The challenges of training, support and assessment of healthcare support workers: A qualitative study of experiences in three English acute hospitals

Sophie Sarre[a,*], Jill Maben[b], Clare Aldus[c], Justine Schneider[d], Heather Wharrad[e], Caroline Nicholson[a], Antony Arthur[c]

[a] Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, UK
[b] School of Health Sciences, University of Surrey, Faculty of Health and Medical Sciences, Rm 22, DK04, Duke of Kent Building, Guildford, Surrey GU2 7XH, UK[1]
[c] School of Health Sciences, University of East Anglia, University of East Anglia,1.27 Norwich Research Park, Norfolk, NR4 7TJ, UK
[d] Institute of Mental Health, School of Sociology & Social Policy, University of Nottingham, Law & Social Sciences Building, University Park, NG7 2RD, UK
[e] Faculty of Medicine & Health Sciences, University of Nottingham, School of health sciences, Room B53, Queen's Medical Centre, Nottingham, NG7 2UH, UK

ARTICLE INFO

ABSTRACT

Background: Ever-growing demands on care systems have increased reliance on healthcare support workers. In the UK, their training has been variable, but organisation-wide failures in care have prompted questions about how this crucial section of the workforce should be developed. Their training, support and assessment has become a policy priority.

Objectives: This paper examines: healthcare support workers' access to training, support and assessment; perceived gaps in training provision; and barriers and facilitators to implementation of relevant policies in acute care.

Design and settings: We undertook a qualitative study of staff caring for older inpatients at ward, divisional or organisational-level in three acute National Health Service hospitals in England in 2014.

Participants: 58 staff working with older people (30 healthcare support workers and 24 staff managing or working alongside them) and 4 healthcare support worker training leads.

Methods: One-to-one semi-structured interviews included: views and experiences of training and support; translation of training into practice; training, support and assessment policies and difficulties of implementing them. Transcripts were analysed to identify themes.

Results: Induction training was valued, but did not fully prepare healthcare support workers for the realities of the ward. Implementation of hospital policies concerning supervision and formal assessment of competencies varied between and within hospitals, and was subject to availability of appropriate staff and competing demands on staff time. Gaps identified in training provision included: caring for people with cognitive impairment; managing the emotions of patients, families and themselves; and having difficult conversations. Access to ongoing training was affected by: lack of time; infrequent provision; attitudes of ward managers to additional support workforce training, and their need to balance this against patients' and other staff members' needs; and the use of e-learning as a default mode of training delivery.

Conclusions: With the current and unprecedented policy focus on training, support and assessment of healthcare support workers, our study suggests improved training would be welcomed by them and their managers. Provision of training, support and assessment could be improved by organisational policy that promotes and protects healthcare support worker training; formalising the provision and availability of on-ward support; and training and IT support provided on a drop-in basis. Challenges in implementation are likely to be faced in all international settings where there is increased reliance on a support workforce. While recent policies in the UK offers scope to overcome some of these challenges there is a risk that some will be exacerbated.

* Corresponding author.
  E-mail addresses: Sophie.Sarre@kcl.ac.uk (S. Sarre), j.maben@surrey.ac.uk (J. Maben), c.aldus@uea.ac.uk (C. Aldus), Justine.schneider@nottingham.ac.uk (J. Schneider),
heather.wharrad@nottingham.ac.uk (H. Wharrad), caroline.nicholson@kcl.ac.uk (C. Nicholson), Antony.Arthur@uea.ac.uk (A. Arthur).
  [1] Research was conducted when at Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London.

What is already known about the topic?

- Healthcare support workers are employed in many healthcare systems across the world to undertake both clinical and clerical aspects of patient care, but the training and assessment of these non-registered staff is not standardised.
- Healthcare support workers' leading role in providing frontline care is not reflected in the allocation of training budgets. They report feeling insufficiently prepared, but take-up of training is often low.
- To date there has been little research examining the factors that influence healthcare support workers' access to training, support and assessment.

What this paper adds

- To support healthcare support workers in the delivery of high quality care for older people, training in the following is required: practical skills in caring for people with cognitive impairment; patients' and families' emotions; managing their own negative emotions; and in having "difficult conversations".
- Barriers to accessing training, support and assessment include: staff shortages; variability in ward managers' enthusiasm and support for training; problems with IT infrastructure and lack of IT literacy in sections of the healthcare support workforce.
- Provision of training, support and assessment could be improved by organisational policy that promotes and protects healthcare support workers' training; formalising the provision and availability of on-ward support; and training and IT support provided on a drop-in basis.

1. Background

1.1. The role of healthcare support workers

In many healthcare systems across the world, there is growing pressure on hospital resources arising from a number of factors, including a shortage of qualified nurses and a rise in demand caused in part by an ageing population (Marangozov et al., 2016). This has led to an increase in the healthcare support workforce, a group of workers known variously, depending on which healthcare system they operate within, as healthcare support workers, healthcare assistants, nursing auxiliaries, certified nursing assistants or aides, or assistants in nursing. There is an assumption that, given adequate training and supervision, they are able to undertake care tasks that do not require nurses' specialist skills (Roberts, 1994). This is particularly evident on wards for older people. Currently much of the direct personal care of older patients in acute settings is undertaken by healthcare support workers, albeit officially under the supervision of a qualified nurse. Their role consists of making beds; assisting patients with hygiene and intimate care; carrying out observations; helping patients to eat and drink; obtaining specimens; wound care; discussing patient care with colleagues; and talking to or reassuring patients and their relatives (Thornley, 2000). In March 2016 there were 365,208 clinical support staff working in hospital and community services in the UK's National Health Service (NHS) (HSIC, 2016).

1.2. Policy and practice on training, supporting and assessing healthcare support workers

The growth of the healthcare support workforce, in terms of numbers and role, has occurred in the UK without systematic education and training (McKenna et al., 2004). Guidance on the application of knowledge and skills required by all NHS staff, including clinical support workers, has been provided centrally since 2004 (DoH, 2004). The core areas are: communication; personal development; health, safety and security; service improvement; quality; equality and diversity.

However, training for healthcare support workers in the UK has been delivered and managed locally. While healthcare support workers make up 40% of the total NHS workforce across settings, and provide around 60% of patient care, this group receives less than 5% of the national training budget (HEE, 2015). A national survey on healthcare support workforce training in acute hospital Trusts in England (Arthur et al., 2017) found that in around half of Trusts induction training lasts a week or less. A survey by the trade union UNISON of nearly 2300 support workforce members working across healthcare sectors found that 40% of respondents felt they had not received sufficient training to carry out their work; and two thirds felt they were not given sufficient training and development opportunities to reach their potential (UNISON, 2016). Despite these findings, an evaluation of the provisions for healthcare support workers at London NHS Trusts (Kessler, 2015) found limited take-up of the in-house training provided.

Skill development of the support workforce has started to receive greater attention and investment in recent years. In part, this is a response to a series of high profile failings in care and a recognition that improvement in care standards is unlikely to be achieved without paying attention to the work of 'front line' staff. In this respect the Francis Report into the failings at Mid Staffordshire NHS Trust has been a catalyst for change (Francis, 2013). Following its publication, a review of training and recruitment of health and social care support workers was undertaken (Cavendish, 2013). The review recognised the importance of healthcare support workers as "a critical, strategic resource" who "feel undervalued and overlooked [with] no compulsory or consistent training" (Cavendish, 2013: 6). As a result of recommendations from the Cavendish Review a training plan for healthcare and social care support workers was developed (HEE, 2014), and implemented nationally in 2015. Although not mandatory, the framework urged employers to implement and develop a training and support programme for support workers that goes beyond mandatory training and annual appraisal. Central to this was the introduction of a certificate of competence (the Care Certificate), predominantly targeted at new staff. An early national evaluation of the implementation of the Talent for Care initiative (which includes the Care Certificate) shows that the Certificate had prompted changes in induction, including increasing the length of induction courses (Kessler et al., 2016).

Despite the increased scrutiny and policy attention on the role and training of healthcare support workers, there is a lack of research evidence to support the successful implementation of new training initiatives. This paper draws on a large qualitative dataset gathered as part of a wider national study to design and test a short training programme for healthcare support workers (Arthur et al., 2017). Data collection took place between February and November 2014, before the national implementation of the Care Certificate, but during the period of intense consultation and review outlined above. The data was collected as part of a study to design a training intervention for healthcare support workers, to improve the experiences of care by older hospital patients.[1] The paper draws lessons from a detailed exploration of the factors that have been found to impact on the implementation of healthcare support worker training, support and assessment, specifically in older people's wards in three NHS hospitals in England. It addresses the research question: What are the challenges of training, supporting and assessing healthcare support workers in an acute setting? It uses findings to suggest actions hospitals might take to create a more effective model.

---

[1] "Can Healthcare Assistant Training improve the relational care of older people? (CHAT) A development and feasibility study of a complex intervention". The aims of the study were to understand the relational care training needs of HCAs caring for older people, design a relational care training intervention for HCAs and assess the feasibility of a cluster randomised controlled trial to test the new intervention against HCA training as usual.

Table 1
Sites and interviewee sample.

	Hospital			
	County	Mercia	Metropolitan	All
Hospital				
Geographical location	Rural county	Midlands	London	
No. of beds	1237	1700	950	
HCSW[a] interviewee sample				
Female	10	8	8	26
Male	0	2	2	4
All	10	10	10	30
Length of service in months Median (range)	51 (5–186)	24 (8–108)	51 (5–180)	30.5 (5–186)
Other staff sample				
Responsible for HCSW training (at Divisional/ Hospital level)	2	3	3	10
Directly managing HCSWs	6	3	5	9
Work alongside HCSWs	2	3	1	9
All	10	9	9	28

[a] HCSW = Healthcare support worker.

2. Methods

2.1. Sample and setting

Data were collected in three English NHS acute hospitals, selected for their diversity on the following dimensions: urban-rural, ethnic mix and London-non-London. They were all multi-site teaching hospitals providing a range of acute clinical and specialist services, one in London (given the pseudonym 'Metropolitan'), one in a rural county ('County') and one in the Midlands ('Mercia'). The sites and sample are shown in Table 1.

Semi-structured interviews were carried out with healthcare support workers and other staff. Eligible 'other staff' were those who directly manage or work alongside healthcare support workers on recruited wards, or managers with responsibility at division or hospital level. These 'other staff' were included because of their direct understanding and influence on training and the day-to-day role of the healthcare support workers.

In each of three hospitals we carried out semi-structured interviews with 10 healthcare support workers (total n = 30) with a broad range of length of service; and 9 to 10 other staff (total n = 28). Sample sizes were decided a priori, on the basis that they were large enough to answer the research question for the larger study[1], yet not too onerous on busy hospital wards. 'Other staff' (OS) interviewed were matrons (n = 2), ward managers (n = 7), other nursing and Allied Health Professional staff (n = 15), and people with responsibility for healthcare support worker training at organisational level (two interviewees at County, n = 4). All ward-based staff were recruited from older people's wards.

2.2. Data collection

The lead researcher at each site introduced themselves and presented the study to ward-based staff at ward handover meetings, and subsequently to individual staff during several visits to the ward. Researchers explained the study and what taking part would involve, including reassurance of anonymity and confidentiality, and answered any questions. They also explained that the researchers were not hospital or NHS staff. Potential interviewees were left with a participant information sheet and an expression of interest form to be completed if they were happy for the researcher to contact them about participating

in the study. Interviews took place in the workplace, during work hours in a private room on or near the ward. Interviewees with responsibility for healthcare support worker training at the organisational level were e-mailed details of the study, and interviews arranged by follow-up telephone calls or e-mails. All interviews were audio recorded, transcribed verbatim by a third party, and checked by the interviewer. Interviews with hospital training leads were conducted over the telephone, and verbal consent recorded. All others were carried out face-to-face, and written consent taken at the start. Interviews lasted on average 33 minutes. Basic fieldnotes on any issues that would aid interpretation of the data (such as interruptions, nervousness on the part of the interviewee, time shortage) were taken, and later added to transcripts.

The semi-structured interviews were conducted with the use of a topic guide, which set out the topics to be covered, the main questions to ask, and suggested prompts and probes. All interviews covered the topics and main questions but, in responding to the interviewees' input they varied in the detail. Interviews with healthcare support workers included questions about any training they had received (i.e. what training have you received? was it voluntary?); what their views on such training were (i.e. were there any training sessions that really stayed with you?; what style of delivery do you find helps you best?; were there any difficulties in accessing or doing any of the training?); what helps or hinders them putting training into practice; what aspects of their work they found most challenging and were least confident about (which might indicate a training or support need). Interviews with ward managers and other professional staff who worked alongside healthcare support workers included the questions: What are your thoughts about the training the healthcare support workers here have received? Do you think there are any gaps or weaknesses in the training programme for the support workforce? (probe re substantive areas, sections of the healthcare support workforce, mode of delivery); In practice are there any difficulties in implementing the Trust's support worker training programme as planned? Interviews with hospital training leads focussed on hospital policies on healthcare support worker training, support and assessment. Questions included: Could you describe what training a Healthcare support worker starting work at your Trust would receive? (Probe: How long does the initial training period last? Is training mandatory or optional? Is training generic or healthcare support worker-specific? What form does training take?); Is there any ward based-training? (Probe what that looks like); How is the assessment of healthcare support workers managed? What do you see as the challenges involved in training the support workforce?

2.3. Data analysis

The aim of the original study concerned application rather than theory-building (Ritchie and Spencer, 2002), and the analysis can be categorised as a thematic description (Sandelowski and Barroso (2003). Anonymised transcripts of interview data from each hospital was coded in NVivo (by SS, CA). Computer assisted qualitative analysis software such as NVivo creates a transparent link between data and analytical codes). The coding framework was informed by a priori knowledge reflected in the topic guide, initial readings and preliminary coding of the transcripts (Ritchie and Spencer, 2002). Peer debriefing (extensive discussion of transcript data meaning and codes) was undertaken in the team (SS, CA, JM, HW, AA). This collaborative work to identify themes ensured analytical validity and reliability. Following this process, a more detailed thematic analysis of the whole data set was then carried out in NVivo by one researcher (SS), using an inductive approach and the constant comparative method, in order to enhance analytical rigour (Silverman, 2001) and the credibility and 'trust-worthiness' of the findings (Lincoln and Guba, 1985). Further peer debriefing and analytical discussion was undertaken between two team members (SS and JM) and negative cases identified and discussed. At this stage differences between sites were teased out. Furthermore, it was during this

process that the challenges that healthcare support workers faced regarding on-ward support and assessment inductively emerged. This had not been included in the topic guide. Credibility and confirmability was enhanced by our data interpretation being 'tested' in a form of member checking with members of our project advisory group which included two healthcare support workers. Creating an audit trail was central to the research process, particularly as the work was undertaken across three sites.

Ethical approval for the interviews was given by the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia (reference number 2013/2014-19), and Research & Development approvals were provided by each hospital. As with hospitals, interviewees have been given pseudonyms.

3. Findings

We present findings relating to the following themes: induction training for healthcare support workers; on-ward support for new starters; assessment of competencies for new starters; ongoing training and support for healthcare support workers; and perceived gaps in healthcare support worker training identified by healthcare support workers and staff that managed or worked alongside them. A summary of hospital policies on healthcare support worker training, assessment and support at the time of fieldwork is shown in Table 2.

3.1. Induction training for healthcare support workers

Induction training is training for new employees at an organisation. At the three study sites it was undertaken in healthcare support workers' first weeks as employees within the Trust. As such it was an important signal to new recruits as to what was important and valued in the organisation. All sites reported providing induction training using a mixture of presentations, demonstrations and supervised practice. Mercia's longer induction additionally included simulation, role play, group work and sessions given by patients and voluntary sector organisations. It included time in a clinical skills room and one day was spent attending clinical areas and undertaking shadowing of experienced staff. Mercia was also unusual nationally (Arthur et al., 2017), for mandatorily extending its current induction programme to existing staff by means of a rolling programme. County Hospital differed from the national norm in that it included placement on a ward, with two classroom based discussion sessions for the duration of the second induction week. At the time the fieldwork was undertaken, induction

training at Metropolitan Hospital was entirely classroom-based, but managers were considering extending their induction training to four weeks and incorporating more ward-based training.

Induction training was generally appreciated by the healthcare support workers we spoke to, but in each of the hospitals some noted a difference between what was presented to them in the classroom, and the subsequent reality of work on the ward:.

Practical things. That's what the [induction] training needs to do. Because at the moment I thought (and a lot of people that were in the training group said) it's just very much theory based, and just sitting there looking at powerpoints constantly. Whereas, you know, people don't know how to change a bed with a patient laying on it and things like that, you know. [.] [That's] something that they could have been taught in training, because when you come to the wards people are seeing what you're doing already, do you know what I mean? (Stephen, HCSW)

I found a lot of the things were irrelevant to being on a ward. You spent a whole day with the Incontinence team […] and they make it all look easy where in reality it's not like that. You've got patients that can't open their legs so they can't sit there and squat their legs open so you can put the pad in. And the ones that are bed bound you never got showed how to do the ones that are bed bound and that sort of thing. (Ailsa, HCSW)

"it doesn't really prepare you. […] like it's all very good, like they're like 'oh close the curtains and the door and put a towel over them when you wash them', blah, blah, but if the person is trying to kick you and punch you at the same time, keeping them dignified is really difficult" (Rhona, HCSW)

3.2. On-ward support for new starters

There are various ways in which healthcare support workers can be supported once they reach the wards. 'Supernumerary' status recognises new staff members' status as learners, since it means that they are additional to the full complement of staff and not included in core staffing numbers. Buddying or shadowing refers to being allocated to a more experienced member of staff to work alongside. Supervision and mentoring of support workers implies a more formal relationship, with supervisors or mentors having greater and more direct responsibility for a healthcare support worker's learning.

Hospital policy at each of the sites, as reported to us by training leads, is shown in Table 2. However, interviews with healthcare support workers and their managers show that mentoring and buddying were

Table 2
Summary of site policies on healthcare support worker training assessment and support.

		Hospital		
		County	Mercia	Metropolitan
Induction	Length	10 days	15 days	10 days
	Mandatory for which HCSW[a] groups	New HCSWs	New + existing HCSWs	New HCSWs
	Location	Classroom & ward	Classroom & clinical skills room	Classroom
On-ward support	Supernumerary period?	No	2–3 weeks at discretion of ward manager	No
	Ward induction by:	HCA buddy	HCA buddy	PDN[b]
	Shadowing period?	Yes	Yes	Yes
	Mentoring/clinical supervision	Yes, by Registered Nurse	Yes, by Registered Nurse	Yes, by Registered Nurse
Assessment of competencies	Mechanism	Competency booklet signed off by trained assessor	Competency booklet signed off by trained assessor	Competency booklet signed off by trained assessor
Ongoing in-house training	Allocated time	No allocated time	Notional 6% of time, at discretion of ward manager	20 days training a year provided for HCSWs, but time to attend not ring-fenced.
	Delivery	Information not provided	On-ward training according to identified need	Monthly drop-in session on ward

[a] HCSW = Healthcare Support Worker.
[b] PDN = Practice Development Nurse.

not clearly defined, the terms were sometimes used inter-changeably, and supervision and a supernumerary period were related in indeterminate ways. This suggests that hospital policies on these issues were fluid and not clearly formalised.

3.2.1. Supernumerary period

County and Metropolitan Hospitals did not give healthcare support workers a supernumerary period, with one training lead saying they were expected to be "independently running" after their induction. Interviewees at Mercia mentioned two to three weeks supernumerary period, depending on need, though a senior member of staff there commented on the need for greater consistency:

"I think perhaps what we need is some standardisation of what we call the supernumerary period that they get, because that will vary from one ward to another, from one nurse to another, and there may be good valid reasons why it varies, but on ward X it will be 'oh well we give them a week's supernumerary with our best [healthcare support worker]' and on another ward they get 2 weeks and they're not quite settling in and we'll give them another one. Perhaps we need to be thinking about standardising that" (James, matron)

At Mercia, where there was a policy supporting a supernumerary period for healthcare support workers, the training lead described the current arrangements for on-ward support as "informal". In response to reports that healthcare support workers arriving on the ward had a "sticky time", the hospital was about to introduce a formal 'preceptorship' programme for healthcare support workers, which would include a supernumerary period of four weeks; and a formalised meeting structure with a nominated preceptor (a senior healthcare support worker), who would themselves be supported by a registered nurse.

One of the difficulties associated with allowing healthcare support workers a supernumerary period was that student nurses and those staff nurses who were on a year's preceptorship were often already working in a supernumerary capacity, and in the words of one interviewee, "*Not everybody can be supernumerary*" (Joanna, manager, Metropolitan). Several interviewees across the sites (healthcare support workers and managers) talked about healthcare support workers being "*chucked in like a headless chicken*" or like "*a rabbit in the headlights*" or "*deer in headlights*" without any supernumerary time, and as one healthcare support worker elaborated:

"I think they just don't feel very confident, because they didn't have enough time to understand what was going on on a day that we have to do. Because when […] they start working here: 'OK, so can you do this? Can you do that?' But we never have a lot of time to explain to them what to do because that is very busy work. […] So you really feel sorry for them." (Deborah, HCSW)

3.2.2. Ward induction, shadowing and mentoring

At Metropolitan Hospital, after the group induction programme healthcare support workers were allocated to a ward and given local induction training on the ward by a Practice Development Nurse. At the other sites local induction was given by 'buddies'. All three sites notionally supported shadowing or buddying, but in each of them at least some healthcare support workers reported not having any shadowing period, and for others it only lasted a few days because of pressures on staff. Staffing levels in wards where older patients had high levels of need required all hands on deck, which was a barrier to staff shadowing. Managing this tension could be emotionally, as well as practically difficult for both parties:

R "*when I first started, like I was meant to have I think it was a week or two weeks where I was shadowing someone. That happened for like a day.*

I Right, because they just didn't have the staff?

R They didn't have the staff and you know, I felt bad because there were buzzers going off everywhere and I was still just like standing with this one person and the poor person [I was shadowing] was obviously naturally going to be like pleased when you go and answer that buzzer that's going off next door. It was just the way this ward especially is because it's so demanding and because people just, there's not enough staff and it just gets very frustrating". (Rhona, HCSW)

At all hospitals, Trust training leads referred to a general principle of providing mentoring or clinical supervision to healthcare support workers. There was a general preference for Registered Nurses to provide this support but, bearing in mind that Registered Nurses had responsibility for supervising large numbers of student nurses, it proved difficult to find enough staff willing and suitable to take on a mentoring role and with sufficient time to do so. Therefore in County Hospital some wards used experienced healthcare support workers as mentors. The training lead in Mercia reported plans for formalising on-ward support for healthcare support worker, which included allocating them to a senior healthcare support worker mentor, and providing that mentor with support from a Registered Nurse. Some of the healthcare support worker interviewees who undertook this role felt this was valuable work and wanted to support less experienced staff in this way, but also spoke about the additional pressure this put on them in a busy ward environment:

"when we've got new trainees here, it can be really hard on the staff because they [new trainees] don't know what they're doing. Then we've got to look after the patient and look after them at the same time" (Barbara, HCSW)

3.3. Assessment of competencies for new starters

Healthcare support workers were required to demonstrate a number of competencies, based on the Knowledge and Skills Framework. All three hospitals issued new healthcare support workers with a competency booklet, which listed the expected competencies. Each competency was to be signed off by a Registered Nurse mentor/supervisor/assessor once the support worker was able to demonstrate it (see Table 2). Competencies were progressive. Some were expected to be completed within the first three months, while others would follow within the first year. The assessment of competencies could act as an indicator of training need and as a trigger for additional training support. Policy in all three hospitals was that healthcare support worker competency should be assessed by a Registered Nurse trained in such assessments; and that if it appeared that a support worker was not progressing in achieving their competencies an action plan of support be put in place. However, in Mercia it was reported that there was no official record of how successfully this policy was achieved; and in Metropolitan Hospital there was some evidence that competencies were not always assessed. One reason for this may be that completion of the competency booklet requires considerable input from a more senior member of staff in assessing each competency up to three times. It was apparent that this input was not always available due to a shortage of time and lack of staff trained to fulfil this role. Individual members of staff needed to be organised and proactive to achieve support, as one healthcare support worker, who had been in post for a year and a half recounted:

"when I came here and I told the healthcare support workers about the competence document and I was asking for a mentor, like somebody who was going to be signing this, they [the other healthcare support workers] told me that they had nobody. So I took it upon myself to ask Sister to give me somebody to […] oversee what I'm doing and be able to fill in the mentor − the competence part. But because you're obviously working on the ward you rarely get the time to sit down and say, 'Look, let's go through this. Have you done this?' So I have my competence document, I

know my mentor, but we actually looked at it in the first few months of when I started and we've not done it ever since." (Aliya, HCSW)

3.4. Ongoing in-house training: provision and access

We were interested in what in-house training healthcare support workers experienced after induction and the new starter period, including periodically updating statutory (required by government) or mandatory (required by the organisation) training.

3.4.1. Provision for ongoing training

County Hospital provided no time allocation for ongoing skills development opportunities for healthcare support workers, though requests for time off the ward to access training would be considered on a case by case basis. At Mercia 6% of support workers' time was notionally available for training, at the discretion of the ward manager. Metropolitan reported providing on average 20 days of training per year, and a quarterly forum for healthcare support workers. However, time for support staff to attend this training was not ring-fenced, and the majority of healthcare support workers we spoke to at Metropolitan reported difficulties in accessing training, including mandatory training.

3.4.2. Access to ongoing training

Barriers to access reported at Metropolitan included lack of IT infrastructure and cancellations. Other barriers, noted across sites, were: ward pressures; IT skills; attitudes of individual ward managers towards training of support workers; infrequency of training sessions. The presence of Practice Development Nurses or equivalent on the ward, proactively offering support improved access to training. These issues are discussed further in what follows.

At all sites ward managers and healthcare support workers commonly spoke of the difficulty of releasing staff from busy wards to undertake any training they had booked to attend. This meant that it was not always possible to complete even the training that the hospitals reported as mandatory:

"HCAs actually are very keen to learn, you know. Probably very keen to do eLearning. But it's just the opportunity. Now, they can get to do it at home, but I've said, 'A lot of this is mandatory and I don't want you to do it at home.' So after trying for years to get sessions on the ward and people's passwords wouldn't work, etcetera, we [now] send them down to the learning zone to do it. But it then also depends on the day; what the staffing issues are like on the ward." (Laura, PDN)

Two healthcare support workers would have liked ring-fenced study days which they could use to catch up on all their training. Similarly, ward managers told us that it was easier to allocate healthcare support workers to an entire day of study rather than release them for training during a shift. Some managers asked support workers to spend any spare time on any day they had been released for training to undertake e-learning, which is how the majority of mandatory training was delivered. E-learning had the advantage of being accessible at any time. However, in hospitals where there was insufficient IT infrastructure there could be bottle-necks with respect to accessing on-line training materials. Managers and trainers reported that the IT skills of healthcare support workers was also said to be variable.

Ward managers were gatekeepers to healthcare support workers' access to training but varied in their support of it. Some actively encouraged access to training and development activities, and others designed and organised additional training activities. But on some wards healthcare support workers felt it was an uphill struggle to get their managers to register them for training. From a ward manager's perspective, the need to ensure adequate ward staffing while meeting the learning needs of support workers was a tension not easily resolved. One ward manager, who was very active in healthcare support worker

development, thought that releasing staff was increasingly difficult as the demands of the job had increased over the years with no parallel increase in staff numbers. She said,

"on a daily basis [.] you have to send someone maybe for infection control, and maybe someone has to go for a few hours training that is run by the [Practice Development Nurse], so then you wonder of your staff 'How can I release all of you?' It's hard". (Joy, ward manager)

Infrequency of training courses meant that if a support worker was on leave, or otherwise not scheduled to work they could have a very long wait. Many we spoke to were willing to attend training on days off (and claim back time in lieu) rather than face further delays. Any delays in accessing mandatory courses could have knock-on effects on other training by limiting access to these, since some managers made completion of all mandatory training updates a condition of nominating a healthcare support worker for other training.

Practice Development Nurses or equivalent provided the majority of ongoing training and support for healthcare support workers. In Mercia the Practice Development Nurses moved between wards to help healthcare support workers as required (reactively) or to proactively provide specifically arranged assistance for individuals (as identified by ward managers). At Metropolitan, Practice Development Nurses organised a monthly programme specifically for healthcare support workers, delivered by clinical nurse specialists on subjects such as continence promotion, encouraging eating and drinking, and approaching confused patients. Because of known difficulties with releasing staff these were carried out on the ward, and support workers were able to drop in on the sessions as their work allowed or not. Some healthcare support workers we spoke to said they had attended such sessions. Their availability on the ward and their length (up to 30 minutes) made them accessible, and one support worker noted that he found the practical nature of the training made it easier to apply.

3.5. Perceived gaps in training

Although no healthcare support workers mentioned this, ward managers and Trust training leads talked about the poor literacy and numeracy skills of some of the support workforce. The interview data highlighted a number of areas in which healthcare support workers reported a lack of confidence, pointing to insufficient training opportunities and support available to them.

3.5.1. Inter-personal skills

A lack of confidence was particularly evident in relation to aspects of their role that required a high level of inter-personal skills such as dealing with the emotional needs of patients and carers, talking to patients and carers about 'difficult' issues, and managing their own stress and negative emotions. At Mercia (where the induction training was longer than the other sites, and longer than the national average) induction training did include training related to inter-personal skills such as a day's training from the Alzheimer's Society, a visit from a cancer patient, a session on reflective practice and Sage & Thyme communication training (UHSM, 2012) for dealing with 'awkward conversations'.

3.5.2. Caring for patients with cognitive impairments

There was an overwhelming demand from healthcare support workers and other staff for more training for support workers on working with patients with cognitive impairments, including dementia, delirium and confusion. Although induction training at all sites included a session on this, healthcare support workers expressed a preference for a more practical approach than that provided at induction, including: how to manage frail older people safely, effectively and compassionately, frequently in the face of challenging behaviour; and communication styles and techniques to use with patients with cognitive impairment. As one interviewee told us:

"trying to reason, sometimes, with a dementia patient doesn't work. Sometimes – if they turn round and say, 'My mum's coming up this afternoon', the worst thing you could turn round and say is, 'No, I think your mum might be dead.'" (Rosanna, Advanced Practitioner).

Healthcare support workers and other staff reported that patients with cognitive impairment also presented other challenges. Their behaviour could be bewildering, repetitive and frustrating, and support workers felt insufficiently trained in how to respond to such behaviour or how to manage their own emotions in relation to it.

"you've got patients getting out of bed all night long, you've got to constantly look that they can't fall. You've got people asking for a commode every one minute literally and after you've got them off the commode they want to go back on the commode, things like that, you know, trying to understand those patients [with dementia] because you do get frustrated and you get angry. On a night shift you're so tired, you know, these patients just ruin your life. You dread coming to work solely because of these patients." (Stephen, HCSW)

3.5.3. Managing emotions

A training gap was identified by several healthcare support workers across sites regarding managing stress or other negative emotions that may arise in their work more generally:

"I think for me personally when I started I didn't think it would be anything like I've been through. I didn't think the job would be half as stressful, half as demanding… and… to come into it and deal with it myself, it, it, it wakes you up. […] I do think there should be training for dealing with your own stress, because when you're on the ward you've got nowhere to vent it, you have to keep it in." (Antonia, HCSW)

Some healthcare support workers called for more training in dealing with the emotions of patients and relatives, including dealing with bad news:

"when you're actually with somebody who has been told bad news, it's difficult. It's always trying to get the right words, and sometimes obviously the patient would like to talk to you and – […] I would probably like a bit more [training on] how to say the right things without putting your foot in it if you know what I mean? […] yes I would probably benefit when somebody is dying. And also talking to the family as well, getting it right." (Hayley, HCSW)

4. Discussion

Induction training was valued by healthcare support workers, but some felt it lacked a sufficiently strong connection with the realities of ward work. Our finding, that further training is welcome, is consistent with other work that suggests both healthcare support workers and nurses favour more formal training and support for support workers, although a blurring of role boundaries is of concern to both staff groups (Coffey, 2004; McKenna et al., 2004; Wilberforce et al., 2017). More specifically there was a perceived need for practical training associated with communication skills, and caring for people with cognitive impairment. If training needs such as these are not met the effects on staff morale can be damaging. For instance, an ethnographic study of staff working in dementia wards found that healthcare support workers tended to draw support from close-knit groups of support workers which disconnected them from the wider ward team (Lloyd et al., 2011). In the United States residential care sector efforts to meet training needs with respect to dementia has had mixed results, with challenges including hesitation by trainees to try new strategies, conflicts with prior training, and preconceived ideas as to the cause of behaviours by people with dementia (Teri et al., 2009).

Following induction training it was recognised that starting work on a ward without a supernumerary period shadowing an experienced healthcare support worker could be extremely challenging for new support workers. Understaffing on wards acted as a barrier to healthcare support workers being supernumerary initially and in releasing them to attend training. Ward mangers (who acted as gate-keepers to support workers' training) varied in their enthusiasm and support for any additional training. The Council of Deans for Health have previously identified a workplace culture that often affords a low priority to the personal development of healthcare support workers (The Council of Deans, 2014). In all three hospitals, insufficient Registered Nurses to act as mentors to support staff was a barrier to the provision of sufficient support, assessment and mentorship for healthcare support workers.

Formalisation of on-ward training through the use of booklets to log and assess specific competencies can potentially facilitate healthcare support workers to acquire new skills. However, trained assessors to 'sign off' such competencies were often not available due to a lack of time or a lack of synchronicity between mentor and support staff rotas. A strategy of reliance on e-learning as the main form of training delivery was vulnerable to problems with computing infrastructure and lack of IT skills among sections of the support workforce.

The themes identified in this study are clearly inter-related and overlapping, providing a richer picture of healthcare support worker training needs and the contextual infrastructure needed to support this than hitherto reported. This paper has described the policies on training, support and assessment at three hospitals, as reported to us by those responsible for healthcare support worker training. It has also identified differences between hospital policies and the realities of training for healthcare support worker in acute care settings where there are important gaps in training provision, difficulties in being able to access training, and challenges for hospitals in providing on-ward support and assessment. Our analysis indicates actions that may help to close the current gap between policy and practice, and create a more effective model of training, support and assessment of healthcare support workers. These are shown, in no particular order, in Box 1.

The delivery of new and planned policies in the UK needs to be mindful of the nature and function of the HSCW workforce and the wider hospital setting. In Canada, a study of similar initiatives aimed at standardising healthcare support worker training, found there was a perception of conflict between training provision and the increasing casualization of the workforce highlighting a disconnection between learning content and working conditions (Kelly, 2017). A lack of attention to this context could potentially exacerbate the problems our study has identified around on-ward support and assessment. Our findings on the difficulties of executing organisational policy on assessment of healthcare support workers even before the implementation of the UK Care Certificate, indicate that the completion of assessments required to achieve the Care Certificate may fail if the existing problems relating to supervision and assessment are not addressed. An early national evaluation of the implementation of the Care Certificate (Kessler et al., 2016) found that for many organisations, the capacity to complete assessments in a timely manner was the most challenging aspect of implementation.

The introduction of the Care Certificate may give healthcare support workers greater leverage with managers to make arrangements for the assessment and sign-off of competencies. Evidence from an evaluation of a national training initiative for healthcare support workers in Ireland suggests trainees reported greater confidence on completion of the programme (Keeney et al., 2005). Guidance suggests that healthcare support workers can also be assessors provided they receive appropriate training and that organisations should protect assessors' time (Skills for Health, 2016). This provides an opportunity for professional development of healthcare support workers, and may ease the problem of assessor shortage though this additional responsibility might not be universally welcome (Kessler et al., 2016).

Recent UK workforce policies may increase strain on hospitals already struggling to find enough appropriately trained staff willing to

Box 1
Actions for closing the gap between policy and practice

- Trust policies to promote and protect healthcare support worker training (including cover on the ward, and helping ward managers to see the benefits of further training for this workforce).
  - Training days booked as whole days away from the ward, and classroom-based training time supplemented by time spent on e-learning to fill the day.
  - An induction period of sufficient duration to include training in inter-personal skills and reflective practice
  - Provide training and support on: practical skills in caring for people with cognitive impairment; managing stress and negative emotions; having difficult conversations with patients and relatives.
  - Providing on-ward training on a drop-in basis, to facilitate access.
  - Trust policies that recognise the need for on-ward support (including the benefits of a supernumerary period), and that formalise the different types of on-ward support and make access to them more consistent.
  - Using experienced healthcare support workers as mentors, provided they are given adequate time and support to take on this role.
  - Place responsibility for the completion of assessment of healthcare support worker competencies onto ward managers.
  - Provide supervised IT sessions to help healthcare support workers with limited IT skills to complete e-learning.

take on a mentorship role. The introduction of a new Nursing Associate role (HEE, 2016) (a role located between unregistered healthcare support workers and Registered Nurses) will generate a new tranche of the workforce requiring supervision and assessment. Secondly, the lifting of the cap on student nurse training places makes it difficult, in the short and medium term, to anticipate the number of student nurses and newly qualified registered nurses who will need supervision.

Responsibility for ongoing training and assessment is currently the responsibility of individual healthcare support workers, but our study has shown that access to such training is often determined organisationally. This helps to explain the fact that a study of support worker training provision within a London region (Kessler, 2015) found limited take-up of the in-house training provided. Similar barriers to continuing professional development have been found with respect to the registered nurse workforce (Gould et al., 2007). Given the structural constraints and healthcare support workers' place in the work hierarchy, we argue that responsibility should lie with organisations, not individuals.

Healthcare support workers spend a great deal of time with patients, and are often the main point of contact for family members. Providing them with the training they need is crucial to enable delivery of high quality care. While the UK Care Certificate has articulated highly relevant outcomes that members of this workforce need to attain, our study suggest that this will not be sufficient without the commitment and investment in training, support and assessment that is aligned to these outcomes and recognises the pressures that individuals and organisations face.

5. Strengths and limitations

Our study findings should be considered within the context of the study design and its methodological strengths and limitations. Firstly, the broader aim of the study from which the data are drawn is related but not identical to the research question that this paper addresses. This means that we do not have data from the entire sample for every one of the issues we address. Nevertheless, the fact that healthcare support workers experiences of on-ward support and assessment emerged so strongly in interviews suggests this is a salient topic. Secondly, the study was conducted in England, and therefore situated in a particular policy context, although increasing reliance on the healthcare support workforce is an international phenomenon and the implications of our findings are relevant to other countries' health systems and beyond the acute setting. Thirdly, interviews were undertaken at a time of great flux in how the role of healthcare support workers is understood. We were not able to re-interview participants and new initiatives may have subsequently affected their views of the challenges they faced. Nonetheless, many of the challenges reported by participants are those

that are likely to persist unless efforts are made to change not just the amount and type of training but the environments in which healthcare support workers learn.

This was a large qualitative study comprising fifty-eight interviews and gathering perspectives from healthcare support workers and those who work alongside them or manage them directly or indirectly. In any study that captures individual narratives, participants choose what they reveal about their experiences and their views. We have no reason to believe that participants felt that a particular view would be more favourably received by the interviewer.

Participants in our study all came from one of three acute hospitals in England. While we accept all hospitals have particular features and cultures that are specific to individual organisations, we are confident that the challenges faced in delivering training to this section of the workforce are likely to cross organisational boundaries. At the same time, by looking at the training, support and assessment policies and practices in different sites we have been able to draw lessons on what policies work well, and what the challenges to implementing policy are. Similarly, the healthcare support workers and the other ward-based staff we spoke to all worked in older people's wards. The nature of older people's hospital care in terms of the business of the ward and the proportion of patients with cognitive impairment are somewhat unique. However, given an ageing population, multi-morbidities and increasing acuity of patients' healthcare needs, staff working on other wards are increasingly likely to share these experiences, at least some of the time.

Acknowledgements:

References

Arthur, A., Aldus, C., Sarre, S., Maben, J., Wharrad, H., Schneider, J., et al., 2017. Can Health-care Assistant Training improve the relational care of older people? (CHAT) A development and feasibility study of a complex intervention. Health Serv Deliv Res 5 (10).

Cavendish, C., 2013. Cavendish Review: an Independent Enquiry into Healthcare Assistants and Support Workers in the NHS and Social Care Setting. Department of Health, London.

Coffey, A., 2004. Perceptions of training for care attendants employed in the care of older people. J. Nurs. Manag. 12, 322–328. http://dx.doi.org/10.1111/j.1365-2834.2004.00442.x.

DoH [Department of Health], 2004. The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process. Department of Health, London.

Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. HMSO, London.

Gould, D., Drey, N., Berridge, E.-J., 2007. Nurses' experiences of continuing professional development. Nurse Educ. Today 27 (6), 602–609.

HEE [Health Education England], 2014. A National Strategic Framework to Develop the Healthcare Support Workforce: Part of Framework 15, the Health Education England Guide to Action. Available at: https://www.hee.nhs.uk/sites/default/files/documents/TfC%20National%20Strategic%20Framework_0.pdfhttps://www.hee.nhs.uk/sites/default/files/documents/TfC%20National%20Strategic%20Framework_0.pdf [Last accessed 17.03.17].

HEE [Health Education England], 2015. Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants. Available at: https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf [Last accessed 17.03.17].

HEE [Health Education England], 2016. Nursing Associate: A Report of Five Workshops. . Available at: https://www.hee.nhs.uk/sites/default/files/documents/Post%20Nursing%20Associate%20workshops%20report%20Dec%202016.pdf [Last accessed 23.03.2017].

HSIC [Health Services Information Centre], 2016. Healthcare Workforce Statistics. England March 2016 Available at: http://content.digital.nhs.uk/catalogue/PUB21783/nhs-staf-sep-2015-mar-2016-rep.pdf [Last accessed 17.03.17].

Keeney, S., Hasson, F., McKenna, H.P., 2005. Healthcare assistants' experiences and perceptions of participating in a training course. Learning in Health and Social Care 4 (2), 78–88. http://dx.doi.org/10.1111/j. 1473-6861.2005.00083.x.

Kelly, C., 2017. Exploring experiences of personal support worker education in Ontario, Canada. Health Soc. Care Commu. 25 (4), 1430–1438. http://dx.doi.org/10.1111/hsc.12443.

Kessler, I., Nath, V., Bach, S., 2016. Talent for Care: Evaluation Report. King's College London, London.

Kessler, I., 2015. Health Education North West London Support Workforce Project: Evaluation Report. King's College London, London.

Lincoln, Y., Guba, E., 1985. Naturalistic Inquiry. Sage, London.

Lloyd, J., Schneider, J., Scales, K., Bailey, S., Jones, R., 2011. Ingroup identity as an obstacle to effective multiprofessional and interprofessional teamwork: findings from an ethnographic study of healthcare assistants in dementia care. J. Interprof. Care 345–351. http://dx.doi.org/10.3109/13561820.2011.567381.

Marangozov, R., Williams, M., Buchan, J., 2016. The Labour Market for Nurses in the UK and Its Relationship to the Demand For, and Supply Of, International Nurses in the NHS: Final Report. Institute for Employment Studies, Brighton.

McKenna, H., Hasson, F., Keeney, S., 2004. Patient safety and quality of care: the role of the health care assistant. J. Nurs. Manag. 12, 452–459.

Ritchie, J., Spencer, L., 2002. "Qualitative data analysis for applied policy research". In: Huberman, A., Miles, M. (Eds.), The Qualitative Researcher's Companion. Sage, London, pp. 305–329.

Roberts, I., 1994. The health care assistant: professional supporter or budget necessity. Int. J. Health Care Qual. Assur. 7 (6), 20–25.

Sandelowski, M., Barroso, J., 2003. Classifying the findings in qualitative studies. Qual. Health Res. 13 (7), 905–923.

Silverman, D., 2001. Interpreting Qualitative Data, 2nd. Sage, London.

Skills for Health, 2016. How to Implement the Care Certificate in Your Organisation. https://www.skillsplatform.org/blog/how-to-implement-the-care-certificate-in-your-organisation?utm_source=Skills+for+Health+Mailing+list&utm_campaign=fc7b5800d2-Bulletin_2016_sep_no_29_28_2016&utm_medium=email&utm_term=0_c0a03bf296-fc7b5800d2-1901877 [Last Accessed 30.09.2016].

Teri, L., McKenzie, G.L., LaFazia, D., Farran, C.J., Beck, C., Huda, P., van Leynseele, J., Pike, K.C., 2009. Improving dementia care in assisted living residences: addressing staff reactions to training. Geriatr. Nur. (Lond.) 30 (3), 153–163. http://dx.doi.org/10.1016/j.gerinurse.2008.07.002.

The Council of Deans, 2014. Shaping the Future: Education and Training for Nurses and Care Assistants. Available at: http://www.councilofdeans.org.uk/wp-content/uploads/2014/10/CoDH-Shape-of-Caring-Evidence-Response-20140917.pdf [Last accessed 23.03.2017].

Thornley, C., 2000. A question of competence? Re-evaluating the roles of the nursing auxiliary and health care assistant in the NHS. J. Clin. Nurs. 9 (3), 451–458.

UHSM, 2012. University Hospital of South Manchester NHSFT]. Sage & Thyme. Retrieved from http://www.sageandthymetraining.org.uk [Last accessed 23.03.2017].

UNISON, 2016. Care on the Cheap: A UNISON Survey of Clinical Support Workers. UNISON, London.

Wilberforce, M., Abendstern, M., Tucker, S., Ahmed, S., Jasper, R., Challis, D., 2017. Support workers in community mental health teams for older people: roles, boundaries, supervision and training. J. Adv. Nurs. 73 (7), 1657–1666. http://dx.doi.org/10.1111/jan.13264.