCSWs and WPS time for training and assessment; enough supervisors and/or dedicated workplace assessors. They needed to address the practicalities of covering bank and temporary staff, differing shift patterns and the potential need for flexibility in work patterns. Boards needed to consider how all staff could be enabled to access the required training and education opportunities to support the maintenance and development of skills, including the practicalities of regular '*protected*' study, development and assessment time. Boards also required resource to address the potential literacy/numeracy issues of both HCSWs and WPS, including preparing individual WPS to address this issue in the supervisory role. Standard (S)13 in particular (*Working in line with the equality, diversity, rights and responsibilities of patients*) was noted as having potentially huge resource implications even though Boards already had many policies and structures in place to address this area.
- 10.8 Secondly, Boards required clarity about the proposed fit with existing structures and processes. Delegates emphasised the role of robust induction in: obtaining 'soft' information from new start workers, by observation and conversation; providing evidence of prior learning towards the standards; and the retention of new staff. They wanted to know how the standards will fit alongside other induction and training programmes (SVQs, HAI).

⁸² Alex Mathieson, freelance writer and editor, Edinburgh

⁸³ This summary of discussion is extracted from the independent workshop report.

- 10.9 An explicit fit with the Knowledge and Skills Framework processes was seen as crucial to future success and any points of difference should be made explicit. *S7 Developing your knowledge and practice* and *S8 Reviewing your working practice to improve your knowledge* in particular, linked with KSF dimension Personal Development, were noted as applicable to all staff.

*S7 Personal Development needs to include all staff not just clinical
S8 needs to link to the generic worker role and the NHS career framework
S13 should make explicit reference to the KSF dimension.*

KSF can support around 80% of standards achievement

- 10.10 There was feeling that on the whole the evidence and assessment required for the standards could be addressed under KSF. However there were still some concerns. The role of the job description should be clear in addressing aspects of the standards not considered to be covered by KSF (which addresses learning and development only). It would be beneficial for job descriptions to reference the Code of Conduct, for both new and existing staff, so any non-compliance might be managed in the same way for both staff groups.

S12 issue re working within own limits needs to be made clearer in job descriptions

- 10.11 At the process level, the main question remaining was what was the maximum length of time for the induction period for the standards overall. There was some feeling that particular individual standards should perhaps have time limits e.g. S1, preventing harm and abuse to be done in three months; the time limit for S2 being fit (healthy) to work. It was noted that only one year was allowed for achievement of the first KSF gateway.

Must be available support towards achievement, training and support needs to be agreed, supplied and recorded

- 10.12 Following this, clear guidance was required on how many times an individual could fail and be reassessed and what would happen if standards were not met. Further clarity on timeframe was required both in terms of achieving the standards overall (*only one year to get through first gateway of KSF*) and in relation to reasonable time to achieve individual standards (*S1, six months too long, three enough especially for S1, preventing harm and abuse; S2, being fit and healthy to work*).

- 10.13 The WPS and HCSW relationship was recognised as key to the pilot success. The initial preparatory meeting between WPS and HCSW was considered beneficial.

Defining role of HCSW & WPS, air fears/anxieties, assess existing knowledge/experience, extol benefits of compliance with standards and promote a patient centred approach

- 10.14 The overall process *'has boosted confidence'* and *'helps maintain and improve skills'*.
- 10.15 Positively the standards were seen to provide assurance to the public on workforce competence, as a useful marketing tool to promote recruitment to healthcare and as a learning and development tool. However there were questions about how any one standard could be applicable for all grades, roles and environments. There were remarkably few comments upon the written format and content of the induction standard statements and criteria, and those that were made related to just half of the fourteen standards. There were concerns about language, how understandable some terms might be for some staff (S11, *will HCSW fully understand the discrete meanings of 'managing' and 'resource'?*; S14 *what do terms mean 'abuse'?*); and about ambiguity (S1, *'is it about patients or staff?'*; S2, criteria 7 *'does this only include essential vaccines (hepatitis) or does it also cover the 'flu vaccine?'*) Some clarification was called for (S1 *more information needed about appropriate lines of communication*; S12 *is 'vicarious liability' covered?*) The title of S14 was *'not transparent'*.
- 10.16 A particular view was that S14 *'Whistle-blowing' should be part of the Code of Practice but not the standards – the Code of Practice supports people to whistle blow but the standards require them to do so*. It was felt inappropriate to expect 'induction-level' workers to comment upon the actions of more experienced staff.
- 10.17 There were some concerns about the observational assessment, its *subjective nature*, clearer guidance on the evidence required (S12, S4, S3) and the need for it to be *continual, iterative v one-off 'snapshot'*. The PDP and review process was noted as useful for achievement of standard (S2, S12). Concerns noted elsewhere about the overall amount of paperwork and poor match between the performance criteria and assessment questions were again noted. Delegates suggested the inclusion of more case studies and examples to aid HCSWs thinking and understanding of the types of appropriate evidence. Evidence could also be applicable across several standards.
- 10.18 Two standards were noted as posing particular assessment challenges. S6 *Working within confidentiality guidelines* promotes positive behaviour but may be difficult to observe in practice and was considered as seeming less applicable to non-clinical staff. S9 *Contributing to team work* may benefit from witness statements from other staff members; may be difficult for lone workers; may be more difficult for HCSWs whose first language is not English if language is an inhibitory factor; possibly more challenging for non-clinical staff.
- 10.19 There was a suggestion that the Code of Conduct Declaration should be signed up to on day one of employment rather than after achievement of the standards.
- 10.20 During the plenary panel Paul Martin, Chief Nursing Officer, confirmed what the pilot was trying to test out. In summary, the standards provide an easily accessible, single route map for patients and public to understand what healthcare support workers do. The pilot will promote, through achievement of competencies (reflecting knowledge, skills and attitudes) the delivery of

common standards for support workers across Scotland, which will promote positive practice and ways of working, underpinning patient safety and public protection within a safe environment. The standards will add to the safety agenda by making it safer still but they are one part of a toolkit amongst others (e.g. Staff Governance Standards, PIN guidelines). The balance of employer and employee responsibilities is being tested by the pilot.

- 10.21 The plenary panel underlined the importance of everyone in the team but also acknowledged queries about staff not yet included in the pilot (e.g. administrative staff), about non-applicability of standards to some and issues to do with equalities and diversity. The difficulties of the multiplicity of development initiatives and acronyms was aired and there was a clear plea from the floor for a single recognisable naming of assurance that was clear to the public. It was also highlighted that KSF cannot be used by the independent sector and Partnership representation presented the view that KSF can cover much of the standards assessment but not elements concerning employee attitudes and behaviours or good employer practice.

The voting questions and results

- 10.22 A series of pre-planned questions (Annexe N) were presented on screen with options for delegates to 'agree,', 'disagree', or express 'no opinion' through pressing the appropriate button on a handset. Total responses for each question were then calculated automatically and the result shown on screen before the presenter progressed to the next question. The following results need to be viewed with some caution as there were some technical difficulties⁸⁴ on the day and also there was a wide variation in the number of delegates voting on each question. Around 110 delegates were present for the afternoon panel and voting exercise and this figure provides the denominator. Around half (53%) voted on 13-14 questions, 16% voted on 10-12 questions and 6% voted on 8 or fewer questions.
- 10.23 There was broad support from delegates present for the principle of the standards. 72% (79) agreed that standards should be mandatory for all HCSWs and 13% (14) disagreed, with 8% (9) saying standards should definitely not be mandatory for HCSWs. There was less interest in voting on sub groups of HCSWs with 32% (35) indicating standards should only be mandatory for clinical support workers. Two thirds (63%, 69) felt the standards would enhance the patient experience of support workers they came into contact with.
- 10.24 There was much less confidence in the piloted assessment tool to test achievement of the standards. Only 24% (26) agreed it should be used and 38% (42) disagreed with it being used in the future regulation of HCSWs.
- 10.25 Delegates supported the Code of Conduct for Healthcare Support Workers as a useful addition to the standards (75%, 83) and felt that it helped HCSWs

⁸⁴ There were some issues with the electronic voting system, it appears delegates may not have voted within the 35 second time limit or not selected the 'no opinion' option. In total 110 hand sets were in active use. (For the last questions only delegates from particular sub-groups were eligible to vote, baseline group numbers were not established and numbers of votes cast were small).

know what is expected of them. The Code of Practice for Employers was also seen as a necessary addition (65%, 71). However delegates largely had no opinion (49%, 54) or disagreed (11%, 12) that the accountability framework for employers, as tested, is fit for purpose.

10.26 Most delegates (81%) did not vote or had no opinion in relation to question 8 on whether there was a case for a 'positive' list of HCSWs in addition to the forthcoming vetting and barring scheme.

10.27 There was support for a positive list to be held at a national level (68%, 75) and the same level of support that the model of standards and listing had potential to enhance public safety. There was a more divided view on whether the model would lay the foundation for future development of HCSWs (52%, 57 agreed and 22%, (24) disagreed).

10.28 In the last four questions delegates were asked to vote if they were a member of a constituent group and to say whether from that viewpoint they could see advantages with the model. Clearly people found these questions confusing or they did not identify with the constituent groups and some people voted for all four questions. Votes ranged from 'as a healthcare support worker' (65%, 13) to 'as an employer' (72%, 23) to 'as a patient' (61%, 67) seeing advantages with the model. 13% (15) voting across the four roles did not see advantages with the model.

Summary

10.29 On day two of the SGHD Regulation October 2008 regulation event, after lively table discussion, delegates expressed their opinion in the afternoon voting session. There was broad support for the Code of Conduct (75%) and for the standards to be mandatory for all HCSWs (72%) and a clear feeling (63%) that standards would enhance the patient experience but there were very mixed views about the piloted assessment tool.

10.30 The Code of Practice for Employers was supported (65%) but there was lack of or negative opinion about the accountability framework as tested. The proposal for a positive list, to be held at a national level was supported (68%) as was the potential for the model of standards and listing to enhance public safety (68%).

11 SUMMARY AND RECOMMENDATIONS

Introduction

11.1 The national minimum standards for Healthcare Support Workers (HCSWs) comprised three elements:

- • A set of induction standards for healthcare support workers
- • A Code of Conduct for healthcare support workers
- • A Code of Practice for NHSScotland Employers

11.2 The responses to the consultation on the national standards (2006) indicated support for the standards to be mandatory; however the potential complexity of the arrangements was such that it was decided to test out the model of employer-led regulation first within a voluntary pilot. The pilot ran from January 2007 to December 2008 within three NHS Boards. Here we summarise some of the main findings from the pilot and present recommendations for the way forward.

Implementation

11.3 NHS QIS and the participating Health Boards have successfully implemented a complex process. Almost one in six (16%, 470) eligible healthcare support workers were recruited and 41% (193) of these had been assessed and entered upon the occupational list. The pilot has been tested with 341 clinical support workers, across a range of roles (nursing assistants and a range of allied health staff). However the pilot attracted few non-clinical staff (63) (mainly domestic assistants and a few medical laboratory officers). The pilot has run within children's, mental health and older people's services across a wide range of urban and rural, hospital and community settings.

11.4 The pilot was hampered by early delay and the lack of coverage of some significant issues in pre-pilot planning. The pilot has highlighted the time required to establish supporting structures at sites including the engagement of partnership and managers at all levels, and the time required to identify eligible workers. The pilot has been very resource intensive requiring a great deal of flexibility from local coordinators to achieve its aims including weekend and evening work. Pilot coordinators successfully tested processes for the training of workplace supervisors and for recruitment and assessment of HCSWs. NHS QIS designed and tested processes for assessing compliance monitoring of the healthcare support worker induction standards and the Employer Code of Practice. There was a large degree of congruity between the NHS QIS additional quality assurance findings and the evaluation findings.

11.5 All HCSW participation was voluntary as there was no legislative underpinning to the pilot to require mandatory participation. The approach to engaging HCSWs or 'marketing' the pilot was therefore critical to its success. Recruitment was most successful within the smaller Health Boards and facilitated by targeting of line managers. In the largest Health Board the evaluation found an untapped pool of potential volunteers had not been captured. HCSWs had not volunteered because they had not been sufficiently

informed about the pilot or did not see the value of taking part; other reasons were the workplace was too busy, or other commitments took precedence. Pilot stakeholders felt that SGHD pressure to increase the numbers of recruits, with consequent focus upon recruitment processes, detracted from efforts to support the HCSW to complete the process.

- 11.6 Reasons given for the failure to attract non-clinical staff include: poor national and local communication, non-recognition of the 'healthcare support worker' title, the voluntary nature and lack of attractiveness of the pilot to ancillary staff. For facilities managers other existing commitments took priority and the low WPS to HCSW ratio made it difficult to resource supervisor time.
- 11.7 From the pilot experience of participating NHS Boards it appeared that future roll-out of the pilot could entail a large and substantial piece of work. This would involve recruitment across a wide range of services and a variety of approaches to engage potentially large numbers of new staff and possibly less well-motivated existing staff. This would require significant resource, beyond the level provided for the pilot, particularly for the larger Health Boards. In particular adequate administrative support to the local and national pilot coordinator's work would be required.

Recommendations

- 11.8 The evaluation indicates that roll-out of the pilot across all NHS Boards in Scotland might potentially carry substantial resource implications. However the resource required would be to some extent dependent upon future arrangements within NHS Boards for the implementation of the Knowledge and Skills Framework, for supporting maintenance of the standards through the KSF development review process, and articulation with local induction processes. We suggest NHS Board level resource may be required to cover the following:
- A lead officer/local coordinator role
 - WPS training and assessment
 - Assessment arrangements for work areas with low ratio of WPS to HCSW
 - Flexibility to cover all HCSW and WPS work patterns including bank, weekend, night staff and short shifts
 - Administration and materials costs
 - Disclosure Scotland applications, new and retrospective (including for some Workplace Supervisors)
 - A national coordinator role
- 11.9 A clear communications strategy is required to inform healthcare support workers and the public of the proposed way forward, including the anticipated timescale and proposals to bring existing employees into the model. Partnership representatives wish to be included in all aspects of future development and implementation, which would also be enhanced by the continued representation of patient and public interests.

Induction Standards for Healthcare Support Workers

- 11.10 Participating HCSWs (82%) and Workplace Supervisors (84%) supported future implementation of the standards. Workshop delegates supported mandatory status of the standards for all healthcare support workers (72%). Stakeholders felt that if the standards were not mandatory then existing pilot sites might keep up the good practice to some extent but that other Boards might well not take up the standards on a voluntary basis given the resource implications.
- 11.11 There was consensus from pilot stakeholders and key informants that the standards apply to clinical support worker roles but much less certainty and a broad range of views about including non-clinical support workers in the definition. Discussion centres on issues of 'direct care', 'applicability' of standards and practicality of arrangements for assessment.
- 11.12 The level of development and support required by Workplace Supervisors to enable them to undertake assessment of the induction standards require further clarification.
- 11.13 All the supporting materials (induction standards, information pack, and assessment tool kit) require some revision to ensure accessibility and consistency of language, to remove some identified ambiguity and to remove duplication across associated performance criteria.
- 11.14 Stakeholders and key informants suggested that a way forward might be to cease considering the induction standards as a single package but rather to repackage them altogether into a modular approach. There would be a core element and then different elements appropriate to different circumstances (e.g. clinical or non-clinical support worker, standards requiring a shorter or longer time frame). A modular format might also enable different supervisors to undertake responsibility for different elements.
- 11.15 It was not possible within the limitations of the pilot to fully explore the mapping between the Knowledge and Skills Framework and other existing induction and development or training programmes in practice. Further detailed exercises were required.
- 11.16 There was also need for further consideration of how the principles and standards might in future be consistently applied across sectors (including the independent sector) and how links across sectors might work.

Recommendations

- 11.17 The evaluation findings confirm support for the induction standards for HCSWs but indicate the need to review their applicability to non-clinical groups and to potentially make some revisions in format. The following can be recommended:

- The standards should be mandatory
- Implement the standards for *clinical* support workers

- Review how the induction standards apply to non-clinical groups who do not deliver direct care (this may necessitate revision of the definition of healthcare support worker underpinning the pilot)
- Explore possibilities for dovetailing the standards requirements with Health Facilities Scotland/NHS Education for Scotland and Development Frameworks for support staff including domestics/housekeepers, catering, porters in order to learn from these programmes and avoid duplication of effort
- Revise the standards and assessment tool kit, potentially to reflect 'core' and 'role specific criteria'
- Revise and repackage the standards and assessment toolkit to remove duplication and make it a more attractive and manageable task for both HCSW and WPS
- Add examples of good practice to HCSW and WPS assessment materials
- Ensure materials are accessible to all HCSW and WPS
- Continue the certificate for HCSWs but review whether a supervisor certificate adds value for clinical supervisors
- Clarify the maximum timescale for meeting individual induction standards and the standards overall
- Clarify guidance on practice for HCSWs not meeting the standards within a given timescale, to cover both newly inducted staff and those who have been employed for some time
- Clarify the implications of not meeting the standards at Board and individual level
- Put in advance arrangements where necessary to prepare WPS and HCSWs to undertake assessment (tackle literacy issues and assessment skills)
- Improve guidance to WPS on utilisation of evidence to meet assessment criteria, including how to assess prior achievements
- Map the standards with common SVQs and induction programmes to clarify applicability of prior evidence
- Motivating factors for non-clinical staff groups require further consideration
- Support the maintenance of standards through the KSF development review process to minimise the burden on supervisors and Health Boards; clarify distribution of assessors and KSF reviewers and whether this is sufficient personnel to assess the standards
- Ensure any recommendations relating to KSF are in line with the 4 UK health departments partnership agreement
- Consider whether behavioural aspects need to be in both the Code of Conduct and the Induction Standards

Code of Conduct for Healthcare support workers

11.18 The Code of Conduct is unanimously supported in its current form by pilot site stakeholders, key informants and healthcare support workers. There were no requests for any changes to content or format. The vast majority of participant healthcare support workers (96%) considered the Code of Conduct to be important. Workshop delegates (75%) saw it as a useful addition to the standards and felt that it helped HCSWs know what was expected of them.

11.19 The Code was seen as setting out best practice and as a useful short reference guide to remind HCSWs what employers and the public might expect of them. There were some remaining questions about the appropriateness of the KSF review process to monitor working to the Code; behavioural aspects of the Code were seen as better fitting under staff governance procedures. There was also some questioning of the timing of the signing of the Code of Conduct Declaration with some suggestion that HCSWs should be working to the Code from day one of employment.

Recommendations

11.20 The Code of Conduct was unanimously supported and the following can be recommended:

- Implementation of the Code of Conduct for Healthcare Support workers in its current format
- Review how the Code of Conduct might be referenced in HCSW job descriptions for both new and existing staff
- Review how working to the Code could be monitored; possibly by reviewing this within the Personal Development Planning process

Code of Practice for NHSScotland Employers and compliance monitoring

11.21 There was general consensus that the Code of Practice content and format was acceptable. It codified guidance and practice which a responsible employer should already have in place. The NHS QIS model of compliance monitoring tested within the pilot was considered to be too onerous upon NHS Boards and staff.

11.22 There were very mixed views from evaluation respondents and from the Workshop delegates as to whether the accountability framework for employers as tested in the pilot (the Board self-assessment and peer review), was fit for purpose.

11.23 The evaluation notes that the original consultation on regulation did not provide much detail on the relative formats, advantages or disadvantages of the many possible forms of regulation. Key informants and stakeholders continue to question the relative advantages and disadvantages of an employer-led model as opposed to a statutory model.

Recommendations

11.24 For the Code of Practice we suggest:

- Implementation of the Code of Practice in its current format
- Review options for compliance monitoring
- Explore the potential for the existing NHSScotland Staff Governance Standard and review process to incorporate the Code of Practice.
- SGHD to consider how more detailed information, on the formats of the many possible forms of regulation, might be made more easily accessible,

taking into account the work currently being undertaken in this area by the Extending Professional Regulation group.

The Occupational List

- 11.25 The pilot has successfully implemented practical arrangements for a simple 'occupational list' of healthcare support workers who have achieved the standards. Verification procedures are in place prior to entry of a limited data set on SWISS. Further procedural work was required to decide who could access data locally, what reports might be made and how employee or employer queries about list information might be answered. There has been insufficient time within the pilot to practically assess how HCSWs entered onto the list might be managed longer term or to consider implications for sharing information across Boards.
- 11.26 The list as tested faces limitations. Most importantly SWISS data is owned by individual Health Boards and is limited to NHSScotland employees. Much further work would be required to clarify possibilities for forming a national list, practically (e.g. national HCSW id, addition of assessment start date) and procedurally (decisions re recording of Disclosure Scotland checks, who might have access to the data). Further exploration is required to clarify requirements for maintaining an occupational list which might inform the achievement and maintenance of standards of HCSWs who moved across sectors.
- 11.27 Stakeholders and key informants remained divided as to the potential added value of implementing a national list over the achievement of the induction standards and Code of Conduct alone. The positive aspects of the list were welcomed in terms of maintaining an audit trail of a minimum level of achievement. However, if the standards are brought under KSF for clinical support workers (and eventually for non-clinical support workers) then eventually e-KSF will be maintaining this audit trail of achievement and continued verification. The real question would seem to be what processes are to be used when an individual breaches the Code of Conduct, and if such a breach results in the HCSW resignation or dismissal, how can this information be relayed to another employer within or outside the NHS. Stakeholders seemed clear that safe employment is dependent upon employers following good practice in the giving and receiving of good references. The PIN guideline on safer pre-employment checks for all is now in place. Further clarification is required on how an NHS only occupational list would add to this arrangement, on whether an NHS only occupational list would be worthwhile and on whether implementation of a list would be a proportionate response to the perceived level of risk. The forthcoming work from the Extending Professional Regulation Group on assessment of risk should help to inform this discussion.
- 11.28 The major disadvantages of an occupational list appear to be that it is perceived as a response which is not proportionate to the perceived risk; it would be very bureaucratic and costly (and it is clear that there would be strong opposition to any suggestion that this low-paid group of workers would pay for registration). Most importantly the instigation of such a national list would require legislation to underpin its mandatory status and to address data protection and human rights issues.

11.29 Under the Protection of Vulnerable Groups Act (Scotland) 2007 employers will be required to assess all HCSW roles to decide whether they entail a certain level and nature of contact with regulated groups of vulnerable adults or children; if so the HCSW will fall under the provision of the PVG scheme. A number of definitional issues concerning the PVG implementation are still being clarified and it is estimated it will take some four years for all relevant staff to be included in the scheme. It appears likely that the vast majority of clinical support workers will be required to join the scheme but the position for non-clinical support workers is not yet clear, although it is likely that those with a direct contact role would be.

Recommendations

11.30 Stakeholders hold mixed views as to whether a national occupational list would be a proportionate response to the perceived level of risk, and we suggest:

- To undertake further work to clarify the potential added value of a national occupational list over the standards and Code of Conduct; this would entail clarification of decision points regarding any potential removal or reinstatement upon such a list and of supporting procedural processes required; it would also take into account forthcoming risk assessment guidance from the Extending Professional Regulation Group
- To undertake further work to articulate the links between the proposed HCSW 'occupational list' and the Protection of Vulnerable groups scheme to identify communication routes, decision points and potential actions by employers
- Consider whether a 'positive' means of acknowledging the achievement of the standards / code of conduct is required

Potential to improve patient safety and public protection

11.31 The overarching aim of the evaluation was to see whether the model of employer-led regulation with the addition of a central occupational list had potential to enhance patient safety and public protection. The varying understandings and depth of knowledge about the key concepts 'patient safety' and 'public protection' found by the evaluation across all respondents suggest that common understanding cannot be taken as a given and that this needs further illustration in future guidance and training materials. Clarity on this would also be required to facilitate the establishment of baseline measures against which change could be measured. The pilot itself was at too early a stage of implementation and operation to assess that as yet in practice. Nevertheless there have been some important findings coming from the pilot which suggest elements of the model have potential to improve patient safety and public protection.

- Participating healthcare support workers felt working towards the induction standards had potential to improve their confidence and knowledge and that they knew more about patient safety (44%) and more able to take action to keep patients safe (46%)

- Approximately half the HCSWs and WPS were motivated to take part in order to improve patient safety and public protection
- Workplace Supervisors said they were more aware of the vital role healthcare support workers play in the healthcare team
- The standards raised awareness of some patient safety issues not covered in the Domestic Workbook
- Board officers involved with the Board self-assessment and review exercise said they revised and felt more knowledgeable about relevant Staff Governance Policies
- A small number of undisclosed (and in these cases very minor) previous convictions came to light with enhanced Disclosure Scotland checks of existing employees
- Workshop delegates expressed their support for the view that the standards would enhance the patient experience and the potential of the model of standards and listing to enhance public safety (68%); the standards were seen as providing assurance to the public of workforce competence

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APPENDICES

ANNEXE A. GLOSSARY

Abbreviation	
A&A	Ayrshire and Arran Health
AfC	Agenda for Change
CHRE	Council for Healthcare Regulatory Excellence
GMC	General Medical Council
HCSW	Healthcare support worker
HPC	Health Professions Council
HPCL	Home Care Practice Licence Tool. Dementia services Development Trust, University of Stirling
KSF	Knowledge and Skills Framework
e-KSF	
LPC	Local pilot coordinator
MLA	Medical Laboratory Assistant
MTO	Medical Technical Officer
NES	NHS Education for Scotland
NMC	Nursing and Midwifery Council
NPC	National pilot coordinator
ScotCen	Scottish Centre for Social Research
SGHD	Scottish Government Health Directorates (formerly Scottish Executive Health Department SEHD)
SWAG	Scottish Workforce Staff Governance Committee
SWISS	Scottish Workforce Information Standards System. A workforce database for NHSScotland.
WPS	Workplace supervisor
NHS QIS	NHS Quality Improvement Scotland

ANNEXE B. GROUPS FOR INCLUSION IN PILOT

Groups for inclusion in the pilot

Pharmacy staff

Pharmacy Assistants

Ancillary Staff

Porters

Mortuary Attendants

Domestics with access to service users

Unqualified Technical Staff

Medical Laboratory Assistant

Medical Technical Officer

Catering Staff

Staff who have direct contact with food

Unqualified Allied Health Professionals

Arts Therapy Assistant

Podiatry / Footcare Assistant

Dietetic assistant

Orthotist and Prosthetist Assistant

Technical Instructor /Handicraft Instructor

Rehabilitation /Clinical Support Assistant

Physiotherapy Assistant

Radiography Assistant

Speech and Language Therapy Assistant

Occupational Therapy Assistant

Play Staff

Nursing and Midwifery Staff

All Whitley equivalents of A, B and unqualified C grades in hospital and community settings

Groups not for inclusion in pilot

Pharmacy Technicians

Porters who transport laundry, refuse etc.

Kitchen staff who have no contact with food

ANNEXE C. OUTPUTS FROM CONSULTATION ON REGULATION (SCOTLAND)

Outputs from consultation on the regulation of healthcare support staff and social services support staff in Scotland – Executive Summary, including summary of responses

Executive Summary

The consultation paper was issued on 6 May 2004, and closed for comment on 20 September 2004. It was targeted towards professional and regulatory bodies, and employers and employees of the health and social services sector. It invited comments on proposals for extending regulation to a wider group of health and social services staff; *health care assistants, assistant practitioners in a wide range of care settings, AHPs assistants, healthcare scientist workforce, social services support staff, pathology assistant practitioners.*

The aims of the consultation paper were to;

- establish whether regulatory arrangements should be extended to include specified assistants and support staff
- consider how to regulate groups of staff who move across or work outside of traditional boundaries
- establish how we can ensure quality
- determine the most appropriate form of regulation
- establish who should regulate these groups of staff
- consider whether there are alternatives to statutory regulation

122 responses were received. Key respondents were; The Nursing and Midwifery Council, The Health Professions Council, Scottish Social Services Council, The Council for Healthcare Regulatory Excellence, NHS Education for Scotland, The Royal College of Nursing and UNISON Scotland, NHSScotland Operating Divisions/Boards, Local Authorities.

Summary Findings

- **93%** of responses indicated that regulatory arrangements **should be extended** to cover health and social services assistants and support staff.
- **81%** of responses felt that health and social services support staff **should be accountable for their own practice**, but that this **should be dependent on their level of training and/or scope of practice.**
- **70%** of responses felt that **setting standards** for assistants and support staff should **be the responsibility of the manager/employer**, but in consultation with support staff.
- The consensus was that 'preferably' assistants and support staff should be regulated as a single group within a single framework. However, it was also

felt that, to avoid multiple registration and to facilitate transferability of staff between the 4 UK countries, it would make sense for existing regulators to work together to develop core/common standards, with some discipline specific standards.

- **90%** of responses indicated that **statutory regulation was the most appropriate** way to ensure public protection.
- **64%** felt that Scotland **should follow** any decision that might be taken in England
- There was no general consensus over which of the regulatory bodies should regulate these staff. 33% indicated it should be the relevant professional organisation. 60% indicated that if the HPC was selected to regulate this group of staff, then it should be done by statutory committee.
- **84%** indicated the **Scottish Social Services Council should not** be the regulatory body, but 33% indicated that the SSSC should be responsible for only for social services staff
- **85%** of responses felt that regulation **would not lead** to problems such as a **second class workforce**, rather it would raise their profile, and lead to an enhanced workforce.
- The majority were content that statutory regulation is the most appropriate way to ensure public protection but **others remain to be convinced that statutory regulation is appropriate and encouraged the consideration of employer-led regulation.**

ANNEXE D. MEMBERSHIP OF NATIONAL (SCOTLAND) GROUP FOR THE REGULATION OF HEALTHCARE SUPPORT WORKERS

NAME	DESIGNATION	INTERESTS REPRESENTED / AREA OF EXPERTISE
Frances Dow	Lay Chair	Interest in regulation and lay member of the Council for Healthcare Regulatory Excellence
Robert Anderson	CDNA (Community and District Nurses Association)	Human Resources Forum (staff side)
Jane Arroll	Director of Allied Health Professions, Greater Glasgow Primary Care Division	AHP groups and employers of AHP support workers
Michelle Bremner	Director (Scotland) Skills for Health	National Occupational Standards
Gerry Cavanagh	Learning Coordinator, Scottish Executive	SEHD – Learning & Careers
Audrey Cowie	National Programme Manager, Scottish Executive	Occupational, Professional & Regulatory Standards
Donna Dawson	Speech and Language Therapy Assistant	Support Workers to Allied Health Professionals
Carol Dobson	Programme Director, NES	NHS Education for Scotland
Geraldine Doherty	Registrar, Scottish Social Services Council	Social Services
Dr Zoe Dunhill	Clinical Director, Children's Services, Edinburgh Sick Children's Hospital	Sick Children's Services
John Findlay	Chief Executive, OnePlus	Voluntary Sector and employers interests
Michael Fuller	AMICUS	Human Resources Forum (staff side)
Uriel Jamieson	Branch Head, Nursing & AHP Directorate, SEHD	Regulation and Education for nursing, midwifery, Allied Health Professionals and support workers
David Killean	Assistant Principal, Borders College	Further Education Institutions
Gillian Lenaghan	RCM (Royal College of Midwives)	Human Resources Forum (staff side)
Jean Maclellan	Head of Branch, Vulnerable Adults Unit, Scottish Executive	Vulnerable Adults' interests
Angela MacNamara	Student Nurse and former HCSW	Healthcare Support Workers pursuing professional registration
Christine McCole	COSLA	Local Authorities
Ewan McLean	Clinical Services Manager	Independent Healthcare Forum and employers interests
Louise McGurk	Joint Future HR Group, SEHD	Joint Future HR Group
Patricia McNally	CSP (Chartered Society of Physiotherapists)	Human Resources Forum (staff side)
Andrew Morrall	Compliance Manager	Disclosure Scotland
Helen Ostrycharz / Linda Tindall	Director of HR / Senior HR and OD Manager	Interface between statutory and employer regulation (vis a vis Richard Inquiry)
Alan Penman	Regional Workforce Director - East	Regional Workforce Directors Group

Professor Jack Rae	Dean of School,	Higher Education Institutions
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	School of Health, Nursing and Midwifery, University of Paisley	
Dr Michael Ross	'Start Well' project	Medical Profession's interest in healthcare support workers
Elinor Smith	Director of Nursing – Grampian Primary Care	Directors of Nursing Group and employers interests
Pat Tonner	External Moderator, Health and Social Care	Scottish Qualifications Authority
Sheila Tunstall-James	Lay member	The public interest

ANNEXE E. GROUP*

MEMBERSHIP OF 4 COUNTRY STEERING

Barbara Bale	Head of Staff Development and Commissioning, Welsh Assembly Government
Susan Brimelow	Director of Healthcare Regulation, Care Commission
Joyce Cairns	Department of Health, Social Services and Public Safety for Northern Ireland
Catherine Clark	Head of Regulatory Unit, Scottish Government Health Directorates
Audrey Cowie	Professional Adviser, Regulation and Workforce Standards, Scottish Government Health Directorates
Geraldine Doherty	Registrar, Scottish Social Services Council
Frances Dow (Chair)	Lay Member
Kathryn Fodey	Nursing Officer, Department of Health, Social Services and Public Safety for Northern Ireland
Sandy Forrest	NHS24
Michael Fuller	AMICUS
Kathy George	Director of Standards and Registration, Nursing and Midwifery Council
Linda Gregson	Care Standards and Sponsorship, Scottish Government Health Directorates
Bruce High	Nuffield Hospitals, representing independent sector
Bridget Hunter	UNISON
Caroline Hutchison	Project Manager, Scottish Workforce Information Standard System (SWISS)
Uriel Jamieson	Head of Policy and Business Support Unit, Chief Nursing Officer Directorate, Scottish Government Health Directorates
Margaret Johnstone	Lay Member
Lynn Leitch	Lecturer - Telford College, Edinburgh
Rosemary Macalister-Smith	Deputy Chief Executive, Council for Healthcare Regulatory Excellence
Dave McLeod	Policy Officer, Adult Support and Protection (Scotland) Act, Scottish Government Health Directorates
Ros Mead	New Regulation Projects Manager, Department of Health
Maureen Morgan	Nursing Officer, Department of Health
Andrew Morrall	Disclosure Scotland
Greg Ross-Sampson	Director of Operations, Health Professions Council
Mike Sabin	Nursing Officer, Scottish Government Health Directorates
Elinor Smith	Nurse Director, NHS Grampian
Gillian Smith	Acting Director/Board Secretary, Royal College of Midwives
Maggie Tierney	Child Protection Policy, Scottish Government Health Directorates
Diane White	Social Services Workforce and Capacity Issues, Scottish Government Health Directorates
Jean White	Nursing Officer, Welsh Assembly Government
Anna Wimberley	National Project Manager, pilot for the Regulation of Healthcare Support Workers, NHS Quality Improvement Scotland
Anne Birch	Senior Researcher, Scottish Centre for Social Research (ScotCen)

* There have been some changes in membership over the course of the Regulation of Healthcare Support Workers project. This is the list for the start of the pilot.

ANNEXE F. MEMBERSHIP OF WORKING GROUP

NAME	DESIGNATION	REPRESENTING
Gerry Cavanagh	Learning Projects Manager, Scottish Executive Health Department	SEHD – Learning & Careers
Jim Clark (up to April 2006)	Porter	UNISON and frontline portering staff
Noni Cobban	Project Leader, University of Stirling	Homecare Practice Licence Project
Audrey Cowie	National Programme Manager, Scottish Executive	Occupational, Professional & Regulatory Standards
Carol Dobson	Programme Director, NES	NHS Education for Scotland
Ann Green	Support Services Manager, NHS Borders	Support Services Staff Management
Maggie Havergal	Manager – Scotland Skills for Health	Sector Skills Council for Health
Margaret Johnstone	Lay Member	The patient and public interests
Lynn Leitch	Lecturer, Telford College, Edinburgh	Pharmacy Technicians
Linda Lynch	Head of Learning and Development, NHS 24	Learning & Development
Eddie McLaughlan	Assistant Director, Health Facilities Scotland	Property and Environment Forum
Andrew Morrall/ Sandy Henderson	Manager/s. Disclosure Scotland	Disclosure Scotland, Scottish Criminal Records Office
Ed Moreton	Trainer, NHS Grampian	Training & Development of ancillary staff
Ian Stephenson	Manager, BUPA	Independent sector
Linda Tindall	Human Resource Manager, Yorkhill Hospital, Glasgow	Human Resources Management and National (Scotland) Group
Jack Rae	Head of Nursing and Midwifery Education, Paisley University	Higher Education and National (Scotland) Group
Raymond Taylor	Head of Training	Scottish Social Services Council
Morag Thomson (until March 2006)	KSF Development Manager	KSF Development, Pay Modernisation Unit
Susan Watt / Ros Derham	Officer/s	Royal College of Nursing

ANNEXE G. PRINCIPLES UNDERPINNING THE 'REGULATION OF HEALTHCARE SUPPORT WORKERS' PROJECT

Core principles

The wider approach towards the regulation of HCSWs reflects the five principles of good regulation set out by the UK government's Better Regulation Commission (formerly Better Regulation Task Force).

These principles are considered relevant to the HCSW project in that regulatory effort, in areas reserved to Westminster, is required to reflect these principles. The 4-country steering group for the project has voluntarily signed up to these as part of the evidence base for good regulatory practice. They have been used therefore, in this project, as guiding principles.

- **Transparency** The existence of a centralised occupational register provides the transparency required by prospective employers and members of the public.
- **Accountability** The approach calls for clear employer and employee accountability in facilitating and maintaining defined standards.
- **Targeting** The project targets employees who are neither regulated nor subject to regulatory plans, yet who have direct contact with or who influence in other ways the patient's outcomes.
- **Consistency** Consistency in the application of standards is a feature of the approach. Identified inconsistencies in current arrangements was a key reason behind the decision to pursue nationally negotiated standards that could be applied throughout Scotland across all sectors, the achievement of which could be captured in a centralised, independently maintained register.
- **Proportionality** The approach of employer-led or service-led regulation reflects the role and accountability of employers in applying staff governance and clinical governance standards. The approach therefore is proportionate to the risk associated with the employment of HCSWs and with the role/s carried out by this group of staff.

Principles identified by the National (Scotland) Group

In addition to the above, the National (Scotland) Group also defined principles which underpinned their preferred option. These reflected the need for:

- **Action** Acknowledging that stakeholders had opted overwhelmingly for some form of regulation.
- **Public protection** Finding a solution that protects the public.
- **Fitness for practice** Building on the development agenda for staff by promoting a positive approach to regulation that could enhance the quality of patient care, while acknowledging that threshold standards for healthcare support workers should relate to public protection and not to the continuing development standards necessarily required for more advanced roles.
- **Partnership** Articulating work on a UK-wide basis while not delaying progress in Scotland.

- **Cost effectiveness** Finding a cost-effective solution for employers and employees.
- **Proportionality** Balancing financial costs with the need for public protection in a way that is proportionate to the risks involved if there was no regulation.
- **Accountability** Building on existing governance arrangements and acknowledging the employer's role in regulation and the employee's role in achieving the necessary standards.
- **Independence** Making sure that, as part of a wider framework of employer-led regulation, any future register is held independently of local and regional employers and that any registration that takes place does so against nationally agreed standards.

These principles have also been used as guiding principles throughout the project.

ANNEXE H. NUMBERS OF HEALTHCARE SUPPORT WORKERS IN NHSSCOTLAND

Headcount of NHSScotland staff as at 30 September 2008

Source: ISD Scotland, NHSScotland Workforce Statistics.
Unqualified healthcare support workers are band 1-4.

Headcount of NHSScotland staff		NHSScotland	Ayrshire & Arran	Lothian	Lanarkshire
All NHSScotland staff (including GPs & GDs)		165,551	10,938	23,250	12,198
All NHSScotland staff (excluding GPs & GDs)		158,978	10,474	22,083	11,588
All nursing and midwifery	Band 5-9	48,220	3,178	7,254	3,961
	Band 1-4	18,915	1,352	2,766	1,537
		67,965	4,657	10,124	5,521
All allied health	Band 5-9	9,314	677	1,435	829
	Band 1-4	1,901	148	240	133
		11,342	833	1,706	964
Other therapeutic services (inc play staff etc)	Band 5-9	2,774	162	417	228
	*Band 1-4	817	34	130	37
		3,722	220	578	266
Healthcare science	Band 5-9	4,055	185	629	313
	*Band 1-4	1,533	107	195	162
		5,781	303	888	475
All support services	Band 5-9	874	43	53	43
	*Band 1-4	19,170	935	2,560	935
		20,086	1,766	2,619	983

* These rows represent a broader range of staff than was specified for the pilot.

ANNEXE I. DESCRIPTION OF PILOT PROCESSES

Workplace Supervisor Identification & Training

- 12.1 Identification of suitable and available WPS was done in two ways: a blanket request to relevant managers from LPCs to invite them to identify supervisors to take part (from August 2007); or after relevant discussion with managers once a particular HCSW had signed up to the pilot. Lanarkshire's measured cohort approach, and the LPC's individual approach to managers (Chapter 6), facilitated quick identification of HCSWs and WPS; in the first cohort all HCSWs were allocated quickly after the WPS was trained and only a few HCSWs of the second cohort were allocated after WPS training. Both of the other sites found identifying a WPS could be very time consuming as information systems did not store this link in a standard way, if at all, and this had to be chased up on an individual basis. On the whole LPCs addressed the identification of WPS for support services staff at a later stage in the pilot.
- 12.2 Training sessions were planned to last around three hours/half a day. The training content included: pilot background & evaluation, introduction to induction standards & learning and assessment process; the WPS role & guidance on conducting assessment & giving feedback; detail on completing the observation and oral assessments; timescales; the standards & Code of Conduct.
- 12.3 Training sessions were run by pilot site lead officers (Vocational Learning Manager plus LPC for a small number (A&A); Professional lead non-registered staff (Lothian); Lead officer development & LPC (Lanarkshire). In Lanarkshire, where recruits were almost exclusively clinical and already at SVQ2/3 level, identification of supervisors was relatively easy and most training sessions were half-day, larger group, more formal classroom sessions at a central venue. In Lothian initial larger group sessions were followed by more informal, smaller group sessions located at various sites. Ayrshire and Arran tended to convene smaller workshop style sessions once a few supervisors had been identified. This site also recruited across a much broader range of staff necessitating great flexibility in training delivery (including night-shift, week-end and a lot of one-to-one sessions (around 2 hours) arranged to suit the WPS' work pattern).

Recruitment

- 12.4 The pilot was published through local staff communications (newsletters, team briefings, established staff meetings and groups) and posters. Information leaflets were distributed to staff and provided in areas frequented by staff (ward notice boards, staff rooms, canteens). Information

was also sent out with staff wage slips (February 2007). One site developed a staff internet access point for all pilot documents.

- 12.5 Eligible HCSWs were identified via human resources departments, managers and IT systems. Site lead officers and LPCS held information sessions of various formats with senior and middle managers of the relevant staff groups and services and with partnerships forums.
- 12.6 Invitation letters were issued to eligible HCSWs, explaining the pilot and inviting them to briefing sessions. Information packs were given out at briefings, on request or at on-to-one sessions. The consent form comprised three sections each requiring separate confirmation of consent:
- Section 1 – to take part in the pilot and work to achieve the public protection induction standards
 - Section 2 – to undertake a Disclosure Scotland check
 - Section 3 – to participate in the independent evaluation
- 12.7 Consent to take part in the evaluation was optional and not necessary to participate in the pilot. The original Guidance stated that consent for a Disclosure Scotland application was required before taking part in the pilot but HCSWs actually began learning and assessment before a DS response was received (section 4.86). HCSWs could use the consent form tear off section to indicate consent to the three elements and/or interest in attending a briefing. Lanarkshire developed further detail about the implications of the Disclosure Scotland application and also a separate non-consent sheet requesting reasons for non-participation. The frequently asked questions (FAQ) sheet developed and was adapted locally to answer HCSWs concerns and to counter misinformation.

Figure 1 Recruitment and Assessment materials

Healthcare support worker information pack

- Introduction to the pilot
- The Guidance for Employers and Employees in Participating NHS
- Healthcare support worker standards
- Evaluation study information leaflet
- Consent form
- HCSW assessment tool leaflet

Healthcare support worker handbook

- Introduction
- Terminology
- Induction standards for healthcare support workers: introductory paragraph to each standard, Public Protection Standard Statements 1-14, (KSF dimension), criteria
- Code of Conduct for healthcare support workers
- The learning and assessment process – shorter version from HCSW perspective - including timescales, re-assessment, complaints and appeals
- Part 4 Oral Assessment questions
- Assessment materials – sample oral and observation assessment papers
- Further information and useful contacts – partnership working, Code of Practice for Employers / SE Guidance, Information pack
- Complaints and appeals procedure

Workplace supervisor handbook

- The learning and assessment process – longer version from WPS perspective - including timescales, re-assessment, complaints and appeals
- Part 4 Oral Assessment questions
- Induction standards for healthcare support workers: Public Protection Standard Statements 1-14, (KSF dimension), criteria
- Sample observation assessment paper – observation criteria relating to each standard (marked as satisfied/not satisfied/not observed), evidence provided, additional demonstration of ability, any action required and an overall assessment section including examples of good practice, strength and challenges, further training required
- Sample oral assessment paper – questions per standard (marks as satisfied/not satisfied), evidence provided, any action required
- Workplace supervisor monthly update form – assessment and reassessment dates arranged, successful assessments completed
- Code of Conduct for healthcare support workers

- Useful contacts and further information – including reference to partnership involvement, the initial HCSW information pack and the SE Guidance for employers and employees

Learning and assessment materials and process

- 12.8 The Learning and assessment materials (Figure 1) included: an introduction to the pilot and terminology used; the public protection induction standards; the full bank of 105 Oral assessment questions, with reference to performance assessment criteria; a sample Oral and the Observation assessment papers; an assessment tracker for HCSW's recording of progress and a personal action plan, a WPS monthly update form (including section for recording any action required by the LPC), the Code of Conduct for HCSWs; guidance on the process to be followed; complaints and appeals procedure; useful contacts and reference to partnership working, the Code of Practice for Employers and the Guidance.
- 12.9 Once the HCSW has consented to take part in the pilot and a WPS has been identified and trained the learning and assessment process can start. At an initial meeting between the WPS and HCSW the information from briefing sessions and the information pack can be discussed in more detail. The WPS passes the HCSW handbook to the volunteer participant and explains how it can be used to support the learning and assessment process. The WPS and HCSW will work together to map out an approach to learning and assessment, identifying whether any training or supported learning is required to enable the HCSW to achieve the standards. The HCSW can choose to provide evidence of previous achievement to demonstrate they are already working at or above the threshold level induction standards. If verified this will be noted down on the assessment papers with no further assessment of that standard being required.
- 12.10 When the HCSW is ready a date is agreed to undertake the observation and oral assessment, at a time, order and format (single or multiple sessions) to suit the HCSW and WPS. The WPS records the date each standard is assessed, the outcome: (satisfied or not satisfied by each criterion) and brief details of the observation or oral evidence provided to demonstrate satisfaction or any evidence of previous achievement. On completion of each part of assessment the WPS discusses the outcome with the HCSW, who receives a copy of the completed assessment and a copy is forwarded to the Local Pilot Coordinator. The observation assessment specifies 25 criteria to be met with space for recording additional criteria. The oral assessment consists of 30 randomly generated questions (drawn from a bank of 105 questions) weighted to match the weight of the standards (some standards have more criteria than others). One question can relate to several criteria across several standards.

- 12.11 It was anticipated that the learning and assessment process should take around three months. In order to achieve the standards all 25 observation criteria and 30 oral questions were to be satisfactorily met. As many reassessments as required may be taken up to a six months time limit. Only failed standards not yet met needed to be reassessed and for the oral assessment, different questions would be generated at re-test rather than repeating the same questions.
- 12.12 Finally the HCSW would sign the Code of Conduct Declaration and commit to working to the Code at all times. Providing the Disclosure Scotland outcome was also known the HCSW could then be entered upon the occupational list (section 12.24). The HCSW would then receive a Certificate of Completion (7.34).
- 12.13 The National Management Group also clarified the process for HCSWs who failed to achieve the standards within the initial six-month period. It was important to be clear, that given the pilot's purpose of testing the assessment process, non-achievement may be a reflection of the pilot rather than the HCSW's capability. Firstly there should be a three way meeting between HCSW, WPS and LPC to review process and all assessment papers and ascertain which aspects of the process were proving to be obstacles to achievement (e.g. challenges for the HCSW in learning, understanding and assessment; securing time for the HCSW and WPS to meet; applicability of the standards to the HCSW's role). Once challenges were identified the LPC should be able to facilitate further support towards achievement of the standards. If standards still could not be met then the HCSW name would not be put forward to be added to the occupational list and the reasons why would be logged for pilot learning. Outside the pilot arrangements, as stated in the Guidance for Employers, the NHS Board would follow existing capability procedures.

Development of the assessment toolkit

- 12.14 The Home care Practice Licence Tool, developed by the Dementia Services Development Centre (DSDC) of Stirling University, is a tool for validating the knowledge, skills and competence of home care workers. The assessment materials draw on the Scottish Executive National Care Standards for Care At Home⁸⁵ and are compatible with the revised National Occupational Standards for Care⁸⁶. The assessment is based upon the Driving Standards Agency model of the UK driving test, consisting of three

⁸⁵ National Care Standards : Care at Home
<http://www.scotland.gov.uk/Publications/2001/12/10461/File-1>

⁸⁶ Care National Occupational Standards
[http://www.sssc.uk.com/Social+Service+Workforce+Planning/Qualification+framework+\(SCQF\)/Care+National+Occupational+Standards.htm](http://www.sssc.uk.com/Social+Service+Workforce+Planning/Qualification+framework+(SCQF)/Care+National+Occupational+Standards.htm)

components: a theory test, a practice observation assessment and oral questions.

- 12.15 In March 2007, the SGHD adviser and NHS QIS pilot manager briefed the HCPL team to undertake a preliminary mapping of the HCPL against the pilot's assessment requirements. The team's project manager had previously contributed to the formulation of the National Standards by participating in the Working Group. There appeared to be potential for adaptation but also some key differences.
- 12.16 Initially the working group, comprised of representatives from the pilot, HCPL and KSF, worked to the same three component model. The focus was on mapping the existing HCPL questions to the HCSW induction standards and consequently early drafts failed to capture all the information required in the standards.
- 12.17 The first draft of the theory or written test was in multiple choice format, with parallel learning materials providing the correct answer and answer justification. It was also unclear how a written element would be marked⁸⁷.
- 12.18 After the May NHS QIS group the working group's focus then shifted to developing the oral and observation assessment materials, away from adapting the HCPL test questions towards re developing questions to fit the HCSW standards and criteria. The tool needed to focus upon the actual jobs being carried out by HCSWs.
- 12.19 The observation assessment aims to allow the WPS to record how the HCSW demonstrates knowledge and understanding of the public protection induction standards whilst carrying out their normal duties. The HCPL team initially developed 25 observation criteria, detailing the skills and qualities of the HCSW's practice to be observed, based upon the HCPL tool. The working group further refined these; in particular they agreed that standards 5 (reporting incidents at work), 6 (working within confidentiality guidelines) and 14 (whistle blowing in cases of harm and abuse), might not be easily observed by a WPS and would be better tackled by the oral questions or evidence of previous achievement. They also noted that the WPS might observe the HCSW demonstrating their knowledge of the standards in ways other than the observation criteria specified and therefore space was allowed for recording additional demonstration of ability where appropriate. Where a WPS is not able to observe particular observation criteria, in a HCSW's working environment within the timeframe they are advised to formulate and record an appropriate question to test this.

⁸⁷ In the HCPL model the written test is marked by the HCPL project team rather than individually by the home care workers' assessor.

12.20 Each of the 14 public protection induction standards has associated performance assessment criteria. The working group developed oral assessment questions which directly related to the assessment criteria, avoiding repetition found within the standards and allowing oral questions to address more than one performance assessment criteria where appropriate. The total 105 questions are designed to test the HCSW's knowledge of the 180 performance assessment criteria. Again the test paper format of 30 questions, generated randomly from the bank of 105 questions was based upon the HCPL model. However the selection is weighted to ensure that the same number of questions per standard is included in every individual paper generated. NHS QIS designed an Access database to randomly select the 30 questions for each unique oral assessment paper. This was provided to each LPC to facilitate local generation of test papers.

The occupational list'

12.21 For the purposes of the pilot, the occupational list is held on the Scottish Workforce Information System (SWISS), a workforce database for NHSScotland⁸⁸. The National Management Group, in consultation with the SWISS representative from the NHS QIS National Project Steering Group and the evaluation team agreed a dataset which could be practically recorded on SWISS. The data is recorded on an existing 'registration' screen⁸⁹ with 'Healthcare Support Worker' chosen from a drop down list of registration types. The database will not, at this point, record achievement of individual induction standards but simply signifies completion of all the standards. The data items recorded are:

- Name (already recorded on SWISS for an NHSScotland employee)
- Pay Number(NHSScotland pay number already recorded)
- Unique ID (unique identification number for the pilot chosen by the Board)
- Date of achievement of the learning and assessment process⁹⁰
- Workplace Supervisor name (for the pilot this can be recorded in a notes field)

12.22 In addition, other existing fields could be added to increase the functionality of the list including: Date of validation, reason and date for end of listing.

⁸⁸ As SWISS is an NHSScotland workforce database, the participants from the participating independent hospital could not be entered onto the occupational list.

⁸⁹ Usually used to record other types of registration e.g. NMC registration

⁹⁰ The Date of achievement is entered into an existing 'expiry date' field, for practical purposes it was agreed that this date would be recorded as being one year in advance of the actual data, for example, a completion date of 27.03.08 is recorded as 27.03.09

- Date of most recent validation (i.e. as used by some registration bodies for annual validation check)
- Reason for registration ending (currently a number code only but a national code list could be generated)
- Date of registration end

12.23 The SGHD guidance outlines the criteria for entry onto the occupational list:

- The healthcare support worker has evidenced that they have met the public protection induction standards
- Achievement of standards is gained and documented through the personal planning and review process
- The employer has evidenced that the healthcare support worker has been safely recruited, against the standards contained in the Code of Practice for Employers
- The employer has provided the necessary support for the healthcare support worker and the workplace supervisor to enable achievement of the public protection standards

12.24 A checklist, developed by LPCs over the course of the pilot, ensured all HCSWs met the same criteria prior to entry upon the list. This included a completed consent form, Disclosure Scotland response, completed observational and oral assessment papers (full compliance), WPS monthly update form and lastly the Code of Conduct Declaration.

ANNEXE J. OTHER POLICY DEVELOPMENTS AND RESEARCH

Protection of vulnerable groups and adults⁹¹

12.25 It was anticipated that the pilot would provide an opportunity to explore the links that might require to be made between any future regulatory framework for HCSWs and forthcoming 'bar' lists of those unsuitable to work with vulnerable groups and children. In fact the implementation of the Protection of Vulnerable Groups (Scotland) Act 2007 has progressed somewhat more slowly than anticipated. Following a series of consultation exercises in November 2007, the Government has issued its response to the analysis of consultation responses on secondary legislation⁹². It sets out its proposals for next steps as it moves towards implementation of the PVG scheme. The proposals will be reflected in Scottish Statutory instruments to be laid before Parliament for consideration and it is anticipated that this will occur during 2009.

12.26 The PVG Act delivers the principal recommendation (19) of the Richard Inquiry Report which called for a registration system for all those who work with children and protected adults. The PVG scheme will:

- ensure that those who have regular contact with vulnerable groups through the workplace do not have a history of abusive behaviour
- deliver a fair and consistent system that will be quick and easy for people to use, ending the need for multiple, written disclosure applications

12.27 The PVG scheme will introduce a strengthened and robust vetting and barring scheme and it will exclude people who are known to be unsuitable, on the basis of past behaviour, from working with children and protected adults and detect those who become unsuitable while in the work place.

12.28 Of most immediate relevance to the national pilot are the proposals, set out in the Government's response, regarding the definition of protected groups. The scope of regulated work with children is to be re-examined to reflect recent changes to the Protection of Children (Scotland) Act 2003 and to ensure a proportionate approach to the scope of the scheme (there will be further consultation on the draft SSI). The definition of protected adult is to be extended to include any individual in receipt of any NHS or private healthcare service or any individual in receipt of welfare services.

⁹¹ Scottish Government website: The Protection of Vulnerable Groups (Scotland) Act 2007
<http://www.scotland.gov.uk/Topics/People/Young-People/children-families/pvglegislation>

⁹² Scottish Government (2008) *Scottish Government response to the analysis of consultation on policy proposals for secondary legislation*

12.29 The scheme membership will be phased in for the existing workforce with the expectation that the entire workforce will have been brought in by four years from go-live. Work is also proceeding on the approach to making listing decisions, based upon the elements proposed in the consultation.

12.30 Under the PVG provisions employers have a duty to assess the type of work carried out by individuals and to decide whether it is regulated work; if so the person doing the work must already be or become a member of the PVG scheme. Employers must also not employ someone to do that regulated work who has been barred from the scheme (there will be separate lists for those working with children and those working with protected adults). The employer will also be under an obligation to make a referral to the scheme if they have reason to believe an individual has done harm to a child or protected adult.

12.31 The implications for the pilot would appear to be

- At present although it appears likely that all *clinical* support workers will come under the provision of the PVG scheme (they provide care, support and guidance) it is not yet clear which *non-clinical* healthcare support worker roles, with less direct contact, will come under the scheme
- It would be at least four years before all existing healthcare support workers deemed to fall under the scheme would be brought into it via phased retrospective checking
- The fine detail of decision making on listing (i.e. barring decisions) is still being developed
- Reciprocal arrangements will operate across schemes across the UK

12.32 If an 'occupational list' of HCSWs were to be put in place then this would appear to be complementary to the PVG scheme. The HCSW list would signify safe recruitment of the HCSW and that a basic induction level competence was reached. Further work would need to be done to clarify what communication links would need to be established between a proposed HCSW 'occupational list' and the PVG scheme. A flow chart showing communication lines between the NHS employer, PVG scheme and individual HCSW would need to be drawn up, illustrating decision points and potential actions concerning the 'occupational list'.

NHS Education (NES) for Scotland developments

12.33 Throughout the life of the pilot there has been interaction with other parallel NES programmes of work including the development of educational frameworks for non-clinical support services and consideration of the future development needs of clinical support workers post induction.

Education Frameworks for administrative and support services

12.34 The NES study *Developing an Education Framework for Staff in Administrative Services and Support services*⁹³ was carried out in parallel to the national pilot for regulation of healthcare support workers. The study carried out a major scoping study to establish a profile of the above non-clinical staff groups and their learning needs. This was a first step to establish a framework to support education for these groups.

12.35 The study found approximately 50,000 staff were employed in administrative services and support services in NHSScotland, more than 25% of the total NHSScotland workforce when measured as whole time equivalent (WTE)⁹⁴. It also found that more than 40% of administrative services staff and 70% of support services staff were employed on a part-time basis and thus make up an even larger proportion of the actual headcount of staff.

12.36 The study identified issues which limit the development of, and access to, work related learning for these staff groups. Key issues of relevance to support services and therefore to the national pilot include:

- The high percentage of the workforce aged over 50 years
- The limited availability of accredited learning programmes

12.37 There was also a lack of

- Acknowledgement of how these roles relate to the patient experience
- Support for the development of management skills (particularly at Agenda for Change Bands 3 and 4)
- Recognised career pathways to allow individuals to plan their own career development

12.38 In addition, the implementation of KSF was seen as a key driver for education for these groups but other drivers, common for other groups were missing (regulation, revalidation, Continuous Professional Development (CPD) requirements).

12.39 Senior managers wished to see the future Education Frameworks addressing strategic goals (improving patient experience, ensuring an appropriate workforce to deliver services, meeting service change demands, implementing frameworks such as KSF and complying with the Staff Governance Standard).

⁹³ NHS Education for Scotland (2008) *Developing an Education Framework for Staff in Administrative Services and Support Services: Scoping study and Stakeholder Consultation Report*.

⁹⁴ As reported in the NES study based on workforce figures September 30th 2004: source ISD.

- 12.40 Other key findings from the NES study paralleled some findings emerging from the national pilot. The NES study also found difficulty in identifying 'administrative services' and 'support services' staff at the time when assimilation under Agenda for Change pay modernisation structures was still underway. Information to define job functions or categories was limited, at times conflicting, and was inconsistent across Health Boards and official statistics. This is being followed up by a skills mapping exercise, mapping generic skills across job-sub-categories to analyse how staff are split. It is finding that Health Boards do not use job families consistently and that KSF and Workforce data do not straightforwardly articulate with each other.
- 12.41 Pilot stakeholders have expressed concern that some HCSWs may have been put off the pilot for reasons connected with literacy or numeracy needs⁹⁵. The NES study tried to explore the barriers to learning connected with issues of language, learning and numeracy or with disability. Data on literacy and numeracy was hard to access but some 10% of staff in support services said they had a disability which affected how they engage with learning. This area is being followed up in future NES work in conjunction with learning providers, Unison and Skills for Health⁹⁶.
- 12.42 The Education and Development Framework for Domestic Services jointly developed by NES and Health Facilities Scotland as part of the initiative to prevent healthcare-associated infection was already in place. There were plans to extend this work to develop frameworks for catering and porter services (late 2008) laundry, security and switchboard (2009). In addition, a supervisors' assessment centre will be implemented from November 2008. The workbook for catering assistants will be developed from the Domestic

⁹⁵ *Adult Literacy and Numeracy in Scotland (ALNIS)* (2001)
<http://www.scotland.gov.uk/Publications/2001/07/9471/File-1>

This report indicated that low or insufficient literacy and numeracy abilities are more widespread than previously thought; the *International Adult Literacy Survey (IALS)* concluded 23% of adults in Scotland may have low skills and another 30% may find their skills inadequate to meet the demands of the 'knowledge' society and the 'information' age. NHSScotland is the largest single employer and around one third would not require a qualification to get a job, and would not have literacy or numeracy assessed at interview. It would be safe to assume that a significant number of staff in support roles within NHSScotland do not feel confident about their basic literacy skills, and would therefore feel threatened of these skills were to be challenged in any formal test environment (Health Workforce Directorate communication to SGHD 29/10/07)

Changing Lives: Adult Literacy and Numeracy in Scotland
<http://www.hmie.gov.uk/documents/publication/clalns.html>

National Adult Learning Survey (NALS) 2005 Scotland Report (2007) Scottish Government
<http://www.scotland.gov.uk/Publications/2007/03/16105856/0>

The most commonly mentioned barrier to learning is lack of time due to work, followed by family time constraints and preferring to spend time doing other things.

National literacy trust, *Literacy policy in Scotland*,
<http://www.literacytrust.org.uk/policy/scotland.html>

⁹⁶ NES Resources for support services staff
http://www.nes.scot.nhs.uk/support_services/resources/default.asp

Assistants Workbook which is already in place. Work is ongoing to articulate this workbook with KSF outlines, safety standards (and the National Occupational Standards and SVQs where possible). After the national pilot's consultative workshop, articulation with the HCSW induction standards has been added to the agenda. Customer care is a central element of the forthcoming catering workbook and it appeared likely that the softer skills of the national induction standards could be incorporated to strengthen the link between HCSW and service user. Any amendment to the Domestic Workbook would need to be added to future revisions.

- 12.43 It is not clear whether the timing of the NES study had any impact on how the national pilot study was received by staff at participating sites but it is a possibility. The actual fieldwork for the NES study was carried out July to October 2007, the consultation with stakeholders phase in November-December 2007, and the final report was published April 2007. 12 territorial Health Boards participated in the work, including the survey, interviews and focus groups with staff. At least one of the national healthcare support worker pilot sites took part in the NES study. Publicity for the NES project went out May 2007, followed by its survey. The national pilot invitation to participate would have followed not long afterwards targeting some of the same staff.

Development of clinical support workers

- 12.44 The SGHD pilot lead officer and the National Pilot Coordinator and other members of the NHS QIS National Project Steering Group have contributed to NES work on developing educational support for clinical HCSWs, going beyond the induction stage. A consultation paper was launched in autumn 2008. There was some view, that keeping the work of the pilot and of this group separate (induction or entry level separate from career progression) may not have been helpful in hindsight, although it has to be acknowledged that one piece of work is about making policy and the other about implementing policy already agreed on. The three potential parallel assessment practices (induction standards, KSF, vocational qualifications) all require supervisor assessment skills and the person taking on the role of the pilot Workplace Supervisor (anticipated to be the KSF reviewer) may well need to cover all three practices.
- 12.45 There was a view that the assessment skills required by the Workplace Supervisor required more recognition and that they could perhaps be addressed in a more cohesive way in future. The use of the SQA A1 City and Guilds assessor unit was cited as an example already in place in Health Boards which could perhaps be built upon. The NES study indicated that some supervisors, delegated as KSF reviewers, may have very large groups of staff to supervise, be given very basic training on assessment for KSF but possibly would not be given the support to develop assessment skills to a consistent level.

Interface between HCSW and Social Care Standards

- 12.46 The evaluation was asked to investigate the interface between the standards required of HCSWs within the pilot and those for support workers in social services and independent healthcare. Given the slow development of the pilot it was not possible to investigate this in practice. However all respondents indicated a wish that standards be as reciprocal as possible and that there be recognition of the joint future agenda and that support workers from both sectors work side by side in many situations and with a wide range of patients.
- 12.47 Nationally work has continued on potential registration and regulation of social care support workers. The Scottish Social Services Council (SSSC) is anticipating extending registration, in 2009, to support workers in care homes services for adults, to housing support workers and to school care accommodation workers. The register is already open to support workers in day care of children services, residential child care services. The SSSC is currently in discussions with the Scottish Government about which groups of workers it might include next in phase three of registration. A recent report⁹⁷ suggests the increasing importance of migrant workers within the social services sector in Scotland and raises issues of validation of previous qualifications.
- 12.48 In England, following the consultation on the registration of domiciliary and residential social care workers (2006)⁹⁸, the General Social Care Council (GSCC) recommended that for these worker groups, entry to the register should be through a competence requirement at the level of induction standards and that there should be a small fee for registrants⁹⁹. The GSCC, subject to ministerial approval, was anticipating the opening of the register to these workers, however in early January 2009 this was still not forthcoming¹⁰⁰.

⁹⁷ MIGRANT WORKERS RESEARCH: A report to the Scottish Social Services Council 2008

⁹⁸ GSCC (2006) Registration of domiciliary and residential social care workers in England Outcome of the consultation and the General Social Care Council's recommendations to Government

⁹⁹ GSSC (2006) Proposals to register domiciliary and residential social care workers in adult and children's services

¹⁰⁰ Smith, J. (2009) *Time to ditch plans to extend care register*, Professional Social Work. www.basw.co.uk

ANNEXE K. THE INDUCTION STANDARDS

The table below shows how each **public-protection standard statement** links to the different parts of the Knowledge and Skills Framework (KSF). Further details and the performance criteria for each of the standards are available at <http://www.healthworkerstandards.scot.nhs.uk/pages/ProfRegInduction.htm>

Knowledge and Skills Framework core dimension	Public protection standards statement
Health, safety and security	Protecting your patients ¹ from harm and abuse Being fit (healthy) to work Maintaining health and safety at work Assessing risks at work Reporting incidents at work
Communication	Working within confidentiality guidelines
Personal and people development	Developing your knowledge and practice Reviewing your working practice to improve your knowledge
Quality	Contributing to team ² work Building "customer" relationships Managing yourself as a resource Working within your own limits
Equality and diversity	Working in line with the equality, diversity, rights and responsibilities of patients "Whistle-blowing" ³ in cases of harm and abuse

Notes:

1 We use the term 'patient' throughout the standards. However, you may hear patients being referred to as 'service users', 'clients' or 'residents'. Basically, the term means any person who needs care that you come into contact with while working .

2 The team not only includes the colleagues you work with every day, but includes everyone involved in the care of the patient.

3 Whistle-blowing is a common term used to describe raising concerns with managers.

ANNEXE L. MEMBERSHIP OF NHS QIS NATIONAL PROJECT GROUP

Hazel Borland	Head of Clinical Governance Support and Development Unit, NHS QIS
Maggie Byers	Project Lead, NHS Lothian
Audrey Cowie	Scottish Government Health Directorates
Ann Fairlie	Project Lead, NHS Ayrshire and Arran
Maureen Henderson	Chair
Bridget Hunter	UNISON
Sandra-Dee Masson	UNISON
Mary McKay	Project Lead, Ross Hall Hospital
Martin Moar	NHS QIS Public Partner
Margaret Johnstone	Lay Representative
Mary Parkhouse	Project Lead, NHS Lothian
Michael Fuller	Scottish Workforce and Staff Governance Committee
Ros Derham	Royal College of Nursing
Fiona Farmer	AMICUS
Caroline Hutchinson	SWISS Database
Heather Tierney-Moore	Scottish Executive Nurse Directors
Sandy Henderson	Disclosure Scotland
Anna Wimberley	National Project Manager, NHS QIS
Anne Birch (Observer only)	Scottish Centre for Social Research

ANNEXE M. MEMBERSHIP - PILOT SITES' STEERING GROUPS

NHS Ayrshire & Arran Local Pilot Implementation Group

Anne Fairlie	Head of Practice Development (Chair)
Sarah Barbour	Local Pilot Coordinator
Mary-Anne Black	Human Resources Advisor
David Black	Vocational Learning Manager
Anne Marie Brown	Domestic Manager – Crosshouse Hospital
Kerry Cassidy	Occupational Therapy Manager
Jean Davies	Senior Paediatric Nurse
Isabella Dickie	Hotel Services Manager – Ailsa Hospital
Owen Jones	Senior Biomedical Scientist/Partnership Rep
Lorna Kenmuir	Head of Organisational Development
Jane Kerr	Speech & Language Manager
Alison McDonald	Physiotherapy Manager
John McGuire	Patient Services Manager – Mental Health
Gordon McKay	Partnership Representative/UNISON
Fiona Orr	Superintendent Radiographer
Ian Smith	Directorate Coordinator – Paediatrics
Eleanor Watson	Nurse Bank Manager
Anna Wimberley	National Project Manager, NHS QIS

NHS Lothian Local Pilot Implementation Group

Mary Parkhouse	Head of Continuous Professional and Practice Development (Chair)
Maggie Byers	Lead Practitioner Non-registered workforce
(Neil Murray to April 08) Kenny Brown	Local Pilot Coordinator
Eddie Egan	Employee Director
Mick McGahey	Unison Steward
Helen Holden	SVQ Coordinator Allied Health Professions
Tracy Stewart	Human Resources Manager
Rosemary Rae	Interim Head of Therapies – Royal Infirmary of Edinburgh
Lesley Thomson	Nurse Bank Senior Manager
David Lee	Associate Director, Workforce & Development
Keith Mackenzie	Domestic Services Manager – Royal Edinburgh Hospital
Peter Campbell	Clinical Nurse Manager (Children's services)
Gail Robertson	Speech Therapy - Royal Hospital for Sick Children
Graham Patterson	Deputy Portering Manager – Western General Hospital
Susan Tennyson	Royal Edinburgh Redevelopment
Shirley Duffy	Healthcare support worker - Children's services
Gerry Freedman	Service User - Mental Health Services
Anna Wimberley	National Project Manager, NHS QIS

NHS Lanarkshire Local Pilot Implementation Group

Karen Alexis	Clinical Support Worker, Older People Directorate
Anne Carlin/ Audrey Arbuckle	Bankaide, NHS Lanarkshire
Marie Cerinus	Associate Director of Practice Development for Nursing, Midwifery and Allied Health Professions
Margo Cranmer	Staffside Representative, UNISON
Lorraine Ferguson	Local Pilot Coordinator, NHS Lanarkshire
Maxine Kinnoch	Support Worker Development Manager and Higher National Certificate Coordinator, NHS Lanarkshire (Chair)
Elsbeth Martin	Head of Employment Services, NHS Lanarkshire
Peter McCrossan	Associate Director of Allied Health Professions
Patricia Anne Murphy	Clinical Nurse Manager, Older People Service, NHS Lanarkshire
Karen Robertson	Associate Director of Nursing, NHS Lanarkshire
Mary Samson	Staff-side Representative, UNISON
Eddie Sutherland	Senior Nurse, Old Age Psychiatry
Maureen Taggart	Service Development Manager, Long Term Conditions, NHS Lanarkshire
Ruth Thompson	Assistant Director of Nursing, Emergency and Medical Services, NHS Lanarkshire
Anna Wimberley	National Project Manager, NHS QIS

National Management Group

Sarah Barbour	Local Pilot Coordinator, NHS Ayrshire & Arran
Kenny Brown	Local Pilot Coordinator, NHS Lothian
Lorraine Ferguson	Local Pilot Coordinator, NHS Lanarkshire
Anna Wimberley	National Project Manager, NHS QIS

ANNEXE N. WORKSHOP – ELECTRONIC VOTING RESULTS

	Agree	Disagree	No opinion	No vote	
Preparation and Implementation					
Following completion of the pilot and any necessary revision of the standards, and whatever the decision on future regulation:	%	%	%	%	<i>*Bases</i>
1a) The standards should be mandatory for all Healthcare Support Workers.	72	13	1	15	110
1b) The standards should only be mandatory for clinical Healthcare Support Workers.	32	21	0		110
1c) The standards should only be mandatory for non-clinical Healthcare Support Workers.	3	13	2	85	110
1d) The standards should not be mandatory for any Healthcare Support Workers.	8	7	7	83	110
2) The standards will enhance the patient experience of the support workers they come into contact with.	63	2		28	110
Assessment					
3) The national assessment tool used in the pilot should be used for the future regulation of Healthcare Support Workers.	24	38	19	19	110
What happens next					
4) The Code of Conduct for Healthcare Support Workers is a useful addition to the standards.	75	4	5	15	110
5) The Code of Conduct helps Healthcare Support Workers know what is expected of them.	75	4	7	14	110
6) The Code of Practice for Employers is a necessary addition.	65	1	14	21	110
7) The accountability framework for employers that has been tested in the pilot is fit for purpose.	7	11	49	33	110
8) Even though a vetting & barring scheme will eventually be in place to protect patients from those who are not fit to work with “protected adults” and children, there is still a case for a “positive” list for Healthcare Support Workers who have met the standards.	6	13	6	75	110
9) There should be a positive list and this should be held at national level.	68	7	7	17	110
10) The model of standards and listing lays the foundation for the future development of Healthcare Support Workers.	52	22	10	16	110
11) The model of standards and listing has the potential to enhance patient safety.	68	10	6	15	110
12a) As a Healthcare Support Worker I can see advantages with this model.	65	20	15	0	20
12b) As an HR professional I can see advantages with this model.	75	25	0	0	8
12c) As an employer I can see advantages with this model.	72	28	0	0	32
12d) As a patient I can see advantages with this model.	61	13	4	23	110

* Base = 110, number of headsets used except for questions 12a-c where delegates voted by role

ANNEXE O. RESPONSE FROM SURVEYS

Table 0.1 Survey response rates

		<i>Returns from 3 surveys (June-August 2008)</i>								
		HCSW – Participants			Non-Participant HCSWs			Workplace Supervisors		
Pilot site		Sample	%	(No)	Sample	%	(No)	Sample	%	(No)
Ayrshire & Arran		103	43	44	340	7	25	72	42	30
Lothian		87	45	39	1711	12	208	72	19	14
Lanarkshire		190	43	81	50	18	9	97	49	48
Totals		380	43	164	2101	12	242	241	38	92

Table 0.2 Percentage of each survey returns by pilot site

		<i>Returns from 3 surveys (June-August 2008)</i>					
		HCSW – Participants		Non-Participant HCSWs		Workplace Supervisors	
Pilot site		%	No	%	No	%	No
Ayrshire & Arran		27	44	10	25	33	30
Lothian		24	39	86	208	15	14
Lanarkshire		49	81	4	9	52	48
Totals		100	164	100	242	100	92

HCSW participant survey

Table 0.3 HCSW participants by job category

	<i>HCSW participant survey (June-July 2008)</i>							
Job Category	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Nursing assistant/Clinical support worker	57	25	67	26	79	64	70	115
Allied health support staff	30	13	21	8	17	14	21	35
Facilities staff	5	2	13	5	0	0	4	7
Laboratory staff	2	1	0	0	0	0	1	1
Not known	7	3	0	0	4	3	4	6
Totals	100	44	100	39	100	81	100	164

One hundred and sixty-four HCSW participant questionnaires were returned, a 43% response rate fairly consistent across sites (Table 0.1). The majority across the three sites came from Nursing/CSW (70%) and Allied Health (21%) plus 4% from Facilities staff, and just 1 laboratory staff (Table 0.3). The majority were Band 2 or 3 and there were a handful of Allied Health assistants at Band 4. Allied Health assistants included podiatry, physiotherapy, music therapy, speech and language therapy and radiography.

The majority were older: aged 40-49 (37%, 58); aged 50-59 (36%, 55); aged 60+ (7%, 10). Around a fifth were under 40 years: aged under 30 (5%, 7), aged 30-39 years (16%, 25). Most HCSWs were female (88%, 139).

Table 0.4 HCSW participants by working pattern

Working pattern	HCSW participant survey (June-July 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Bank/Bankaide	0	0	3	1	25	20	13	21
Weekends	27	12	38	15	37	30	35	57
Night shifts	23	10	31	12	44	36	35	58
9-5 hours	45	20	36	14	21	17	31	51
8 hours	5	2	26	10	15	12	15	24
12 hours	41	18	44	17	32	26	37	61
Very short shifts	7	3	5	2	5	4	5	9
Totals	100	44	100	39	100	81	100	164

There was good representation across the range of work patterns (Table 0.4) but only a small number (5%, 9) worked very short shifts of 2-3 hours at a time and these included domestic, catering, some clinical support workers and allied health assistants. There were 20 Bankaide staff from Lanarkshire, mostly with older people's services and working a mixture of full and part-time. More than half (56%) worked full-time and 40% part-time (almost all working 20-30 hours per week).

Table 0.5 HCSW participants by service area

Service area*	HCSW participant survey (June-July 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Mental health services	68	30	46	18	17	14	38	62
Children's services	9	4	33	13	1	1	11	18
Older people's services	7	3	26	10	79	64	47	77
Other service	23	10	10	4	17	14	17	28
Totals	**100	44	**100	39	**100	81	**100	164

* Old Age Psychiatry was not marked on this first questionnaire

** Percentages may sum to more than 100 as HCSWs could work in more than one service area

Of the 47% (77) of those working in older people's services, the majority were from Lanarkshire and of the 38% (62) from mental health services, the majority were from Ayrshire & Arran. Just over 1 in 10 (11%, 18) were from children's services and 17% (28) from other services.

Table 0.6 HCSW participants by work location

Work location	<i>HCSW participant survey (June-July 2008)</i>							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Hospital	70	31	77	30	86	70	80	131
Community clinic or unit	14	6	10	4	5	4	9	14
Community-patients homes	30	13	5	2	14	11	16	26
Schools	9	4	10	4	0	0	5	8
Other	7	3	0	0	2	2	3	5
Totals	100	44	100	39	100	81	100	164

Most returns were from a hospital base (80%, 131) and almost half of these were Clinical Support Workers from Lanarkshire. The rest worked in the community. 5% (8) Allied health assistants worked in schools (Ayrshire & Arran and Lothian only).

Table 0.7 HCSW participants by post

Currently hold another post	<i>HCSW participant survey (June-July 2008)</i>							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
NHS – this Health Board	18	8	18	7	20	16	19	31
NHS – other Health Board	0	0	0	0	0	0	0	0
Private health care post	2	1	3	1	1	1	2	3
Social care post	0	0	8	3	1	1	2	4
Previous held another post								
NHS – this Health Board	25	11	10	4	11	9	15	24
NHS – other Health Board	0	0	0	0	5	4	2	4
Private health care post	5	2	8	3	7	6	7	11
Social care post	14	6	15	6	9	7	12	19
Totals	100	44	100	39	100	81	100	164

Most had been employed at their Health Board for more than 10 years (57%, 91) and in their current post for more than six years (55%, 76). Just 12 came from people new to the Health Board or in post less than one year.

The returns suggest some mobility across care sectors but little across NHS Boards. 19% (31) currently held another post at the same Health Board and 7 staff currently held either a private health or social care post elsewhere. 12% (19) had previously held a social care post and 7% (11) a private health care post but only 4 individuals from Lanarkshire, all Clinical Support Workers had been employed via another Health Board in the past.

Workplace Supervisor Survey

Ninety two Workplace Supervisor questionnaires were returned, a 38% response rate, with the majority from Ayrshire & Arran and Lanarkshire and just a 19% (14) response from Lothian (Table 0.1).

Table 0.8 WPS by job category

Job Category	WPS survey (July-August 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Nursing assistant/Clinical support worker	57	17	36	5	65	31	58	53
Allied health support staff	37	11	43	6	35	17	37	34
Facilities staff	3	1	21	3	0	0	4	4
Laboratory staff	3	1	0	0	0	0	1	1
Totals	100	30	100	14	100	48	100	92

Most (58%, 53) came from nursing assistants (referred to as Clinical Support Workers (CSW) in Lanarkshire). 37% (34) came from allied health professions plus just 4 domestic and 1 laboratory staff.

The majority of supervisors were on Band 5 (40%, 37) or Band 6 (39%, 36) plus a few at Band 7 (15%, 14). Two facilities staff noted Band 2 & 3 and three were not recorded. Many (79%, 68) already carried out a formal assessment role. The majority were female (90%, 81).

Table 0.9 WPS by working pattern

Working pattern	WPS survey (July-August 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Bank/Bankaide	0	0	0	0	10	5	5	5
Weekends	33	10	21	3	31	15	30	28
Night shifts	20	6	14	2	27	13	23	21
9-5 hours	50	15	64	9	35	17	45	41
8 hours	10	3	29	4	35	17	26	24
12 hours	37	11	14	2	23	11	26	24
Very short shifts	0	0	0	0	0	0	0	0
Totals	100	30	100	14	100	48	100	92

* Percentages may sum to more than 100 as WPS could work more than one work pattern

The majority (75%, 69) worked full-time and the rest worked upwards of 17.5 hours. The returns included a reasonable representation across shift patterns (Table 0.9): most (45%, 41) worked 9-5 hours; 23% worked nights and 12 hour shifts were worked by 26% and 5 WPS were from Lanarkshire Bankaide. No WPS worked short shifts.

Table 0.10 WPS by service area

Service area*	WPS survey (July-August 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Mental health services	57	17	43	6	0	0	25	23
Children's services	17	5	36	5	0	0	11	10
Older people's services	3	1	7	1	83	40	46	42
Old age psychiatry	23	7	21	3	6	3	14	13
Other service	17	5	7	1	13	6	13	12
Totals	*100	30	*100	14	*100	48	*100	92

* Percentages may sum to more than 100 as WPS could work in more than one service area

The WPS returns are biased towards older people's services (46%. 42) almost all from Lanarkshire, plus 14% were from old age psychiatry. A quarter were from mental health services and just 11%, 10) from children's services. 7 of the WPS worked in more than one service area.

Table 0.11 WPS by work location

Work location	WPS survey (July-August 2008)							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Acute hospital	37	11	50	7	42	20	41	38
Community based hospital e.g. long term care	27	8	14	2	35	17	29	27
Community clinic or unit	27	8	21	1	6	3	13	12
Community-patients homes	17	5	21	3	19	9	18	17
Schools	20	6	7	3			10	9
Other	10	3		1			4	4
Totals	100	30	100	14	100	48	100	92

There was response from WPS across a range of work locations. At least a third worked in a community setting (12 in community based clinics, 17 in patient's homes and 9 in schools) and most of these were from allied health professions. A further (27) worked in a community based hospital and these were mostly CSWs from Lanarkshire. 38% worked in an acute hospital setting.

Non-participant HCSW survey

Two hundred and forty-two non-participant HCSW questionnaires were returned, a 12% response rate. The large majority came from the site with the largest potential pool of volunteers, Lothian (86%, 208) plus some from Ayrshire & Arran (10%, 25). Lanarkshire had relatively few non-participants because of its recruitment approach at the time of the survey and very few are from there (4%, 9) (Table 0.2).

Table 0.12 Non-participant HCSWs by job category

Job Category	<i>Non-participant survey (July 2008)</i>							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Nursing assistant/Clinical support worker	36	9	71	148	89	8	68	165
Allied health support staff	12	3	8	17	11	1	9	21
Facilities staff	52	13	14	29	0	0	17	42
Other	0	0	4	9	0	0	4	9
Not known	0	0	2	5	0	0	2	5
Totals							10	
	100	25	100	208	100	9	0	242

The majority were nursing assistant/clinical support workers (68%, 165) and 17% (42) worked in Facilities, and just 4% (9) came from other occupational groups. Most non-participant HCSWs were female (88%) and just 29% were aged under 40 years.

The majority of people had been employed in this environment more than 10 years (40%, 97) or 1 to 5 years (38%, 93) and 19% (47) more than 6-10 years. Only 5 individuals had been employed there less than a year.

Table 0.13 Non-participant HCSWs by working pattern

Working pattern	<i>Non-participant survey (July 2008)</i>							
	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Bank/Bankaide	0	0	3	7	33	3	3	7
Weekends	44	11	43	90	22	2	43	104
Night shifts	28	7	38	79	11	1	36	88
9-5 hours	12	3	12	24	44	4	12	28
8 hours	12	3	16	33	11	1	17	40
12 hours	36	9	39	82	11	1	38	92
Very short shifts	0	0	4	9	0	0	4	9
Totals	100	25	100	208	100	9	100	242

* Percentages may sum to more than 100 as HCSWs could follow more than one work pattern

Returns reflected a range of working patterns (Table 0.13) including night shifts (36%, 88), weekends (43%) and a few on short shifts (4%,) and Bank/Bankaide (3%). Two fifths (42%) worked full-time and 58% worked part-time. Part-time was 10 hours up with the majority working 20 - 30 hours per week.

Table 0.14 Non-participant HCSWs by service area

		<i>Non-participant survey (July 2008)</i>						
Service area*	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Mental health services	72	18	28	58	33	3	33	79
Children's services	12	3	13	27	0		12	30
Older people's services	4	1	50	104	78	7	46	112
Other service	12	3	10	20	0		10	23
Totals	*100	25	*100	208	*100	9	*100	242

* Percentages may sum to more than 100 as HCSWs could work in more than one service area

Most non-participant HCSW returns worked in older people's services (46%, 112), a third in mental health service (33%) and from children's services (12%, 30) Table 0.14

Table 0.15 Non-participant HCSWs by work location

		<i>Non-participant survey (July 2008)</i>						
Work location	Ayrshire & Arran		Lothian		Lanarkshire		Total	
	%	No	%	No	%	No	%	No
Acute hospital	44	11	51	107	22	2	49	118
Community based hospital e.g. long term care	44	11	27	57	33	3	28	68
Community clinic or unit	48	12	0	0	11	1	5	12
Community-patients homes	0	0	3	6	0	0	2	6
Schools	0	0	4	9	0	0	4	9
Other	12	3	7	15	11	1	7	18
Totals	*100	25	*100	208	*100	9	*100	242

* Percentages may sum to more than 100 as HCSWs could work in more than one service area

Returns covered a fair range of work locations (Table 0.15)

HCSW participant and WPS views on the pilot process

Table 0.16 Initial communications

	HCSW & WPS surveys 2008)			
How you first heard of the pilot	HCSW Participant		WPS	
	%	No.	%	No.
Line manager	57	93	84	77
Briefing	30	50	20	18
Letter	10	16	3	3
Information pack	9	14	8	7
Other workers/supervisors	6	10	10	9
Newsletter/publication	1	2	2	2
Totals*	100	164	100	92

* Percentages may sum to more than 100

Table 0.17 Getting involved with the pilot

	<i>HCSW & WPS surveys 2008)</i>			
How voluntary was the pilot?	HCSW Participant		WPS	
	%	No.	%	No.
Own decision/shared decision	94	154	67	62
Manager decided	5	4	33	30
Received enough information	68	107		
Wanted to take part			63	58
No concerns pre-sign up	30	49	26	24
Totals*	100	164	100	92

**Each percentage stands alone as these were separate questions in the surveys*

Table 0.18 Participants early concerns

	<i>HCSW & WPS surveys 2008)</i>			
Did you have any concerns about getting involved with the pilot?	HCSW Participant		WPS	
	%	No.	%	No.
Might be too much work	33	54	48	44
Too busy at work	28	46	47	43
Might be too difficult for me	21	34		
Other personal commitments	12	19	9	8
Too many to supervise at once			16	15
Totals*	100	164	100	92

**Percentages may sum to more than 100*

Table 0.19 Reasons for taking part

	<i>HCSW & WPS surveys 2008)</i>			
Why did you want to be involved with the pilot??	HCSW Participant		WPS	
	%	No.	%	No.
Help patients/improve safety	56	92	50	46
Help HCSWs in my unit			71	65
Do my job better	54	88		
Learn new things	45	73	29	27
Job and career opportunity	41	67	28	26
Have my say	30	50	16	15
Totals**	100	164	100	92

**Percentages may sum to more than 100*

Table 0.20 Time spent on pilot

	<i>HCSW & WPS surveys 2008)</i>			
	HCSW Participant		WPS	
	%	No.	%	No.
General preparation required	62	102	52	48
All in work time	28	46	37	34
Some in own time	34	55	53	49
All in own time	15	24	8	7
No comment	24	39		
Own time – 4 hours or less	49	80	70	64
Totals**	100	164	100	92

Table 0.21 HCSW & WPS support for the pilot

	<i>HCSW & WPS surveys 2008)</i>			
	HCSW Participant		WPS	
	%	No.	%	No.
<i>Should undertake standards</i>				
• HCSWs doing my job	82	135	84	77
• HCSWs doing different jobs	79	129	84	77
Code of Conduct important	91	149		
<i>All Health Boards should</i>				
• Have standards in place	87	142	92	85
• Have occupational list	64	105	83	76
Totals**	100	164	100	92

**ANNEXE P. EVALUATION QUESTIONNAIRE TO
HEALTHCARE SUPPORT WORKER VOLUNTEERS TO PILOT**



Evaluation

Regulation and Listing of Healthcare Support Workers

Questionnaire for HCSW volunteers to the Pilot

The questionnaire should only take a few minutes to complete.
Please answer questions with a tick in the appropriate box.

If you wish to add further explanation or any general comments please do so in the space provided at the end of the questionnaire.

About your job

1. Which service area do you work in?

Please tick all that apply

- | | | | |
|-------------------------|--------------------------|---|---|
| Mental health services | <input type="checkbox"/> | 1 | 1 |
| Children's services | <input type="checkbox"/> | 1 | 2 |
| Older people's services | <input type="checkbox"/> | 1 | 3 |
| Other service | <input type="checkbox"/> | 1 | 4 |

2. What is your job?

Please write in

Title: 5

Grade (AfC banding if known)..... 6

3. Do you work full-time or part-time?

Please tick one only

- | | | | |
|-----------|--------------------------|---|---|
| Full-time | <input type="checkbox"/> | 1 | 7 |
| Part-time | <input type="checkbox"/> | 2 | |

4. If part-time, how many hours per week?..... 8

5. Do any of these work patterns apply to you?

Please tick all that apply

- | | | | |
|--|--------------------------|---|----|
| I am employed via Bank or Bankaide | <input type="checkbox"/> | 1 | 9 |
| I work at weekends | <input type="checkbox"/> | 1 | 10 |
| I work night shifts | <input type="checkbox"/> | 1 | 11 |
| I work 9-5 hours | <input type="checkbox"/> | 1 | 12 |
| I work an 8 hour shift pattern | <input type="checkbox"/> | 1 | 13 |
| I work a 12 hour shift pattern | <input type="checkbox"/> | 1 | 14 |
| I work some very short shifts (e.g. 2-3 hours at a time) | <input type="checkbox"/> | 1 | 15 |

6. Where do you work?

Please tick all that apply

- | | | | |
|-----------------------------|--------------------------|---|----|
| Hospital | <input type="checkbox"/> | 1 | 16 |
| Community clinic or unit | <input type="checkbox"/> | 1 | 17 |
| Community – patient's homes | <input type="checkbox"/> | 1 | 18 |
| Schools | <input type="checkbox"/> | 1 | 19 |
| Other | <input type="checkbox"/> | 1 | 20 |

7. For how long have you been?

- | | employed at
this
Health Board | | in your
current
post | |
|----------------------|--|---|-------------------------------------|---|
| | <i>Tick One</i> | | <i>Tick One</i> | |
| Less than six months | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 1 |
| Less than one year | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 2 |
| One to five years | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 3 |
| Six to ten years | <input type="checkbox"/> | 4 | <input type="checkbox"/> | 4 |
| More than ten years | <input type="checkbox"/> | 5 | <input type="checkbox"/> | 5 |

8. What about other health or social care posts?

- | | <u>Currently</u>
hold another
post | | <u>Previously</u>
held another
post | |
|--|---|------|--|------|
| | <i>Tick all that
apply</i> | | <i>Tick all that
apply</i> | |
| NHS – this Health Board | <input type="checkbox"/> | 1 23 | <input type="checkbox"/> | 1 24 |
| NHS – other Health Board | <input type="checkbox"/> | 1 25 | <input type="checkbox"/> | 1 26 |
| Private health care post | <input type="checkbox"/> | 1 27 | <input type="checkbox"/> | 1 28 |
| Social care post
(local authority, voluntary or private sector) | <input type="checkbox"/> | 1 29 | <input type="checkbox"/> | 1 30 |

Information given to you about the pilot?

9. How did you first hear about the healthcare support worker pilot?

Please tick all that apply

- | | | | |
|--------------------------------------|--------------------------|---|----|
| Letter posted to me | <input type="checkbox"/> | 1 | 31 |
| From my line manager | <input type="checkbox"/> | 1 | 32 |
| From other manager | <input type="checkbox"/> | 1 | 33 |
| Attending briefing/introductory talk | <input type="checkbox"/> | 1 | 34 |
| From local newsletter/publication | <input type="checkbox"/> | 1 | 35 |
| From other workers | <input type="checkbox"/> | 1 | 36 |
| Information pack | <input type="checkbox"/> | 1 | 37 |
| Other | <input type="checkbox"/> | 1 | 38 |

10. Have you received the Healthcare Support Worker Handbook?

Please tick one only

- | | | | |
|------------|--------------------------|---|------|
| Yes | <input type="checkbox"/> | 2 | →Q11 |
| No | <input type="checkbox"/> | 3 | →Q13 |
| Don't know | <input type="checkbox"/> | 4 | →Q13 |

11. Did the Healthcare Support Worker Handbook have: *Tick one only* 40
- Too much information ☐ 1
- About the right amount of information ☐ 2
- Too little information ☐ 3
- Can't say ☐ 4
12. Was the Healthcare Support Worker Handbook: *Please tick one only* 41
- Easy to read ☐ 1
- About right ☐ 2
- Too hard to read ☐ 3
- Can't say ☐ 4
13. Looking back, did you get enough information before starting the pilot? *Please tick one only* 42
- More information than I needed ☐ 1
- All the information I needed ☐ 2
- Enough information on some things but not enough information on others ☐ 3
- Did not get the information I needed ☐ 4
- Can't say, can't remember ☐ 5

Consenting to take part in the Pilot?

14. Looking back, how clear were you about what the Pilot involved before you signed consent? *Please tick one only* 43
- I had a fairly clear idea ☐ 1
- I had some idea but not very clear ☐ 2
- I had very little idea ☐ 3
- Can't say, can't remember ☐ 4
15. Looking back, why did you decide to get involved with the Pilot? *Please tick all that apply*
- I like learning new things ☐ 1 44
- I wanted to have my say and influence how it might be in future ☐ 1 45
- Strong direction from senior staff ☐ 1 46
- To develop job and career opportunities ☐ 1 47
- To get the Certificate ☐ 1 48
- Help my patients/ improve patient safety ☐ 1 49
- Do my job better ☐ 1 50
- Time to think about what I do in my job ☐ 1 51
- Other staff I knew were doing it ☐ 1 52
- So patient's know we are doing a good job ☐ 1 53
- My union was supporting it ☐ 1 54
- Other reason ☐ 1 55

16. Who made the decision for you to sign up?

Please tick one only

56

It was my decision ☐ 1

The decision was shared with my line manager ☐ 2

My line manager decided ☐ 3

A senior manager decided ☐ 4

Can't say ☐ 5

17. Did you have any concerns before signing up?

Please tick all that apply

Might be too much work ☐ 1 57

Might be too difficult for me ☐ 1 58

Too busy at work ☐ 1 59

Might not be appropriate for my job ☐ 1 60

I had other personal commitments ☐ 1 61

I was worried that I might have to pay ☐ 1 62

I worried it might disadvantage me in some way ☐ 1 63

Soon due to retire/change job ☐ 1 64

Other ☐ 1 65

None ☐ 1 66

18. Are you aware of the Complaints and Appeals procedure relating to the pilot?

Please tick one only

Yes ☐ 1 67

No ☐ 2

Your Workplace Supervisor for the Pilot

19. Do you have a Workplace Supervisor for the Pilot?

Please tick one only

68

Yes ☐ 1 →Q20

No, not yet ☐ 2 →Q40

20. Who is your Workplace Supervisor for the Pilot?

Please tick one only

69

My usual line manager ☐ 1

Another member of staff in my work section ☐ 2

Another member of staff in a different work section ☐ 3

Other ☐ 4

21. Was there any difficulty in arranging a Workplace Supervisor for you?

Please tick one only

70

No difficulty ☐ 1

Some difficulty ☐ 2

A lot of difficulty ☐ 3

Don't know ☐ 4

22. At the first meeting, how well did the Workplace Supervisor explain what was required of you?

Please tick one only

71

- Very well ☐ 1
- Fairly well ☐ 2
- Not very well ☐ 3
- Not at all well ☐ 4
- Not had first meeting yet ☐ 5 →Q40

Learning Process

23. Has your Workplace Supervisor discussed taking prior achievements (qualifications or training) into account?

Please tick one only

72

- Yes ☐ 1 →Q24
- No ☐ 2 →Q26
- Don't know ☐ 3 →Q26

24. Was there any difficulty in deciding which prior achievements, if any, might be counted as evidence towards the Standards?

Please tick one only

73

- No difficulty ☐ 1
- Some difficulty ☐ 2
- A lot of difficulty ☐ 3
- Don't know ☐ 4

25. Which of these prior achievements did you already hold? Which, if any, could be noted as evidence for the Standards for you?

	Already held?		Can be noted as evidence for Standards	
	Tick all that apply		Tick all that apply	
SVQ2	<input type="checkbox"/> 1 74		<input type="checkbox"/> 1 75	
SVQ3	<input type="checkbox"/> 1 76		<input type="checkbox"/> 1 77	
Certificate/Diploma/Degree	<input type="checkbox"/> 1 78		<input type="checkbox"/> 1 79	
Short Course	<input type="checkbox"/> 1 80		<input type="checkbox"/> 1 81	
Other training	<input type="checkbox"/> 1 82		<input type="checkbox"/> 1 83	
None/Can't say	<input type="checkbox"/> 1 84		<input type="checkbox"/> 1 85	

26. Has your Workplace Supervisor discussed any personal development you may need in order to meet the Standards?

(By 'personal development' we mean specific development activities agreed with your Workplace Supervisor e.g. mentoring, self-learning about particular guidelines, attending a training course)

Please tick one only

Yes ☐ 1 →Q27 86

No, not yet ☐ 2 →Q28

27. Has your Workplace Supervisor made any arrangements for you to do such agreed personal development work towards the Standards?

Please tick one only

Yes, personal development work is planned/ arranged ☐ 1 87

Yes, I have already done some personal development work ☐ 2

No personal development work arranged yet ☐ 3

No personal development work required ☐ 4

28. Is general preparatory work for the Standards required?

By this we mean time spent reading the written materials and thinking about answers in preparation for assessment

Please tick one only

Yes ☐ 1 →Q29 88

No ☐ 2 →Q33

Don't know ☐ 3 →Q34

29. Have you spent any of your own time preparing for the Standards?

Please tick one only

All in my own time ☐ 1 →Q30 89

Some in my own time ☐ 2 →Q30

All in work time ☐ 3 →Q32

30. Roughly how much of your own time have you spent preparing for the Standards?

Please write in

90

31. Was using this amount of your own time for preparation:

Please tick one only

Reasonable ☐ 1 91

Unreasonable ☐ 2

Don't know ☐ 3

32. Do you need any help with the preparation process?

Please tick one only

92

A lot ☐ 1

Some ☐ 2

Little ☐ 3

None ☐ 4

Can't say ☐ 5

33. Who helps you in preparing for the Standards?

Please tick all that apply

Other Healthcare Support Workers ☐ 1 93

My Workplace Supervisor ☐ 1 94

Other senior or manager ☐ 1 95

Someone else ☐ 1 96

No one ☐ 1 97

Assessment Process

34. What plans, if any, have been made for your assessment?

Please tick one only

98

Observation and Oral assessment together – a few Standards at a time ☐ 1

All the Observation assessment first ☐ 2

All the Oral assessment first ☐ 3

Observation and Oral assessment together – all Standards covered at once ☐ 4

Some other way ☐ 5

No plans made yet ☐ 6

35. What stage of assessment for the Standards are you at?

	Observation assessment <i>Tick all that apply</i>		Oral Assessment <i>Tick all that apply</i>	
Just getting started	<input type="checkbox"/>	1 99	<input type="checkbox"/>	1 100
Achieved some Standards first time	<input type="checkbox"/>	1 101	<input type="checkbox"/>	1 102
Achieved all Standards first time	<input type="checkbox"/>	1 103	<input type="checkbox"/>	1 104
Re-assessment meeting planned	<input type="checkbox"/>	1 105	<input type="checkbox"/>	1 106
Achieved some Standards at reassessment	<input type="checkbox"/>	1 107	<input type="checkbox"/>	1 108
Achieved all Standards at reassessment	<input type="checkbox"/>	1 109	<input type="checkbox"/>	1 110

36. Have there been any difficulties in arranging the Observation element of the assessment?

Please tick one only

- No, not really ☐ 1 →Q38 111
- Yes, some ☐ 2 →Q37
- Yes, a lot ☐ 3 →Q37
- Don't know ☐ 4 →Q38

37. What kind of difficulties?

Please tick all that apply

- Someone who was not my Workplace Supervisor had to observe me ☐ 1 112
- My Workplace Supervisor and I had to make special arrangements to be working at the same time ☐ 1 113
- Some of the things required are not part of my usual job ☐ 1 114
- There are not many occasions to show certain types of skills in my job ☐ 1 115
- Other ☐ 1 116

38. Overall, is the amount of time you need to put into working towards and being assessed for the Standards:

Please tick one only

- Too much ☐ 1 117
- About right ☐ 2
- Too little ☐ 3

39. How long has it (or will it) take you to achieve the Standards?

Please tick one only

- Less than one month ☐ 1 118
- Two to three months ☐ 2
- Four to six months ☐ 3
- More than six months ☐ 4
- Don't know ☐ 5

The Induction Standards

40. Overall, how easy or difficult do you feel the Standards are?

Please tick one only

- Too easy ☐ 1 119
- About right ☐ 2
- Too difficult ☐ 3
- Don't know ☐ 4

41. Are the Standards applicable to you?

Please tick one only

- Mostly applicable ☐ 1 120
- Applicable in some parts ☐ 2
- Applicable in few parts ☐ 3
- Mostly not applicable ☐ 4

42. Do the Standards have the potential to affect the way you do your job?

Please tick one only

121

Yes, a lot ☐ 1

Yes, somewhat ☐ 2

No, not at all ☐ 3

43. To what extent do you agree with these statements:

Please tick one box per row

Working towards the Standards:

Agree Neither
Agree Disagree
nor
Disagree

I feel more confident at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	122
I feel less confident at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	123
I know more about my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	124
I know more about patient safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	125
I feel more able to take action to keep patients safe	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	126
My career/job opportunities will be improved	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	127
It will be easier for me to move to another Health Board job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	128
It will be harder to get another job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	129

44. How important is it to you that a Certificate is given for achievement of the Standards?

Please tick one only

130

Very important ☐ 1

Fairly important ☐ 2

Not important at all ☐ 3

45. Have you signed the Code of Conduct Declaration?

Please tick one only

131

Yes ☐ 1

No, not yet ☐ 2

46. Do you feel that a Code of Conduct is important for people in your job?

Please tick one only

132

Very important ☐ 1

Somewhat important ☐ 2

Not very important ☐ 3

Don't know ☐ 4

47. Have you heard of the Knowledge and Skills Framework (KSF)?

Please tick one only

133

Yes ☐ 1

No ☐ 2

Don't know ☐ 3

48. Do you have a Knowledge and Skills Framework (KSF) outline in place for your post?

Please tick one only

134

Yes ☐ 1

No ☐ 2

Don't know ☐ 3

49. Will the Induction Standards contribute to the Knowledge and Skills Framework (KSF) stages?

	Foundation gateway? Tick one only	135	KSF Review? Tick one only	136
Yes	<input type="checkbox"/>	1	<input type="checkbox"/>	1
No	<input type="checkbox"/>	2	<input type="checkbox"/>	2
Don't know	<input type="checkbox"/>	3	<input type="checkbox"/>	3

50. In the last year, and outwith the pilot, have you had a meeting with your supervisor which resulted in a written Personal Development Plan?

This would be a review of your work to discuss your work, development and training needs and the plan would be shared with you. It might be known locally as Personal Development Planning and Review (PDPR), formal appraisal or clinical supervision.

Please tick one only

Yes ☐ 1 137

No ☐ 2

Don't know ☐ 3

The List

51. Do you understand what the occupational List is?

Please tick one only

138

I have a good understanding ☐ 1

I have some understanding ☐ 2

I have little understanding ☐ 3

I have no understanding ☐ 4

52. Are you happy for your name to be entered on the List?

139

Please tick one only

Yes ☐ 1 →Q54

No ☐ 2 →Q53

Not sure ☐ 3 →Q53

53. If 'No' or 'not sure' at Q52, why is that?

Please write in

140

.....

.....

The future

54. For the future, how important is it that the following arrangements are in place?

Please tick one box per row

	Important		Not important		Don't know	
Everybody doing my job should undertake the Standards	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3	141
Everybody doing different healthcare support jobs in my Health Board should undertake the Standards	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3	142
All Health Boards should have the Standards in place	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3	143
All Health Boards should have the occupational List in place	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3	144

About you

55. Are you?

145

Male ☐ 1

Female ☐ 2

56. What is your age?

Years: 146

57. Had you previously had a Disclosure Scotland check before signing up to the Pilot?

Please tick one only

Yes ☐ 1 →Q58

No ☐ 2 →Q59

Don't know ☐ 3 →Q59

58. If, 'yes' – how long ago?

Years: Months..... 148 149

59. Did you have any concerns about the Disclosure Scotland application for the Pilot?

Please tick one only

No, no concerns at all ☐ 1

Yes, some concerns ☐ 2

Yes, a lot of concerns ☐ 3

150

60 Please add any further comments you may have in the space below

151

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.....

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.....

We may wish to follow up this questionnaire with a telephone interview to get more in-depth views on the pilot. (An interview would take about 20 minutes).
If willing to take part please give your name and phone details.

Yes ☐ 1 152No ☐ 2

Name (<i>please print</i>):	
Home tel:	
Work tel:	
Mobile:	
Where and when is best to contact you?	

Thank you very much for taking the time to complete this questionnaire.

Please return the questionnaire in the prepaid envelope provided to
Scottish Centre for Social Research
73 Lothian Road, Edinburgh EH3 9AW

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