Health care assistants comprise 17 per cent of the 1.3 million NHS workforce and make a significant contribution to patient care. The title ‘health care assistant’ covers a range of occupations, including nursing assistants, nursing auxiliaries and occupational therapy assistants. There is evidence that around 50 per cent of individuals in these roles see it as a position from which they can progress into nurse training (Thornley, 1998). Ensuring that relevant learning opportunities are available and accessible is therefore important to both these individuals and the NHS.

While HCAs are the most likely source for increasing nurse numbers, there is also a great need to expand their skills and competencies to take on duties previously carried out by nurses and other professionally qualified staff (Wanless, 2002).

Aims
In 2004 the former NHSU carried out a scoping study to provide a first glimpse of the position on progression for HCAs in order to clarify its role in support of this staff group. The study had two aims: first, to find out what strategic health authorities (SHAs) and workforce development directorates thought was happening relating to HCAs’ learning and progression; and second, to analyse Department of Health figures to find out what was actually happening.

Common routes for HCA progression
There are several ways in which HCAs can progress into nurse training. Currently, NVQs of competence at levels 2 and 3 are the most commonly awarded qualification underpinning the HCA role (Thornley, 2004). Attainment of an NVQ at level 3 is one of the best-worn paths for progression to a higher education diploma in nursing (HEDip Nursing), a three-year, full-time course. HCAs can also apply for a degree in nursing studies, on which they are eligible for a non-means tested bursary of £6,000 and they can apply for half a student loan, which is repayable.

Foundation degrees are accessible to HCAs with NVQ level 3 or equivalent. Foundation degrees are flexible, work-based programmes designed to equip learners with a combination of technical or vocational skills, academic knowledge and transferable skills. They can be completed in two years full time or three to four years part time. Foundation degrees are at level 4 of the national qualifications framework.

Understanding Health and Social Care K100 is a course designed by the Open University specifically to support HCA progression. Working in collaboration, the OU, Unison, the Workers’ Educational Association, the National Extension College and Care Connect offer a suite of courses that are delivered in the workplace in work time, allowing staff to earn while learning. This can lead to preregistration nursing, or a social care or a foundation degree programme.

Method
This scoping study adopted a qualitative approach, using semistructured telephone interview techniques guided by a pro forma sent prior to contact. The 28 SHAs were approached concerning the progression of this group of staff, as well as pertinent statistics being collected from the DoH. The rationale behind contacting the SHAs and workforce development directorates was that, being responsible for secondment, commissioning of education and the
progression of support staff, they would have knowledge of any structural barriers. The StHAs and workforce development directorates directed the NHSU to the most appropriate person, whose roles and responsibilities ranged from director of workforce development to head of education, NVQ lead and others such as widening access manager. Generally, most workforce development directorates had one person to coordinate the response but more than one contributing to its completion. For the most part, the workforce development directorates’ contacts possessed the appropriate strategic and operational knowledge. All 28 StHAs/workforce development directorates responded, indicating a significant level of interest in this subject.

Results
There was an abundance of examples of good practice by organisations towards supporting HCA progression. Individuals in StHAs/workforce development directorates responsible for NHS learning accounts and NVQs have published examples of innovations across England and the achievements of NVQs, learning accounts and Skills for Life funding applications since 2001 in Best Practice and Innovation Guide (Strategic Health Authority Publication, 2004). Difficulties in establishing the exact numbers of HCAs in the NHS were made apparent in this study. The DoH figures were adjusted to show HCA numbers only.

StHAs/workforce development directorates are responsible for reaching DoH targets for HCA progression, such as accessing NVQs and secondments into the HEDip Nursing (Fig 1). Collecting numbers for HCA progression involves going to a number of sources within StHAs/workforce development directorates, all of which may hold different categories of figures. Generally, numbers of learners are collected around funding streams rather than staff groupings, data is not usually collected at individual or candidate level, or the level of NVQ or the course, and registration of NVQs rather than completion is collated, making the evaluation of this scheme problematic.

A range of methods is used to monitor HCAs’ achievements, which may account for an overall discrepancy seen in figures for HCA progression from trusts, workforce development directorates and the DoH, suggesting room for improvement in the systems used for collating figures.

Other routes for monitoring NVQ attainment, by organisations such as the Qualifications and Curriculum Authority, do not hold data at candidate level so information for the sector as a whole is therefore not known. Using only DoH figures it can be shown that NVQs make up 37 per cent on average of the target for NHS learning accounts and NVQs (Table 1, p34).

Discussion
The following categories are considered factors hindering progress:

Definition of the role
One of the key factors affecting the measurement of progression of HCAs is the lack of an agreed definition of the HCA role and the level at which HCAs operate in the workplace. Reliable baseline figures are important for future policy development, workforce planning and gauging learning requirements of HCAs. Yet the DoH occupational coding for ‘HCAs, nursing assistants and support workers’ is open to interpretation and figures can differ among trusts, so the data collected is not strictly comparable.

The outcomes of the DoH consultation on registration and regulation of HCAs ought to assist in defining the role (DoH, 2004). The definition could helpfully state that HCAs provide direct patient care.

Fig 1. Percentage of NVQs that StHA/WDD achieved against target, by StHA

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REFERENCES


Figures and images should be described or replaced with text where necessary.
in clinical settings and be clear about whether or not they are involved in administering treatment under the supervision of professionally qualified staff.

A distinction between HCAs and nurses is required, as is a definition of HCAs that assists in understanding emerging roles of practitioner staff who support a group of professionals, so HCAs can make clear career choices. The first recommendation is therefore to create a new definition for the role of HCA.

Lack of financial support
A key factor that determines whether HCAs access programmes and courses for progression is financial security. Secondment is one option for HCAs who wish to enter nurse training. The funding available for these secondments covers the costs of replacing an HCA. From the non-medical education and training (NMET) levy, which forms part of the multiprofessional education and training (MPET)
budget, the DoH provides 80 per cent of the salary for a secondment, with the remaining 20 per cent covered by the trust, which also carries the cost of coordinating and administrating the scheme. However, some trusts do not provide the 20 per cent, causing a shortfall in salary and in some cases they demand that the HCA works the 20 per cent paid, treating it as 'owed time'. To combat this, some SIHAS/workforce development directorates are planning to change to 100 per cent replacement costs, with a subsequent drop in the target numbers set by the DoH, which may result in fewer HCAs entering preregistration training.

Entry to most HEDip Nursing courses is attainment at NVQ level 3 or equivalent. Funding to support NVQ attainment can be accessed from the NHS Learning Account and NVQ scheme, which is in its fourth year and allocated until March 2006. However, only an average of 37 per cent of the overall target applies to NVQs, which, from whole workforce numbers, means about 10 per cent of NHS staff working in care accessed NHS learning accounts and NVQs in 2003, from which only a proportion are HCAs (Table 1).

Ultimately, secondment is a costly business as it involves covering both the salary of the replacement HCA as well as the salary of the individual seconded, and currently depends upon monies from NMET. Even so, a DoH source has said that to drive up numbers the department has increased targets for the total student population on nursing courses to come via the secondment route from 15 per cent (March 2004) to 18 per cent (April 2005) and is aiming for 25 per cent (May 2006) where possible. However, such figures will need to be re-examined, as cuts to the MPET funding in May 2006 will undoubtedly affect all aspects of funding outside SIHA formal contractual arrangements.

Funding for NVQs can come from sources other than the DoH, such as the Learning and Skills Council. However, the required collaborative partnerships between SIHA/workforce development directorates and the local LSC are not seen uniformly across England. The vast majority of trusts now rely solely on workforce development directorate funds to support NVQs, with notable exceptions in some mental health trusts. As there has been no measure of the impact on the service of the NHS Learning Account and NVQ scheme across England to date, there are no means to indicate whether discontinuing this funding support from government or the move away from targets towards more local discretion will have a detrimental impact on the progression of HCAs and warrants investigation.

The second recommendation is to evaluate the impact of devolved budgets and absence of central targets on financial support of HCAs into nurse training or other role development.

**Low numbers accessing secondments**

Currently, secondment remains the only viable option for HCAs in terms of affordability, particularly among mature staff. The total number of candidates accepted for preregistration training for 2003 was 20,797. Of these, 15,810 were for the HEDip (NMAS, 2004). The DoH target for the number of learners coming through the secondment route for 2003 was 15 per cent. Across SIHAS, 82 per cent of this target was reached on average.

In the context of whole workforce numbers, an average of 2.5 per cent of HCAs are seconded into nurse training at any one time. There is significant variation between SIHA/workforce development directorates reaching their targets for secondments. A comparison with absolute figures of 229,000 HCAs shows this can be as few as one per cent of the workforce accessing this learning route.

The actual demand for and access to secondments from the NVQ route remains unclear. The process of selection for secondment involving both trusts and higher education institutions varies across organisations and SIHA/workforce development directorates. The workforce development directorates suggested that line managers’ beliefs about whether the HCA will return after qualification is a key factor in whether or not secondment will be supported. Overcoming this barrier of misperception of the usual outcome of offering opportunities to staff and the increase in loyalty towards the employer would mean providing leadership support for middle managers, developing a learning culture and approaching the issues at a whole-systems level. To ensure objectivity, demonstrable equity in opportunity for this group of staff deserves the attention of the Healthcare Commission.

The third recommendation is to establish transparent systems designed to support opportunities for HCA progression at trust level that permit evaluation across boundaries.

**Lack of recognition of existing knowledge**

HCAs often find that the contents of the first year of the Access to the HEDip in Nursing repeats the knowledge and skills they already have. They want accreditation for learning they have already acquired. Duplication and the time taken to progress through nurse training, which could be several years, could be reduced if existing clinical skills and competencies were recognised.

These findings are particularly pertinent for those involved in developing foundation degrees. Efforts to widen participation and access to higher education have resulted in no set entry requirements for many foundation degrees. This raises the issue of different learner needs, with experienced HCAs at NVQ level 3 beginning a programme alongside an individual new to care and organisations like the NHS. Not
acknowledging knowledge and experience may deter HCAs from undertaking foundation degrees. Workforce development directorates suggested that there is still a need for an accreditation of prior experiential learning (APEL) system that is transferable across higher education institutions and would help prevent duplication, ensure greater satisfaction and provide a step-off point. There were also concerns about overlap and transferability of the content of foundation degrees and the common foundation programme of the diploma.

Confidence in meeting academic demands
Many respondents reported that HCAs find the step to academic study to be a struggle. Several workforce development directorates suggested that there was a lack of confidence, particularly coping with academic writing and course content such as physiology, as well as assessment. A few HCAs were concerned about joining a group of ‘young learners’. The fourth recommendation is that APEL systems with support for HCAs should be offered by all higher education institutions.

Workplace and education provider policies
This scoping study highlighted that different models for allocating the NHS Learning Accounts and NVQ fund (£60–65m for 2005–2006) exist across the 28 StHA/workforce development directorates. Such differences in distributing funds may result in some of the allocation not reaching its intended audience.

There is no agreed policy from StHA/workforce development directorates about trusts offering HCAs support to access courses such as life skills, numeracy and literacy development. Some trusts are wholly dependent on their local education provider, irrespective of whether that provider meets their needs. Education providers and organisations charge different rates for NVQs and tuition fees, resulting in variation in spend against numbers accessing learning. Further development therefore requires individual champions ensuring equitable distribution of and access to funds to support HCAs who have been poorly served.

Even so, would consistency in these practices mean more HCAs taking up nurse training? Not every member of care staff embarking on a programme of learning necessarily wants to pursue a journey that concludes in professional qualification. In a recent NHSU survey 66 per cent of HCAs indicated that they wanted training in further skills to help them carry out their current role (NHSU, 2004). In response to a question on priorities, only 42 per cent of HCAs placed training to take on higher level roles as a priority, compared with 68 per cent who felt training on how to deliver best possible quality of service for patients was the priority (NHSU, 2004). These figures indicate that although HCAs make up a large proportion of NHS staff fewer than half want to progress to higher level roles. With the implementation of Agenda for Change and the Knowledge and Skills Framework, HCAs wishing to access learning leading to improved quality of service to the patient should, in theory, be rewarded. Remuneration by moving up the pay scales will be possible in acknowledgement of competency development and/or progression along the lines of the Skills Escalator, should the HCA wish it.

Conclusion
HCAs are considered a cornerstone for realising the NHS modernisation agenda. Given the potential of this group of staff to progress in their work it is surprising that, despite a number of programmes being available, numbers accessing learning opportunities are low. It would appear that the vast majority of staff do not know about funds to which they are entitled or how to access them. Perhaps a more coordinated national campaign informing HCAs of entitlements could have been called for in the past. With the advent of devolved budgets, even more effort is required to provide information on how to access funding and support.

Not all HCAs want to progress in relation to higher level roles but, for those who do, there are methods for doing so. This study highlighted clear differences between StHA/workforce development directorates in reporting NVQ attainment and secondment opportunities. There are difficulties and inconsistencies in practice from education providers such as differences in entry criteria, course costs and variable levels of support. Lack of recognition of existing knowledge coupled with perceived academic challenges by both HCAs and higher education institutions hinder their progress.

Mechanisms for monitoring progress need to be considerably more robust. The rates of access to and completion of courses need to be monitored if the impact on service and improved patient care is to be evaluated. More information on options, procedures, examples of mapped career progression routes could be clearly offered and APEL systems in place which recognise previous qualifications, clinical skills and competencies.

An accurate picture of HCA progression will only come about following an agreed definition of the role. The recent consultation on regulation of this role may move towards obtaining agreement and registration of HCAs and, as a corollary, assist in providing an indication of figures on programmes. Only with the development of robust mechanisms for collating numbers from workforce planning and human resources with agreements on what is measured across trusts will reliable and meaningful data be available that can evaluate demographic, geographical and workforce trends.