

Examining the evidence for new roles in health and care

This paper sets out the findings from a review of evidence about new roles in health and care. This review was undertaken by The King's Fund for Health Education England.

Summary

The King's Fund has examined evidence from the United Kingdom and abroad about roles that sit between a support worker who holds a care certificate and a registered health care professional. This included a review of the English-language literature and a small number of semi-structured interviews with stakeholders.

Our report is limited to assessing experience with existing schemes and the approaches they adopted. This evidence is therefore not an appraisal or evaluation of the specific proposals set out in the consultation *Building capacity to care and capacity to treat – a new team member for health and social care*.

Previous reviews have already considered the importance of career progression for support workers, which we noted but do not repeat. With this in mind, the review of experience to date does provide evidence that may be useful to Health Education England as it considers the way forward for these potential new roles.

- Most importantly, it found that such roles can provide high-quality care when introduced as part of a planned workforce strategy, with the evidence strongest for community and task-focused roles.
- There is little consistency of banding, training or role definition for existing intermediate roles, which have developed largely on an ad hoc basis. The lack of clear national role definition means that staff cannot easily transfer between organisations.
- The blurring of role boundaries was highlighted as a key issue for both staff and patients. Any new national approach requires a clear scope of practice and job description for these roles to overcome this, as well as a consistent approach to training.
- It is likely that regulation will be required to unlock the benefits these roles may offer. Regulation appears to support consistency and standards of education and makes clear where accountability can be devolved to such staff, reducing pressure on existing registered staff.
- Creating these new roles will not be sufficient to help current support workers move towards registered roles (including helping health care assistants to become registered nursing) unless other barriers to graduate training are addressed.

We note that the consultation document makes clear that these roles are not intended as substitutes for registered nurses.

Background

The issues surrounding nurse recruitment in England are widely recognised with high numbers of vacancies and organisations struggling to recruit permanent staff. Spending on agency staff, including agency nurses, has increased significantly in recent years and is a major factor in the declining financial position of many provider organisations.

The Workforce Advisory Board asked Health Education England – the body responsible for workforce planning, education commissioning and education provision for the health care workforce in England – to consider options for roles sitting between a support worker holding a care certificate and a degree-level registered nurse. Health Education England subsequently commissioned The King’s Fund to support this work.

Objective and methodology

The King’s Fund examined evidence from the United Kingdom and abroad about roles that sit between a support worker who holds a care certificate, and a registered health care professional. In this paper we use the term HCA (health care assistant) to refer to the support worker role and ‘AP-type role’ (assistant practitioner-type role) as a catch-all term for similar roles that include assistant practitioner, licensed practical nurse, licensed vocational nurse, enrolled nurse and others.

Our work comprised:

- **a review of English-language literature** – this encompassed both published and grey literature, and included studies from the United Kingdom, Australia, Canada, the United States and New Zealand. The literature review examined the development and implementation of AP-type roles in a range of settings. This included drivers for the development of such roles, evidence on quality and effectiveness and views about safeguards
- **a series of semi-structured interviews** – we carried out six semi-structured interviews with senior stakeholders in England identified by Health Education England. The purpose of the interviews was to gather views and perceptions on AP-type roles, including the scope of these roles, their strengths and weaknesses, appropriate training and regulation, and issues related to implementation.

We started work in August 2015 and presented the findings to Health Education England in November 2015.

Scope of this paper

This paper sets out the key findings from our review of the evidence and from the interviews. Where we use the term ‘evidence’ we mean findings from published literature. Where we use ‘views’ we mean views expressed in interview. These findings are presented in two parts:

- analysis of the evidence on the experience of implementing these types of roles; drivers for development; types of tasks and settings; safeguards
- evidence about the wider impact of such roles and in particular the impact on quality of care.

A. Lessons from the implementation of AP-type roles

A1. Drivers for development and current situation

The literature and interviews provided an insight into the current situation regarding nursing and other roles, including the experience of the introduction of the assistant practitioner role in England in recent years.

Our key findings were:

- > professional boundaries have been blurred and stretched in recent years (particularly since the introduction of the European Working Time Directive) with other registered health care professionals taking on tasks previously undertaken by junior doctors, and health care assistants taking on roles previously undertaken by registered professionals
- > AP-type roles have developed across the country. Changes such as the implementation of new care models have made the development of innovative roles more attractive, particularly in community settings. In addition, a shortage of registered professionals means organisations are exploring new roles
- > to date a 'grow-your-own' strategy has been adopted by Health Education England, rather than a national programme. This has allowed innovation but led to lack of consistency
- > there is little consistency of banding, training or role definition – many AP-type roles are graded at Agenda for Change band 4, but can be anywhere between band 2 and band 4. This means staff cannot easily transfer between organisations
- > various reviews have looked at the importance of career progression and regulation for support workers (see Cavendish (2013) and Willis reviews (Health Education England 2015) in particular).

A2. Settings and tasks

In terms of the settings in which AP-type roles tend to operate, and the nature of the tasks they typically undertake our key findings were:

- > most current experience in England suggests that AP-type roles work better in community settings, where staff are implementing an agreed care plan, than they do in acute settings
- > international evidence suggests these roles are often used in long-term care rather than in acute settings
- > interviewees suggested that within acute care these roles can work in areas where care is particularly task-focused, such as outpatient settings, renal dialysis, or theatre. These roles could include very defined competencies/tasks as part of a patient pathway
- > there is some evidence from the United Kingdom and internationally that 'task-focused' care and a broad skill mix (ie where different members of staff provide different aspects of care) runs the risk of fragmented care from the perspective of the patient

- > interviewees suggested that AP-type roles would need to include some assessment capability if they were to relieve the burden of registered professionals.

A3. Role boundaries

The issue of role boundaries was highlighted as a key issue in both the literature and in interviews with stakeholders. In particular:

- > experience of implementing AP-type roles in England and internationally shows that it can be hard to distinguish these roles from those immediately above or below. The longer these roles have been in place, the more blurred the boundaries appear to become
- > there is some evidence that blurring of boundaries makes it harder for other staff to understand the role and can lead to negativity/hostility. This in turn can result in demotivated staff
- > some evidence suggested that blurring of role boundaries is confusing for patients and that introducing more hierarchy through more staggered grades is unhelpful.
- > interviewees suggested that these roles require a very clear scope of practice, job description and documentation to be in place to avoid role confusion.

A4. Regulation

The issue of regulation for AP-type roles was also highlighted in many of our stakeholder conversations, and was also identified as an issue in the literature. In particular, we noted that:

- > interviewees believed that accountability cannot be devolved to unregulated staff which means AP-type roles cannot be used as a direct replacement for a registered professional
- > interviewees and evidence suggested that professional regulation is particularly important in community settings where staff are often working in isolation
- > there is evidence that regulation supports consistency and standards of education
- > interviewees suggested that the Health and Care Professions Council may be a more appropriate regulator than the Nursing and Midwifery Council due to the wide variety of roles taken on by band 4 staff in areas outside nursing and midwifery such as occupational therapy or physiotherapy.

A5. Training and career development

We looked at evidence about career development and appropriate training and found:

- > interviewees believed that there is a need for formal training for health care assistants (HCAs), building on the Care Certificate, giving them the opportunity to improve practice
- > views and evidence suggested that providing enhanced training also requires good workforce planning – there must be higher banded jobs available for the staff with further training to move into. Our work found that in some cases HCAs receive enhanced training as

a 'reward' for good performance rather than the role being created as a product of workforce planning

- > the current AP-type role appears not to be a route to creating more registered professionals, as progression from band 4 to band 5 is not common.
 - HCAs can rarely benefit from accreditation of prior learning (APL) as the APL process is time consuming, individualised and costly and higher education providers are not incentivised to undertake APL.
 - Even with a bursary for nursing training, staff already working in HCA posts would need to take a pay cut to access nursing training, particularly as these staff tend to be older and are more likely to have family responsibilities.
 - Some NHS organisations prefer staff to access in-house training rather than academic training that takes staff away from the workplace.
- > interviewees suggested that a national framework for training for AP-type roles would be important as the current roadmap is inconsistent and confusing.

B. Evidence about the wider impact of AP-type roles

B1. Impact on quality of care

The literature and our stakeholder interviews provided some lessons on the potential impact of AP-type roles on quality of care and patient experience. In particular:

- > AP-type roles are valued particularly in community settings and for people with dementia, where they can provide a richer level of additional support to individuals (for example, through providing additional therapeutic activities or working with families)
- > international evidence suggests that in acute settings even where AP-type roles are in place an increased ratio of graduate nurses to less skilled staff is strongly related to improved outcomes (including mortality and avoidable harm)
- > there is some evidence that fragmentation of tasks and skill mix (ie, multiple staff providing different aspects of care) can result in a poorer patient experience.

B2. Impact on registered professionals

The evidence also highlighted the possible implications on registered staff of introducing AP type roles. This included:

- > evidence that staff in AP-type roles may take on some tasks currently undertaken by registered professionals, but while the role remains unregulated they also introduce new responsibilities for registered professionals around supervision and delegation

- > interviewees suggested that registered professionals do not necessarily want to get too far from the bedside – if most ‘care’ tasks are delegated it can take professionals further away from the aspects of the job that most motivate them
- > one interviewee suggested that registered professionals might be better supported by administrative and logistics support than AP-type roles
- > one interviewee suggested that, while AP-type roles remain unregulated, organisations might get more value for money by recruiting additional lower-grade registered professionals.

Conclusions

In this section we draw together our conclusions from the literature and our stakeholder conversations on whether the AP- type role should be developed in England. We also draw out the key lessons for implementation if these roles were to be adopted.

Should AP-type roles be developed?

Overall, evidence suggests that AP-type roles can provide high quality care, but that these roles are likely to work better in some contexts than others. It is unlikely that the introduction of AP-type roles will lead to an increase in graduate professionals.

- > Evidence suggests that a role between support worker and registered professional may work best in community settings, or in more task-based acute settings.
- > Evidence suggests that in acute settings the presence of more graduate nurses (compared to less skilled staff) is strongly related to improved outcomes including mortality and avoidable harm.
- > Experience of the implementation AP-type roles (in England and internationally) highlights the risk of blurred role boundaries and confusion for both patients and professionals.
- > These roles can provide valuable career progression opportunities for HCAs, but are unlikely to be a route to creating more registered professionals unless other barriers to graduate training are addressed (including barriers relating to APL and salaries).

Lessons for implementation

Were AP-type roles to be developed, the following factors should be taken into consideration during implementation.

- > AP-type roles are likely to work best in settings where tasks are easily and clearly defined.
- > Implementation of these roles is most effective when they are introduced as part of workforce planning, not to reward individual HCA performance.

- > The single biggest issue holding back the development of the AP-type role is the need for registered professionals to retain close supervision and accountability. To be most effective these roles would need to be regulated but not necessarily by the Nursing and Midwifery Council
- > Unregulated, these roles remain career development opportunities for HCAs and cannot be used as substitutes for registered professionals.
- > There would need to be a national programme with standardised education and training to allow staff to transfer between organisations and to ensure enough critical mass for the roles to be understood. Regulation would also enable a standardised national approach to education.

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