# HEALTHCARE SUPPORT WORKERS – MANDATORY STANDARDS AND CODES

## FIRST MEETING OF THE STRATEGIC IMPLEMENTATION GROUP

**31 August 2009, 1430-1630,**
**Conference Room C&D, St Andrew's House, Edinburgh**

**Present:**

**Karen Adams (KA), Programme Manager - NHS Education for Scotland (NES)**
**Irene Barkby (IB), Nurse Director - NHS National Services Scotland**
**Anne Campbell (ACa), National KSF Lead - Scottish Government**
**Marie Cerinus (MC), Director of Nursing, Midwifery & Allied Health Professions (NMAHPs) Practice - NHS Lanarkshire**
**Catherine Clark (CC), Head of Regulatory Unit – Scottish Government Health Directorates**
**Audrey Cowie (Chair) (ACo), Professional Adviser - Regulation and Workforce Standards, Scottish Government Health Directorates**
**Linda Davidson (LD), Associate Director of Human Resources - NHS Lothian**
**Frances Dow (FD) – Lay Member**
**Lynne Hollis (LH), Director of Finance - NHS Lothian**
**Liz Jamieson (LJ) – Programme Director, NHS Education for Scotland (NES)**
**Brian Main (BM), Head of Support Services/Site Manager - Ninewells Hospital & Medical School**
**Julie Mckinney (JM) - Health Finance Directorate, Scottish Government**
**Mary Parkhouse (MP), Head of Continuing Professional and Practice Development - NHS Lothian**
**Alasdair Pattison (AP), AHP Lead - NHS Borders**
**Mary Porter (MP), Associate Director of Nursing - NHS Fife**
**Jan Warner (JW), Director of Patient Safety & Performance Assessment – NHS Quality Improvement Scotland**
**Brian Wilson (BW) – Facilities Manager, NHS Greater Glasgow & Clyde**

**Apologies:**

**Lily Bryson (LB), Assistant Director of Finance, Golden Jubilee National Hospital**
**Dawn Carmichael (DC), Associate Director of Finance - NHS Lothian (Lynne Hollis deputising)**
**Lilian D'Arcy (LD), patient representative**
**Ros Derham (RD), RCN Professional Officer - Royal College of Nursing**
**Ann Fairlie (AF), Head of Practice Development, NHS Ayrshire and Arran (and her deputy Chris Rodden (CR), NHS Ayrshire & Arran)**
**Colette Ferguson (CF), Associate Director NMAHPS, NES (Liz Jamieson deputising)**
**Martin Henry (MH), Facilities Manager, State Hospital**
**Mary-Anne Kane (MAK), General Manager for Facilities, North East and Citywide Catering, NHS Greater Glasgow & Clyde (Brian Wilson deputising)**
**Claire Ronald (CR), Senior Negotiating Officer, Chartered Society of Physiotherapy**

**In attendance: Robert Girvan (minutes)**

| Item | Topic | Action By: | Due Date: |
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| **1.** | **Welcome, introductions and apologies** | | |
| | ACo introduced herself as Chair and welcomed members to the first meeting of the Group. Apologies were recorded as above. There had been two new nominations since the papers were distributed:<br><br>Linda Davidson, Associate Director of Human Resources, NHS Lothian, representing Executive Directors of HR (with Alan Boyter supporting)<br><br>Julie McKinney of Health Finance Directorate, Scottish Government. | | |
| **2** | **Membership SIG/2009/01** | | |
| | ACo noted that the membership of the Group was now finalised. Only one representative had been secured from the HR Executive Directors forum: Linda Davidson.<br><br>ACo explained that membership of the Group had been chosen on the basis that its role was to remain strategically focused and to give general and specialist strategic advice on aspects of implementation. It would not have a role in the operational detail of implementation as existing parallel workstreams were progressing what was necessary.<br><br>The purpose of the Group was not to develop policy as the way forward had already been agreed in conjunction with key stakeholders. The Group's role was to provide strategic advice around implementation across NHS Scotland.<br><br>ACo noted that, should the discussions suggest that work needed to be progressed outwith the Group by members, then agreement would be reached on this. | | |
| **3** | **How we got here – summary of developments SIG/2009/02** | | |
| | ACo took the Group through the summary paper and provided an opportunity for questions; none were forthcoming. | | |
| **4** | **Terms of Reference SIG/2009/03** | | |
| | ACo took the Group through the paper and reiterated the Group's objectives.<br><br>It was noted by all that Boards will not have made financial provision for implementation of the model as yet. | | |
| **5** | **Model of mandatory standards and codes** | | |

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| | a Pilot outcomes – research summary<br>SIG/2009/04 (for information)<br><br>ACo asked members to receive this paper and offered further discussion outwith the meeting if required.<br><br>b Induction standards – verbal update from NES<br><br>ACo invited Liz Jamieson, then Karen Adams, to share high level information on action plans relating to work on the induction standards for both clinical and non-clinical support workers.<br><br>LJ said that NES had been handling the framework for HCSW education and role development and produced a guide in June 2009. The electronic toolkit would be active at the end of the financial year – dependent on the context of other NES work, as it was a sizeable task. It was expected that the Induction Standards and Codes would sit within the toolkit. The toolkit was intended to be a repository for access by managers, employers and HCSWs.<br><br>On non-clinical HCSWs, KA noted that they would follow LJ's lead. With regard to this group of workers, clarity was required on whether the definition would incorporate all non-clinical staff groups.<br><br>ACo said that the Induction Standards were shown to be relevant to clinical HCSWs but that there might still be some work required on the performance criteria lying behind the overarching public protection standard statements. NES would also have a role in developing the performance criteria for non-clinical staff. The overarching public protection standard statements appeared to apply to non-clinical staff, however the pilot evaluation report highlighted that non-clinical staff did not have the same tradition of regulation as the clinical HCSW groups and that further work should be done on the applicability of the standards, as worded, to the non-clinical group. MC noted a need for clarity with regard to the applicability of the standards to clinical and non-clinical staff. This was a key finding that needed to be addressed, given the differences in the tradition of supervision.<br><br>BM highlighted that there would be significant cost implications from implementing the model for non-clinical staff but stressed that anything was possible with appropriate resources. Managers on the shop floor would feel the strain in the context of cuts and ratios of supervisors which were 1:35 in some areas. He noted the need to dovetail implementation with parallel processes and frameworks. IB reported that staff ratios would also be challenging for clinical staff. ACa said that the issues arising were no different from those arising from the implementation of KSF. Implementation had to be within | | |

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| | the context of existing frameworks. For example, the KSF had a number of scheduled review periods that could be utilised.<br><br>It was agreed that the model should make full use of existing frameworks. IB asked that the pilot leads share the detail on how KSF dovetailed with the model as tested during the pilot. She cautioned that there might be a need to revisit job descriptions and KSF outlines in light of implementation of mandatory standards and codes. MC said that although the timing of KSF implementation did not allow it to be tested fully in the context of the pilot, it proved to be a potential lever for achieving better practice. The timing was unfortunate in that KSF was at an early phase of implementation at that point, but achievement of standards should be an integrated process that did not separate out the work of the KSF reviewer. There was a need to look at the skill mix available and make the requirements a component part of the supervisory system. ACa said that consistency in KSF outlines would develop over time. Material demonstrating achievement of the Induction Standards would provide good evidence for the Foundation Gateway Review and there was the potential for e-KSF to record standards achievement, albeit on a longer timescale.<br><br>ACo highlighted that mandatory status would apply to new starts, however there would obviously be a requirement for equity in the treatment of all staff should capability be an issue. FD asked if there was room in the plan for phasing implementation. It was noted that each potential Board plan would be different and implementation would hinge on, for example, the respective numbers involved in each Board. Boards needed to think about the specific risks for them and the best way to start implementation. IB suggested that concrete start and end dates would be useful; the remaining timelines could be left to the Boards to decide. It was agreed that strategic intelligence needed to be in place prior to implementation, drawing on the pilot sites' experiences.<br><br><u>c Code of Conduct for Healthcare Support Workers</u><br>SIG/2009/05 (for information)<br><br>ACo highlighted that the Code of Conduct had been updated since conclusion of the pilot, bringing references and website links up to date where appropriate without changing the essence of the code. The reference to the NMC work on good character had been removed as it had since been superseded.<br><br><u>d Code of Practice for Employers</u><br>SIG/2009/06 (for information)<br><br>ACo reported that the Code of Practice for Employers had | | |

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| | also been updated since conclusion of the pilot, making links across to existing governance monitoring frameworks and generally updating sources of information. The Standard statements and both Codes would be launched by the Cabinet Secretary on 28 October 2009 at the second day of the Annual Regulation Event.<br><br>e Definition of Healthcare Support Worker<br>SIG/2009/07 (for decision)<br><br>ACo explained that a robust definition of Healthcare Support Worker was vital to the successful implementation of the model of mandatory standards and codes.<br><br>The outputs from the Group's discussion would be used to strengthen the definition and ensure that no support worker who should be included is missed, and that no support worker who need not be included is inadvertently included in mandatory arrangements.<br><br>The Protection of Vulnerable Groups (Scotland) Act, once commenced, would offer something important to the protection of "protected adults" and children, however it was focused on those within what will be defined in legislation as "regulated work", ie a direct engagement role with an associated potential to do harm.<br><br>The model of mandatory standards and codes provided, however, a wider net of assurance for service users, building on the premise that they are entitled to interface with staff who have been safely recruited, properly inducted, developed within their employment role and encouraged to consistently comply with a fundamental code of conduct based on the principles of public protection and patient safety.<br><br>ACo went on to point out that the correct categories of support worker must be captured by the definition, as indicated in the paper. The definition would then be used as part of the Direction from Scottish Ministers. She noted that the Direction from Ministers had the equivalent status to secondary legislation, in that the power to "direct" came from primary legislation, ie the National Health Service (Scotland) Act 1978 (as amended).<br><br>ACo directed members to paragraphs 10 and 11 of paper 07, and to the questions posed below paragraph 11 which required an answer. She invited discussion on the list at paragraph 11 particularly, noting that requests for changes would be accommodated as far as possible then put to solicitors for final clearance.<br><br>It was pointed out that there was a difficulty of definition for Facilities staff, in that some porters, for example, might have a lot of contact with patients while others had none. | | |

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| | ACo said that, when she met with Directors of Facilities, they had reported that flexibility in the workforce was desirable. There might be times when staff were required to work with patients in unusual circumstances. A more inclusive approach to implementation had therefore greater flexibility potential.<br><br>IB noted difficulties with the use of the term "patient" in that this might not be seen to encompass those donating blood, for example. It was suggested that "people" be used instead.<br><br>It was suggested that the wording of the section that outlined the contractual status of staff should be refined.<br><br>It was also requested that the definition of 'healthcare professional' be expanded.<br><br>It was agreed that maintenance workers should be included in the definition if they could potentially affect patient safety. BM commented that drivers should be in the facilities category. He agreed to provide a bullet point for the Facilities Services category, using the same convention as in the draft paper, and to send this to secretariat. | **BM** | **ASAP** |
| | KA noted that the Facilities question linked in with Administrative Services staff, a complex issue in that they were dispersed throughout departments. This area required care as all those who served patients had the potential to cause harm. Following discussion on those with "back-room" functions, the question was posed, should, for example, the Director of HR be required to meet the standards? Discussion led to a query as to whether the standards and codes being feasibly applied to everyone working in the NHS. FD cautioned that the decision to implement the model for each group of staff had to be justified.<br><br>KA asked what was explicitly meant by a "direct or indirect" effect on service users? This could encompass any contact with personal information and those who maintained facilities/environment. She suggested relying on key principles rather than job categories for the definition.<br><br>BM pointed out that focusing only on the lower grades of staff could be construed as punitive rather than encouraging. There was further discussion around whether the focus should be on those whose customer was a service user rather than on a group of staff. BM noted that the exercise of applying the definition in practice would be role/post specific. IB said that the question was, what was the primary principle? If it was public protection, what kind of public protection? ACa said that the issue of proportionate risk was relevant. There might be contact, | | |

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| | but not in a providing care context; was this about key services or key care? She advocated a risk based approach linking the principles to risk assessment.<br><br>IB said that there could be generic standards that applied to everyone, but a specific element for those who delivered care. ACo commented that it was important that the definition was right from the start. Legal advisers wanted a specific, comprehensive approach. In response to questioning, she confirmed that the standards and codes were for NHS Scotland staff, and not for Social Services staff who had their own arrangements. However, if workers were already regulated by the SSSC they could get credit for prior achievement. ACo also noted that the Codes were very similar for health and social care. JW said that the definition read as a hospital orientated one and therefore needed to be clear for all.<br><br>It was agreed that the HCSW Definition would be redrafted by **Audrey Cowie** and **Robert Girvan,** taking account of legal advice received to date, to accommodate changes requested. It would then be electronically circulated to the Group for comments before the 12 October meeting and before final submission to legal advisers. The 2nd and 3rd bullets in paragraph 10 of paper SIG/2009/07 would also be re-worded by secretariat to better differentiate between these two points. | **ACo/RG** | **ASAP** |
| **6** | **Draft Implementation action plan**<br>**SIG/2009/08 (for decision)** | | |
| | ACo commented that the implementation action plan provided information on the recommendations from the independent evaluation. These recommendations had been largely endorsed by the Cabinet Secretary for Health & Wellbeing.<br><br>ACo clarified that the Group's task was to reach agreement on:<br><br>• Board levels leadership / sponsorship;<br>• timescales for implementation (working back from the end date of 2010);<br>• cost analysis work and articulation with existing structures and processes.<br><br>It was agreed that decisions on Board level leadership / Executive sponsorship should rest with the Boards themselves. This might need to be reflected in the Direction from Scottish Ministers.<br><br>There was a discussion around timescales for implementation with reference to the fact that it took seven months for pilot sites to put arrangements in place before | | |

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| | commencing roll-out. LJ said that this needed careful thought, as Boards might have operational implementation issues dependent on the content of the Codes, Standards, assessment materials, etc. The end of 2010 would be preferable, given that there were also cost implications.<br><br>ACo clarified that the content of the Codes would not change, except for presentational amendments which had already been achieved. The Codes were all tested in the pilot and were supported as they stood. The Induction Standards had also been tested and were supported, although there might still be the need to review the performance criteria – particularly for non-clinical staff. The overarching statements themselves would however remain the same.<br><br>There was discussion around whether achievement of the standards and codes would affect banding as this would have cost implications. It was noted that core job descriptions were not likely to be changed, as the standards themselves were fundamental to dealing with the public; and that the package of standards and codes merely provided the HCSWs with the tools necessary to do this.<br><br>On timescales it was noted that in preparation for the pilot, Board pilot sites took seven months to put the necessary structures and processes in place, with a lot of learning taking place as a result. Therefore, Boards could prepare themselves for implementation at the same time as the supporting work from NES was being done. MC advised that preparatory work was not predicated on the NES package being available. NES aimed to deliver their implementation project plan by the end of September 2009, with the priority being work to support the October launch by the Cabinet Secretary. | | |
| | It was agreed that roll-out of mandatory standards and codes across the NHS would not commence before October 2010. Pilot leads **Marie Cerinus** and **Mary Parkhouse** would break down the component parts of the pilot implementation process, attach realistic timeframes for each and feed this back to the group electronically before the next meeting to further inform decisions on timescales for NHS Scotland. | **MC/MP** | |
| | JW asked about a formal communications strategy. ACo said that the stakeholder event was part of this and something formal could be put to SWAG. ACo would update SWAG on plans. | **ACo** | |
| | On the articulation of the model with KSF ACa said that this was for Boards themselves to progress, taking into account their own KSF implementation plan and resources. ACa said that she did not consider that the process underpinning the achievement of the standards was a | | |

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| | parallel process within KSF, but that it was more about guiding how the evidence produced might be used for the Foundation Gateway. It needed testing and there should not be duplication of process. | | |
| **7** | **Workstreams, owners and timeframes** | | |
| | ACo highlighted that the last two bullet points at item 6 were most likely to merit additional consideration in the form of separate workstreams. She asked if the Group wanted to take these issues out of the Group and report back in a month's time with papers that would inform discussions at the next meeting.<br><br>It was agreed that **Anne Campbell** would take forward a discussion with **Ros Derham, Claire Ronald, Marie Cerinus** and **Mary Parkhouse** on the articulation of the model with KSF processes, then feed back to the Group before the next meeting.<br><br>Drawing on the information received from **Marie Cerinus** and **Mary Parkhouse**; **Julie McKinney, Lynne Hollis, Dawn Carmichael and Lily Bryson** would take forward the required cost analysis**, as soon as practical.**<br><br>**Liz Jamieson** would check on whether October 2010 was a realistic date for commencement, from the perspective of the work that NES still had to do and NES would provide feedback at the next meeting.<br><br>**Karen Adams** would provide a line to secretariat for consideration for inclusion in the Implementation Action Plan, that explicitly mentioned the need for a robust Quality Assurance mechanism around the assessment tool for HCSWs.<br><br>**All members** agreed that they would send a deputy to Group meetings if they were unable to attend in person. | **ACa RD/CR MC/MP**<br><br>**MC/MP JM/LH DC/LB**<br><br>**LJ**<br><br>**KA**<br><br>**ALL** | **By 12 October 2009**<br><br>**ASAP**<br><br>**By 12 October 2012**<br><br>**Before 12 October 2009**<br><br>**As required** |
| **8** | **Frequently Asked Questions**<br>**SIG/2009/09 (for information)** | | |
| | ACo introduced paper 09 and advised that the intention was that the FAQs would assist members by providing information for use as a type of 'core script' when responding to questions from stakeholders. | | |
| **9** | **AOCB** | | |
| | It was agreed that the meeting papers could be shared with colleagues outwith the group. | | |
| **10** | **Next meeting and future meetings** | | |
| | 12 October, 1430-1630, SAH<br>12 November, 1000-1200, SAH (if required) | | |