European Commission

Core Competences of Healthcare Assistants in Europe (CC4HCA)

An exploratory study into the desirability and feasibility of a common training framework under the Professional Qualifications Directive

Willemijn Schäfer, Marieke Kroezen, Johan Hansen, Walter Sermeus, Zoltan Aszalos & Ronald Batenburg

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Contact: Directorate-General for Health and Food safety

Unit B3

E-mail: SANTE-PUBLICATIONS@ec.europa.eu

European Commission
B-1049 Brussels

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Contents

List of abbreviations

Abbreviation	*Meaning*
CC4HCA	*Core Competences of Healthcare Assistants in Europe*
CPD	Continuous Professional Development
CTF	Common Training Framework
EC	European Commission
EQF	European Qualifications Framework
EU	European Union
HCA	Healthcare Assistant
MS	Member State

1 Executive summary on the main findings of the study

The CC4HCA study

This report presents the findings of the study '*Core Competences of Healthcare Assistants in Europe*' (CC4HCA). The aim was to map the position of healthcare assistants in all 28 EU Member States and to explore the feasibility and interest among Member States for adopting a common training framework for this professional group under Directive 2013/55/EU, amending the Professional Qualifications Directive (2005/36/EC). The CC4HCA study was carried out on behalf of the European Commission (DG SANTE) and funded by the European Union in the frame of the Third Health Programme 2014-2020.

Healthcare assistants, a growing category of health professionals in Europe

In many European countries, the role of healthcare assistants (HCAs) has developed over recent years and HCAs are becoming a significant part of healthcare teams, working closely with registered nurses and other health professionals. Because clarification of the roles and responsibilities of team members is known to be crucial in improving multidisciplinary collaboration and efficient care delivery, an overview of the knowledge, skills and competences of HCAs is needed. Such an overview can help define HCAs' roles and responsibilities and give a clearer understanding of their position in healthcare teams. Moreover, in the context of growing mobility of healthcare professionals across Europe, it is becoming ever more relevant that there should be clarification and definitions of HCAs' core competences across EU Member States. Such an overview can help ensure patient safety while at the same time facilitating professionals' mobility. One specific instrument that can support this process is the common training framework (CTF), a new legal tool set out under Directive 2013/55/EU, amending Directive 2005/36/EC.

What is a common training framework?

A common training framework (CTF) is a legal tool that introduces a new way of recognising professional qualifications across EU countries automatically. A CTF will let EU Member States expand the system of automatic recognition to professions that are not automatically recognised as part of Annex V of Directive 2005/36/EC. A CTF is based on a common set of core (or minimum) knowledge, skills and competences needed for pursuing a specific profession. A CTF has to comply with the following conditions set out in Directive 2013/55/EU (Article 49a, paragraph 2), amending Directive 2005/36/EC:

1. The CTF shall facilitate mobility between Member States;
2. The profession or the education and training leading to the profession is regulated in at least one third of the Member States;
3. The CTF combines knowledge, skills and competences required in at least one third of the Member States;
4. The CTF is based on European Qualification Framework levels;
5. The profession concerned is not covered by another CTF and does not benefit from

automatic recognition under another system;
6. Preparation of the CTF following a transparent due process;
7. The CTF permits nationals from any Member State to acquire the professional qualification under such framework without being required to be a member of- or registered with any professional organisation.

What were the objectives of the CC4HCA study?

The central aim of the CC4HCA study was:

To explore the level of consensus among all 28 EU countries concerning the desirability and potential content of a common training framework for healthcare assistants within the EU

The three objectives that follow from this central aim were:

1. To identify the competent authorities in each Member State and the representative national or European professional organisations that are interested in working on a suggestion for a CTF for HCAs;
2. To set up a network that can establish a common position on a set of knowledge, skills and competences combining the knowledge, skills and competences required in at least 12 Member States;
3. Provide input (a common position on the set of knowledge, skills and competences and a feasible roadmap) for interested representative European or national professional organisations (or competent authorities) that might want to engage in working on a suggestion for a CTF for HCAs.

What were the main components of the CC4HCA study?

The study consisted of three main tasks:

1. Mapping out the position of HCAs in all 28 EU Member States;
2. A Delphi study among the competent authorities and/or representative national professional organisations for HCA regulation and/or education in each Member State;
3. Two workshops for further exploration of a common position on the desirability and feasibility of a potential CTF for HCAs within the EU.

All 28 EU Member States participated in all tasks, with the exception of Austria and Malta for the Delphi study.

What results were obtained by mapping out healthcare assistants' current position in Europe?

Definition and position of HCAs in the EU Member States

The occupational titles of HCAs used across EU Member States show that the terminology differs considerably between countries. In some countries the HCA occupation is defined broadly, while in others its scope is more limited. Generally, HCAs work under the supervision of nurses but they are sometimes also supervised by other healthcare

professionals, most notably medical specialists. HCAs are employed in hospitals, home care and long term care and (to a lesser extent) in primary care and psychiatry as well.

Regulation of healthcare assistants

The HCA profession is regulated in 14 Member States, while HCA education and training is regulated in 22 out of the 28 EU Member States. One of the conditions for a potential CTF is that the profession, or the education and training leading to the profession, is regulated in at least one third (i.e. 10) of the EU Member States. Hence, this condition is met for HCAs.

Education of healthcare assistants

In nearly all EU Member States, the curriculum for HCA training and education is defined at the national level. Considerable variation was found in the entry requirements for training and education across the EU (from no requirement through to high school or secondary school), the minimum entry age (from no restriction to 18 years) and duration of the education (from 3 months up to 2 or 3 years, with 6 years in Latvia as an exception). Most Member States have curricula stating that about 60% of the total education time should be spent in practical situations. In half of the Member States, HCAs are obliged to follow some sort of continuous professional development (CPD) programme.

Core knowledge, skills and competences of healthcare assistants

Knowledge, skills and competence items that are part of HCAs' curriculum in most Member States are strongly related to their tasks and duties in everyday practice. This means that they are mainly focused on non-medical care provision, such as supporting patients in their activities of daily living (ADL), clerical and administrative knowledge, cleaning and washing, preparing meals and communication.

Core tasks and duties of healthcare assistants

In most EU Member States, the core tasks and duties of HCAs consist of monitoring and measuring patients' vital signs, providing non-medical care (e.g. cleaning, washing, preparing and serving meals), supporting other health professionals and applying safety, quality and hygiene techniques. HCAs often only provide 'basic care' to patients.

What are the results for the desirability and feasibility of a common training framework?

The content and qualification level of a potential CTF for healthcare assistants

The results from the Delphi study and workshops provided the foundations for drawing conclusions about the content and qualification levels that a potential CTF for HCAs within the EU should have, according to the Member States. There was consensus between the Member States about a core (or minimum) set of knowledge, skills and competences of HCAs. In two Delphi rounds, a list of 18 knowledge requirements plus 17 for skills and 4 for competences was judged to be relevant by at least one third of the Member States as part of a potential CTF for HCAs. However, it was also noted that further refinement of this set would be required.

At the same time, there was a great deal of discussion about the differences between Member States with regard to the qualification level that this combined set of knowledge, skills and competences for HCAs should have. During the workshops, both Member States and European stakeholders feared that assigning a single, universal EQF level could have severe and potentially undesirable consequences. Determining a singlee common and appropriate EQF level for a potential CTF for HCAs therefore appears to be a sensitive and complicated topic at the moment, due to the many differences between Member States.

The desirability and feasibility of a potential CTF for healthcare assistants

The following can be concluded regarding the desirability and feasibility of a CTF for HCAs as currently perceived by the 28 European Member States. First of all, there appears to be consensus among EU Member States on the need to define the role of HCAs across Europe. Also, most study participants expressed a willingness to be engaged in a further exploration of a CTF for HCAs. In terms of feasibility of a CTF, however, Member States and European stakeholder organisations see barriers regarding a number of conditions that are formally required for proposing a CTF. Many of the barriers relate to the existing differences between and within countries and sectors, especially related to the levels of education, qualification and autonomy of HCAs. Other barriers concern the perceived uncertainty about a CTF as a new EU legal instrument that there is no practical experience with as yet. One important issue is the legal consequences that a CTF would have for national training, occupation and financing systems. Ongoing transformation of the national health workforce and education system was perceived as a barrier in a number of Member States too, although others perceived this as an opportunity. Finally, some Member States and European stakeholders fear that a CTF may increase mobility, with negative effects for the countries of origin.

Conclusion and discussion

Further exploration of a CTF for healthcare assistants and potential follow-on steps

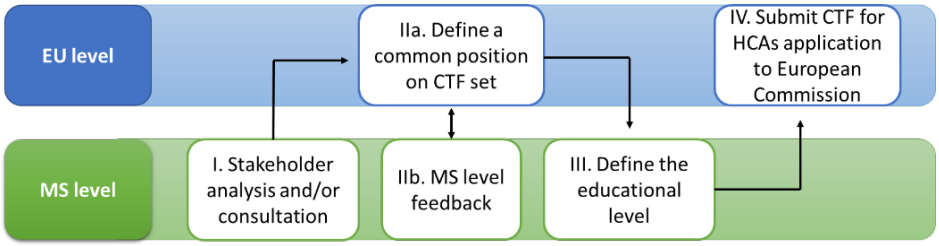
Based on the results summarised above, we conclude that there is a common position of willingness to explore the desirability of a CTF for HCAs further – even though the perceived feasibility is currently uncertain. We have recapped the seven conditions below as set out in Directive 2013/55/EU, amending Directive 2005/36/EC, summarising the extent to which its 'building blocks' are already in place so that the CTF development process for HCAs can be started, should interested parties wish to undertake such a further exploration.

A CTF shall comply with the following conditions (Dir. 2013/55/EU, art. 49a) Error! Bookmark not efined.**:**	**Study results and description of the building blocks for further CTF compliance/exploration in place:**
a) The CTF enables more professionals to move between Member States	This cannot be predicted at this time.
b) The profession or the education and training leading to the professions is regulated in at least	Currently, the HCA profession is regulated in 14 EU MSs and HCA education is regulated in 22 EU MSs.

one third of Member States	
c) The CTF combines knowledge, skills and competences required in at least one third of the Member States	This study showed that there is consensus on a potential set of knowledge, skills and competences of HCAs (> one third MSs agreeing), but the levels of autonomy, supervision and other aspects need further discussion.
d) The CTF is based on European Qualification Framework levels	This study showed that it is currently not feasible to reach agreement on a single EQF level for HCA knowledge, skills and competences among Member States.
e) The profession concerned is not covered by another CTF and does not benefit from automatic recognition under another system	HCAs are not covered by another CTF and do not benefit from automatic recognition under another system.
f) Preparation of the CTF following a "transparent due process", including the relevant stakeholders from Member States where the profession is not regulated	This study provides an initial building block for this through a mapping of representatives from all 28 EU MSs and a number of European professional organisations, and consulted them through the Delphi study and workshops.
g) The CTF permits nationals from any Member State to acquire the professional qualification under such a framework without being required to be a member of or registered with any professional organisation.	This would be an effect of an actual CTF and cannot be determined at this time. Some participants are concerned about the representation of HCAs by professional organisations.

'Roadmap to guide a potential suggestion for a CTF for healthcare assistants

As a final step of this CC4HCA study, we have sketched out a roadmap that may guide interested representative European or national professional organisations or competent authorities that may want to be engaged in developing a CTF for HCAs. Based on the conditions for a CTF as set out in Directive 2013/55/EU, amending Directive 2005/36/EC, and the outcomes of the CC4HCA study, the major tasks and their interrelationships can be depicted as follows:



When applying this roadmap, one important recommendation is to make sure that the position of HCAs in Member States and the national discussion about their position in the healthcare system needs to be aligned with the CTF development process at the EU level. This requires the situation to be mapped out fully with involvement of stakeholders within every Member State, with all parties being kept informed accordingly throughout the whole CTF development process.

Part I:
Background

2 Background to the CC4HCA study

This report presents the results of the study '*Core Competences of Healthcare Assistants in Europe*' (CC4HCA) conducted between April 2015 and October 2016. The CC4HCA study was carried out on behalf of the European Commission (DG SANTE) and funded by the European Union in the frame of the Third Health Programme 2014-2020. The study is a follow-up of the pilot study '*Creating a Pilot Network of Nurse Educators and Regulators*' that was conducted between 2010 and 2013 (Braeseke *et al.*, 2013). The main aim of the CC4HCA study was to explore the interest among all Member States of the European Union in developing a common position on the knowledge, skills and competences of healthcare assistants (HCAs) in Europe. In this first chapter we explain the rationale, objectives and research questions that guided the study.

2.1 Rationale for the CC4HCA study

In many European Union (EU) Member States, healthcare assistants (HCAs) are becoming increasingly important. A number of factors, such as the ageing of both citizens and healthcare personnel, combined with sometimes inadequate workforce planning and recruitment and retention policies, have led to growing shortages in nursing (Ashby et al., 2003; Gerrish & Griffith, 2004; Keeney, Hasson, McKenna, & Gillen, 2005; McKenna, Hasson, & Keeney, 2004; Spilsbury & Meyer, 2004; Buchan & Aiken, 2008; Sermeus et al., 2011). Subsequently, this can lead to an increasing demand for HCAs, as they are often deployed to take over tasks from nurses and support medical staff in providing care (Spilsbury & Meyer, 2004). At the organisational level, reasons for managers to employ HCAs are related to cost-efficiency, as HCAs usually have lower qualifications and lower salaries (Thornley, 2000). It can also be expected that the role of HCAs in EU Member States will increase with the growing trend towards self-management and empowerment of patients and their informal carers. HCAs play a key role in answering the increasing need for better communication between patients and healthcare professionals, and play a part in many initiatives to improve inter-professional cooperation to achieve people-centred care.

The rationale behind the study can be summarised by the following line of reasoning:

- In many European countries, the role of HCAs has developed over recent years as HCAs comprise a significant part of healthcare teams (MacAlister, 1998; Vail *et al,*. 2011), working closely with registered nurses and other health professionals;
- At the same time, it has been found that clarifying the roles and responsibilities of team members is very important for improving multidisciplinary collaboration in healthcare (Williams & Laungani, 1999);
- This implies that an overview of the knowledge, skills and competences of HCAs is needed, to define their roles and responsibilities and to achieve a clearer overview of their position in healthcare teams;

- Consequently, this can improve the delivery of high-quality patient care based on the optimum division of tasks and responsibilities within the team;
- Healthcare is a key sector for employment, driven by increasing healthcare demands. HCAs, like many other health professionals, are expected to become increasingly mobile in order to meet population needs in the EU;
- The CTF is one specific legal instrument that can support the goals described above;
- A CTF for HCAs across Europe may also facilitate cross-border mobility of HCAs while safeguarding patient safety.

Given that this rationale applies to all countries (i.e. Member States and their healthcare systems), it is clear that specific added value can be achieved by comparing the roles and responsibilities of HCAs in different countries. This will not only increase awareness among policy-makers about the existing diversity in the position of HCAs, but will also encourage exploration of cross-national collaboration. This can be done for example by exchanging best practices, formulating common challenges for the HCA profession and exploring what could comprise a common basis for training and professionalisation. While requiring a longer horizon of preparation and action, a long-term goal of defining 'core competences' for HCAs across countries may also be able to facilitate cross-border mobility.

One specific legal instrument that could potentially support the goals described above is the common training framework (CTF). The background and design of this instrument is described in the next section. However, it is as yet unknown and unexplored (1) whether a set of core competences for HCAs can be defined supra-nationally as the basis for a CTF and (2) whether a CTF is a desirable and feasible instrument for supporting collaboration, exchange and cross-border mobility of HCAs across EU Member States. The CC4HCA study was therefore initiated in order to address the following main goal:

To explore the level of consensus among all 28 EU Member States concerning the desirability and potential content of a common training framework (CTF) for healthcare assistants within the EU.

2.2 Objectives of the CC4HCA study

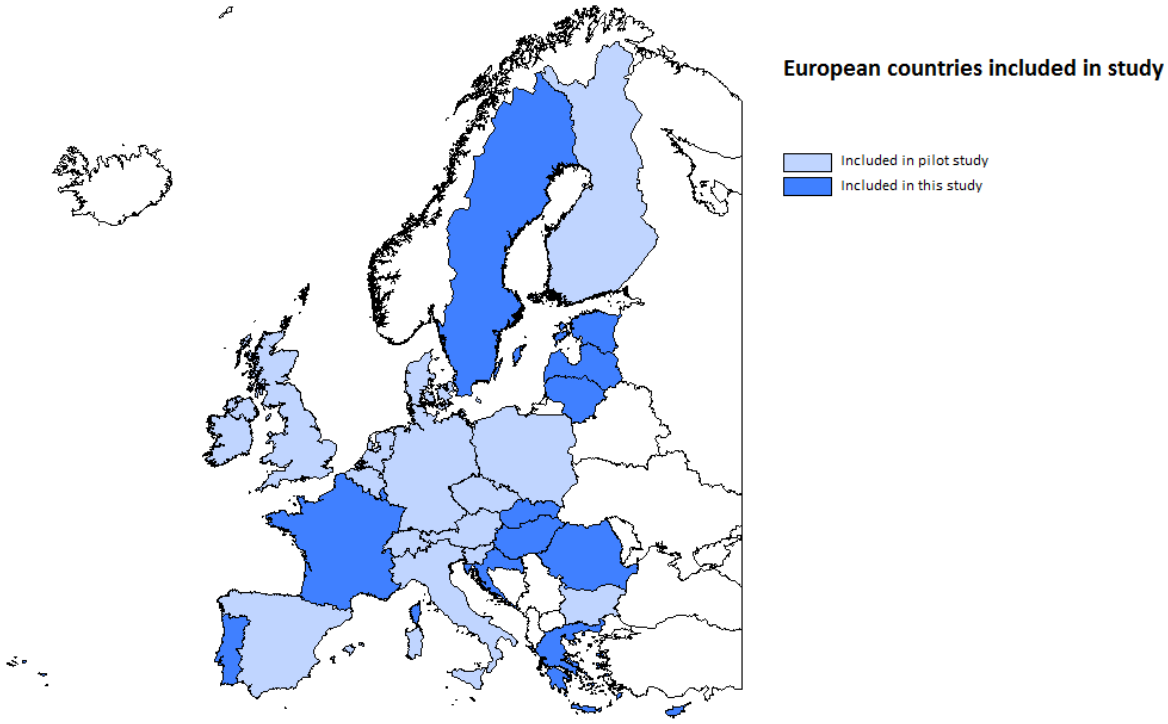
The main aim of the CC4HCA study was to explore the level of consensus among all 28 EU countries concerning the desirability and potential content of a common training framework (CTF) for healthcare assistants within the EU. We would like to emphasise that the CC4HCA study was *exploratory* in nature. This study should *not* be considered as a first step in a formal CTF process. The CC4HCA study presents the explored level of consensus among the stakeholders consulted and the building blocks from which an actual CTF process could potentially be started, should there be any parties interested in doing so.

To achieve the main aim, the overall scope and objectives of the study were operationalised as:

1. To identify the competent authorities in each Member State and the representative national or European professional organisations that are interested in working on a suggestion for a CTF for HCAs;
2. To set up a network that can establish a common position on a set of knowledge, skills and competences combining the knowledge, skills and competences required in at least 10 Member States.
3. Provide input (a common position on the set of knowledge, skills and competences and a feasible roadmap) for interested representative European or national professional organisations (or competent authorities) that might want to engage in working on a suggestion for a CTF for HCAs.

To achieve these aims, the pilot study by Contec and partners (2013) provided an important starting point as it has already mapped out the position of HCAs in 14 EU Member States. This CC4HCA study complemented that mapping exercise for the other 14 EU Member States (Croatia, Cyprus, Estonia, France, Greece, Hungary, Latvia, Lithuania, Luxembourg, Malta, Portugal, Romania, Slovakia and Sweden), based on the current situation of HCAs in these Member States (Braeseke *et al.*, 2013). Figure 2.1 shows the countries included in the CC4HCA study (dark blue) and the countries included in the pilot study conducted by Contec (light blue). Data from the pilot study was updated where possible, as data collection for that study took place in 2011. This drew a full and up-to-date picture of the position of HCAs in all 28 EU Member States.

Figure 2.1: Countries included in the Contec pilot study in 2012/2013 and countries included in the CC4HCA mapping study in 2015/2016



2.3 What is a Common Training Framework?

A common training framework (CTF) is a legal construct that introduces a new way of automatic professional qualification recognition across EU countries. With a CTF, EU Member States can expand the system of automatic recognition to new professions. In Directive 2013/55/EU, amending Directive 2005/36/EC[1], a CTF is described as: "*a common set of minimum knowledge, skills and competences necessary for the pursuit of a specific profession*" (see Box 2.1 for the exact definitions of what is understood under 'knowledge, skills and competences'). In other words, a CTF aims to define a benchmark in terms of what a person should know, understand and be able to do in order to practice a given profession. A CTF for healthcare assistants (HCAs) would therefore form a benchmark for the HCA profession that EU Member States would have to adhere to when developing their own HCA training programmes.

[1] See for a full explanation of the CTF and all conditions: Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013, amending Directive 2005/36/EC. To be found here.

Box 2.1: Definition of 'knowledge, skills and competences'

- **'Knowledge'** means the outcome of the assimilation of information through learning. Knowledge is the body of facts, principles, theories and practices that is related to a field of work or study. In the context of the European Qualifications Framework, knowledge is categorised as theoretical and/or factual;
- **'Skills'** means the ability to apply knowledge and use know-how to complete tasks and solve problems. In the context of the European Qualifications Framework, skills are categorised as cognitive (involving the use of logical intuitive and creative thinking) or practical (involving manual dexterity and the use of methods, materials, tools and instruments);
- **'Competence'** means the proven ability to use knowledge, skills and personal social and/or methodological abilities in work or study situations and in professional and personal development. In the context of the European Qualifications Framework, competence is described in terms of responsibility and autonomy.

Source: https://ec.europa.eu/esco/portal/escopedia/

Implications of a common training framework for EU Member States

Suggestions for a CTF may be submitted to the European Commission by representative professional organisations at the EU level, as well as national professional organisations or competent authorities from at least one third of the Member States. If all the conditions described in Box 2.2 below are met, the Commission will be empowered to adopt a delegated act to establish a CTF for a given profession. This means that the CTF would become legally binding for all EU Member States. However, Member States can be exempted from the obligation of introducing the CTF on their territory if they fulfil one of the following exemption conditions:

- There are no education or training institutions available in its territory to offer such training for the profession concerned;
- The introduction of the CTF would adversely affect the organisation of its system of education and professional training;
- There are substantial differences between the CTF and the training required in its territory, which entail serious risks.

It should also be noted that a CTF is voluntary for professionals and does not replace a national training programme. In other words, a CTF is neither a European curriculum or diploma nor a qualification. It is a common training framework.

Box 2.2: Conditions which every common training framework must meet

A common training framework must meet the following conditions, as set out in the Directive 2013/55/EU (Article 49a, paragraph 2), amending Directive 2005/36/EC:

(a) The CTF shall facilitate **mobility** across Member States
(b) The profession or the education and training leading to the professions is **regulated** in at least 1/3 of Member States
(c) The CTF combines **knowledge, skills and competences** required in at least 1/3 of the Member States
(d) The CTF is based on **European Qualification Framework** levels[2]
(e) The profession concerned is not covered by another CTF and **does not benefit from automatic recognition** under another system
(f) Preparation of the CTF following a "**transparent due process**", including the relevant stakeholders from Member States where the profession is not regulated
(g) The CTF permits **nationals from any Member State** to acquire the professional qualification under such framework without being required to be a member of- or registered with any professional organisation.

Development process of a common training framework

The adoption process of a CTF consists of several stages. Firstly, suggestions for a potential CTF are made by representative professional organisations at the EU level and/or national professional organisations or competent authorities from at least one third of the EU Member States. The European Commission can also make suggestions. Secondly, a proposed CTF is checked by the European Commission to see whether it meets all conditions as set out in Directive 2013/55/EU (Article 49a, paragraph 2), amending Directive 2005/36/EC. After the preparation of a proposed CTF - through a transparent due process - discussions will be held about the CTF by the Member States. The CTF will be transformed into a delegated act describing the CTF. A delegated act enters into force only if no objections are expressed either by the European Parliament (EP) or the Council within a period of 2 months after notification of that act to the EP and Council. The final step is the process of implementing the act, including listing the national qualifications and national professional titles that comply with the common training framework adopted.

[2] A qualifications framework is an instrument for classifying qualifications according to a set of criteria for specified levels of learning achieved, aiming to integrate and coordinate qualification subsystems and improve the transparency, access, progression and quality of qualifications in relation to the labour market and civil society.

2.4 Research questions

To achieve the central aim of this study, it was broken down in two main parts that structure the results section of this report and its chapters.

The first part of this study was carried out to describe the role, knowledge, skills and competences of HCAs in the EU Member States. The following research questions were answered:

- How can the position of HCAs be described in each of the 14 Member States that were not included in the Contec study? *Inter alia* this was in terms of the following general aspects:
    - occupational title
    - the number of HCAs
    - other elements such as their age and gender distribution, employment/unemployment rate, job retention, annual wages and international and vertical mobility
- How are these distributed within a Member State, *inter alia* in terms of the areas of employment?
- What are the tasks and duties of HCAs within the Member States?
- How can the position of HCAs be described in each of the 28 Member States, in terms of the following aspects:
    - their minimum age at the beginning of the education
    - the duration of the education
    - source of funding the education
    - curriculum details, type of training
- Are the education and/or education objectives regulated in the Member States? And if so, is the curriculum and/or examination regulated?
- Is the profession regulated and registered in the Member States? And if so, how is it regulated?
- Is this registration voluntary or obligatory, and if the first applies, what is the estimated registration coverage of healthcare assistants?
- How can the details and conditions of this regulation be described?
- What is the set of the knowledge, skills and competences of HCAs within the Member States?

The second part of the CC4HCA study aimed to explore the desirability and feasibility of a common training framework for HCAs, and provide input for a potential common position among the 28 EU Member States on the minimum set of knowledge, skills and competences. As preparation for this part of the study, the following research needed to be answered first:

- For all 28 Member States, which organisations (or authorities) that are represented by the recruited country experts for the first part of the study are authorised to

define the national set of knowledge, skills and competences or training tests for HCAs in their country?

- What *is* the content of these national sets and how are they documented, implemented, controlled, communicated and versioned?
- For all 28 Member States, which organisations (or authorities) can ensure that their national administrations are engaged in and interested in working on a suggestion for a CTF for HCA at the European level?

Subsequently the following research questions were addressed:

- What are the visions of the representatives of the organisations identified, and representatives of other EU Member States?
- What consensus emerges from group discussions on a potential CTF and its components, in terms of applicability, usefulness, desirability and feasibility of implementation?
- What is a common position on the minimum set of knowledge, skills, and competences of HCAs?
- What further steps should be taken to reach consensus on a minimum set of knowledge, skills, and competences that can support a CTF proposal at the EU level?
- To what extent did the one-day workshop lead to a common position on the minimum set of knowledge, skills and competences of HCAs?
- What are the views on this position of the stakeholders that were not present, and can consensus among them be achieved?
- If no common position can be determined that is shared by a minimum of one third of the Member States, what steps need to be taken in additional Member States to reach such a position?
- What are the next steps for a suggestion for a CTF, including a feasible timeline, a relevant legal framework and the plan to include relevant organisations or authorities?

2.5 Content of the report

This report describes the results of the CC4HCA study conducted between April 2015 and October 2016 and it is divided into three parts.

Part I of the report describes the background of the study (this chapter), as well as the methods and processes used to collect the data for answering the research questions (Chapter 3).

In Part II, the current position of HCAs in the 28 EU Member States is described. Chapters 5 to 8 present the results of the Europe-wide mapping exercise, describing the education and training systems, and the main tasks and duties of HCAs (including their knowledge, skills and competences) across the EU. Separate chapters are devoted to describing the

regulation and registration of the profession and education of HCAs in the EU Member States.

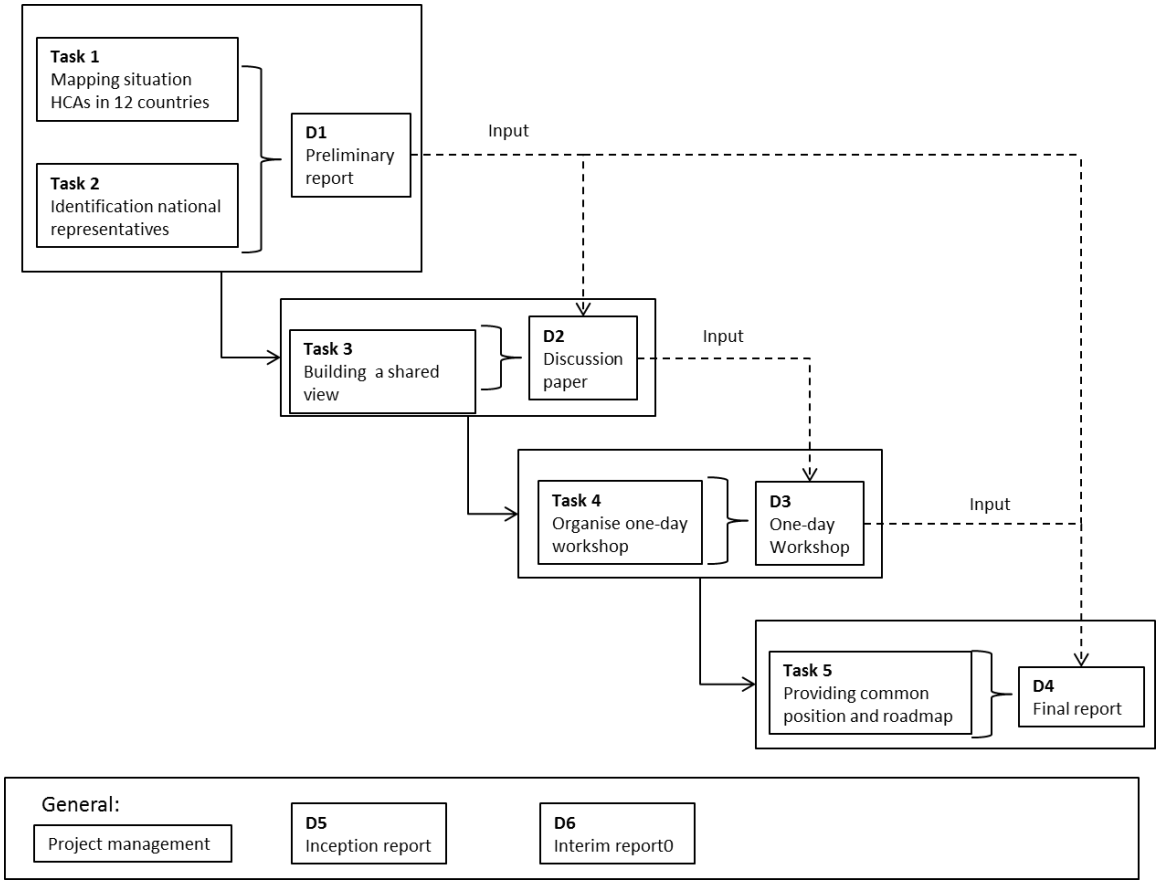
Part III of the report provides the exploration of a potential CTF for HCAs. Firstly, the content of a potential CTF for HCAs is described in terms of a set of core competences for HCAs. Secondly, the desirability and feasibility of a CTF as a legal instrument is elaborated, describing the drivers and barriers mentioned by the Member States and taking the position of European stakeholders into account. Part III also includes a conclusion and discussion of the results and the process of this study.

3 Methods

To explore the feasibility and desirability of a common training framework (CTF) for healthcare assistants in the European Union, we performed the following six main tasks:

1. Mapping out the current situation of HCAs in each EU Member State;
2. Identification of the competent authorities and/or representative national professional organisations for HCA regulation and/or education in each EU Member State;
3. An expert consultation round among European organisations on the *completeness and comprehensibility* of the planned Delphi study;
4. Building a shared view among interested national and European professional organisations (and/or competent authorities) on the minimum set of knowledge, skills and competences required for HCAs, as needed for preparing a suggestion for a CTF, through the Delphi study (exploration of the level of consensus) among competent authorities and national representatives;
5. Organisation of CC4HCA study workshops to explore a common position on the minimum set of knowledge, skills and competences further;
6. Preparation of the final report including recommendations for stakeholders willing to prepare a suggestion for a CTF for HCAs by providing:
   a) A common position among interested representative national or European professional organisations (or competent authorities) on the minimum set of knowledge, skills and competences of an HCA required for preparing a suggestion for a CTF;
   b) A roadmap for preparing a suggestion for a CTF, including a feasible timeline and the relevant legal framework and a plan to include relevant professional organisations or competent authorities from Member States where the profession is not regulated.

Figure 3.1 Flowchart showing the main tasks and their interdependencies



3.1 Mapp of the current situation of healthcare assistants in each EU Member State and identification of competent authorities

To map out the current situation of HCAs and to identify competent authorities for HCAs in each EU Member State, the following tasks were performed:

- Literature search
- Statistics search
- Questionnaire research among country informants

Each of these tasks will be described in more detail below.

3.1.1 Literature search

The first step was to search all available literature in the European languages that are mastered by the consortium partners (English, French, German, Dutch and Hungarian). In addition, Italian was included in order to include a southern European language as well. Box 3.1 includes an overview of the search terms used in these 6 languages. Various search engines were used, including PubMed, Google Scholar and Google. The aim was to collect and assess as much relevant material as possible about the role of HCAs in all 28 Member States, so that this could be used as input for the country consultation rounds of Task 1 and Task 2. The following sources were excluded: documents concerning only (national) competence profile descriptions; documents that were not based on qualitative,

quantitative or literature research; and documents that only covered a very specific topic such as the role of elderly patients in the communication process of care.

As well as literature database research, manual searching and snowballing were used among past studies as reference points. Country informants from all 28 Member States were asked to identify relevant publications on healthcare assistants in their country and/or provide an English summary. This literature was used to support the answers to the survey on the national situations.

Box 3.1: Search terms used for identifying literature in six European languages

Dutch: helpende zorg en welzijn / zorghulp / verzorgende IG / taken
English: healthcare assistants / HCAs / skills, knowledge and competences (of HCAs)
French: aide soignante / tâches / compétences
German: Pflegeassistent / Pflegehelfer, Heimhelfer / Aufgaben
Hungarian: ápolási asszisztens / kompetenciák
Italian: operatore socio-sanitario / operatori socio-sanitari / OSS / competenze / ruolo / conoscenze

3.1.2 Statistics search

In addition to the literature, we also consulted available international and national statistics about HCAs. First of all, the informants from the 14 'new' Member States (i.e. those not covered in the pilot study) were asked to collect national figures on the following topics: number and FTE of HCAs, unemployment rates, graduates per year, distributions by e.g. age, gender and country of birth, number of HCAs in the various areas of employment and mobility.

In addition, the Eurostat database and EU Single Market regulated professions database were studied for figures on healthcare assistants in all 28 EU Member States.

It must be noted that comparative country statistics about the numbers of trained, employed or active HCAs are hard to extract due to different definitions and classifications, and due to incomplete or missing reliable data sources and registrations. This was clearly inventoried in the pilot study on HCAs (Braeseke *et al.*, 2013). The figures found in the databases in this study have therefore been compared to the figures reported by the 14 country informants from the 'new' countries. The fact that we were able to combine statistics from several sources id not only provide an initial starting point for the mapping exercise, but also provided an external reference point for determining the adequacy and accuracy of the information that was provided by country informants.

3.1.3 Development of the questionnaires

The final step of data collection was through questionnaire research among country representatives. The aim of the survey was twofold:

1. To gain insights in the role of healthcare assistants in 14 EU Member States not covered by the pilot study;

2. To identify the representative organisations/ competent authorities of HCAs in all 28 EU Member States.

Various sources were used for the development of the questionnaire. In order to achieve comparability with the data from the pilot study already collected, the basis for the item list was the questionnaire used in the pilot study. Replicating this questionnaire for the 14 Member States provided a full picture of the EU with regard to these elements of the HCA position. Moreover, the questionnaire was complemented with additional elements of interest. The aim was to collect more information about (1) the status of HCA registration per country, (2) whether this is voluntary rather than obligatory, and (3) the degree to which such a registration covers the active HCA workforce in a country. This is of interest as it can be expected that voluntary memberships or registration figures will underestimate the actual number of (active) HCAs. Another element added to the item list and data collection was the distribution of tasks and skills of HCAs within a country. This addressed the question of whether all HCAs are trained for the same tasks and skills, or whether these differ between subsectors and types of workplaces. If the latter is the case, this is an important aspect to take into account for the minimum set of knowledge, skills and competences. As these items were new in the CC4HCA study, this implies that it is not be possible to compare all EU countries on these topics. Because of this, and due to reasons of unavailability of information, some of the tables in the next chapter contain empty cells for some countries.

When making the new questionnaire, the findings from the literature search were used to formulate the new items concerning the position of HCAs. Various draft versions of the questionnaire were discussed among the study partners and the questions were reformulated or items added where this was deemed necessary. To check whether the questions were comprehensible, the questionnaire was piloted among external experts not involved in the study itself, in the Netherlands and Hungary. Finally, before the questionnaire was sent out to country experts of the 14 Member States, a draft version was sent to the project officers at DG SANTE/CHAFEA, to review its content and applicability.

The final result was a questionnaire consisting of two parts:

1. An extensive questionnaire on the role of HCAs in each country, including questions on definitions and job descriptions of HCAs, education, regulation and registration and employment and the labour market (see Appendix A). This questionnaire was only sent to the 14 Member States that are included in this study.
2. A short questionnaire to identify the representative organisations/competent authorities of HCAs in all 28 EU Member States (see Appendix B). This questionnaire was sent to e.g. national contacts, including chief nursing officers, nursing associations, and university departments in the field of nursing. Organisations or countries were asked to indicate whether they would be willing to sign either an Expression of Interest or a Letter of Commitment (see Box 3.2).

Box 3.2: Information provided to respondents concerning expressions of interest and letters of commitment

An Expression of Interest implies that you will participate in the next steps of our study on behalf of your organisation and country. In practice, you will be invited to take part in an online consultation round later in autumn of this year, and a workshop in Brussels in the spring of 2016.

A Letter of Commitment also implies that you will participate in the next steps of our study on behalf of your organisation and country. In practice, you will be invited to take part in an online consultation round later in autumn of this year, and a workshop in Brussels in the spring of 2016. Additionally, by signing the Letter of Commitment, you express your country's commitment to support the development of a common training framework for healthcare assistants at the level of a minimum set of knowledge, skills and competences. This commitment and support is acknowledged provisionally and at a general level. The content of a potential common training framework will be explored and discussed further within this project involving the views of all EU Member States.

3.1.4 Collecting responses

Subcontractors from all 14 Member States served as country informants for this task. Appendix C gives an overview of these country informants. Hungary was covered by MESZK as member of the study consortium. Each country informant received instruction on how to complete the item list. To validate the information, country informants were also invited to share their preliminary information with other experts in their professional networks. This type of 'national peer review' has been shown to be very helpful in filling blind spots and ensuring that information is cross-referenced.

While the countries already covered in the pilot study were not formally part of this study, we preferred to approach the country informants who had been responsible for the data collection in that pilot study. They were asked by e-mail if they would be willing to update the data on their country, if major changes had taken place since 2011. Updates were received from Austria, Ireland, Italy, the Netherlands and Slovenia.

3.1.5 Mapping exercise

As key element of this report, the information provided by all country informants is described in Part 2 of this report in order to answer the research questions concerning the first two aims of the study. Where possible, data is also presented for the 14 countries that were the subject of investigation in the pilot study. This provides an overview of the situation in all 28 EU Member States. For some topics, only data in the 14 'new' countries was collected. Results of the countries are presented in tables, providing an overview of the countries. For a number of key topics, the information is aggregated and combined into an overall table, in order to allow information to be compared clearly. Finally, an overview is

provided of the representative organisations/competent authorities identified in all countries.

The results from the mapping exercise and the identification of competent authorities in all EU Member States fed into the next stage of the CC4HCA study, namely the Delphi study. In order to conduct a high quality Delphi study, this process started with an expert consultation among European organisations.

3.2 Expert consultation round among European organisations on Delphi study

As a potential CTF for HCAs would become legally binding at the Member State level, it was decided in consultation with the European Commission that participants in the CC4HCA Delphi study should either be representatives of a 'competent authority' for HCAs at Member State level and/or representatives of Ministries of Health and/or representatives of national professional organisations. However, considering the important role that European organisations play in the current landscape surrounding HCAs and the knowledge and expertise they have in this area, their insights were deemed highly important to the CC4HCA study as well. In September 2015, representatives of European organisations were therefore asked to participate in an expert consultation on the development of the Delphi study (see also Section 3.3 below).

The aim of the expert consultation round was to ensure the *completeness* and *comprehensibility* of the Delphi survey, making sure it contained all relevant and important items surrounding a potential CTF for HCAs. Nine European experts in this area were asked to review and give advice about the design and contents of the Delphi questionnaire. More specifically, we asked them to comment on:

- The completeness of the Delphi, identifying any relevant missing items or superfluous items;
- The appropriateness of the question formats and response options;
- The comprehensibility of the Delphi (also where the level of English was concerned)

We received responses from six of the experts within the set deadline (see Box 3.3). Their comments and suggestions were processed in the final version of the Delphi study.

Box 3.3: Participants in the expert consultation round for the CC4HCA Delphi survey

- EPSU - European Federation of Public Service Unions
- ESNO - European Specialist Nurses Organisations
- FEPI - European Council of Nursing Regulators
- FINE - European Federation of Nurse Educators
- HOSPEEM - European Hospital & Healthcare Employers' Association
- ICN - International Council of Nurses

3.3 Delphi study among national representatives

The aim of the Delphi study was to explore (1) to what extent EU Member States are willing to support a CTF proposal for HCAs, and (2) to what extent consensus can be reached among EU Member States on a minimum set of knowledge, skills and competences that a potential CTF for HCAs should include. The Delphi study was conducted from November 2015 to February 2016 and involved three Delphi rounds.

3.3.1 Delphi questionnaire development

In total, three Delphi rounds were conducted. During the first two rounds, similar questionnaires were used. During the third round, a different set of questions was developed to gain a deeper insight in participants' viewpoints.

Round 1 Delphi questionnaire

As a first step, a questionnaire was developed based on the results of the mapping exercise. For each of the 28 EU Member States the relevant items from the mapping exercise were listed under either the knowledge, skills or competences category.

Subsequently, we formulated additional categories for items that were identified in the mapping exercise, but which did not fall within the three core categories. These could be relevant and be part of a CTF as well. This resulted in in matrices for each of the countries as displayed below:

Table 3.1: Schematic display of the resulting matrix for one country

CATEGORIES				
Knowledge	**Skills**	**Competences**	**Addit. cat.**	**Addit. cat.**
EQF definition: the outcome of the assimilation of information through learning. Knowledge is the body of facts, principles, theories and practices that is related to a field of work or study. In the context of	*EQF definition: the ability to apply knowledge and use know-how to complete tasks and solve problems. In the context of the EQF, skills are described as cognitive (involving the use of logical, intuitive and creative thinking) or practical (involving*	*EQF definition: the proven ability to use knowledge, skills and personal, social and/or methodological abilities, in work or study situations and in professional and personal development. In the context of the EQF, competence is described in*	….	….

CATEGORIES				
Knowledge	**Skills**	**Competences**	**Addit. cat.**	**Addit. cat.**
the EQF, knowledge is described as theoretical and/or factual	*manual dexterity and the use of methods, materials, tools and instruments)*	*terms of responsibility and autonomy*		
Q item 1	Q item 4	Q item 6		
Q item 2	Q item 5	Q item 7		
Q item 3		Q item 8		

The items were translated into learning outcomes, which have been defined as '*a statement of what a learner is expected to know, understand, or be able to do at the end of a learning process'*. Based on these steps, a first-round questionnaire was developed focusing on the desired content of a potential CTF according to the national stakeholders. The items concerned the skills, knowledge and competence items, additional criteria that should be part of a CTF (e.g. minimum level of education) and questions on the desired European Qualification Framework (EQF) levels. The first round of the Delphi study started in November 2015. The participants had two weeks to complete the questionnaire.

Round 2 Delphi questionnaire

The second round of the Delphi study started in December 2015, again with an official runtime of two weeks. In this round, the participants were given a summary report from the previous round in which they could compare their own response to the responses of the other countries (anonymised). They were then asked for each item of the questionnaire of round 1 if they wanted to change their answers based on the answers of other countries. The second round questionnaire was largely similar to the one used in the first round. Six additional knowledge and skills items were added based on suggestions from Delphi participants in the first round.

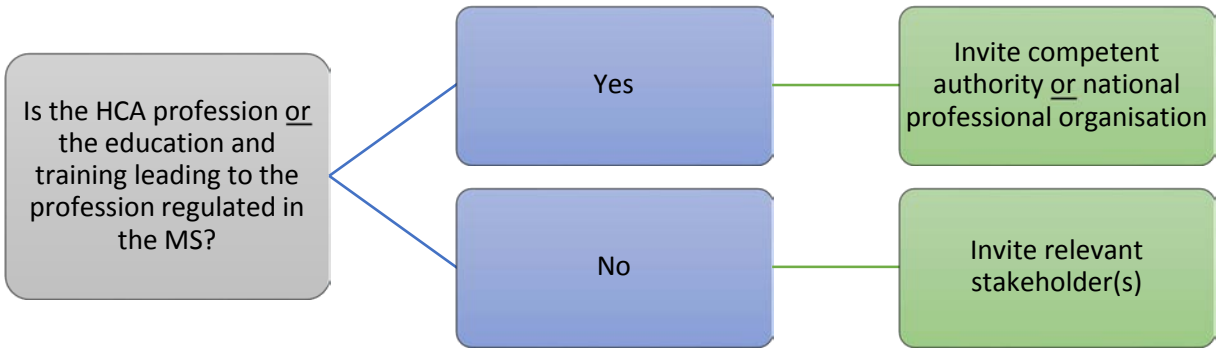
Round 3 Delphi questionnaire

Compared to the first round, only a few changes were made in respondents' answers in the second round. This indicated that the second round did not lead to further consensus building among the participants. It was therefore decided to issue a questionnaire with different questions in the third round. This questionnaire was based on the results of the first two rounds and asked for clarification on a number of findings. The third and final round of the Delphi survey ran from January to February 2016.

3.3.2 Selection procedure for participants Delphi study

As a potential CTF for HCAs would become legally binding at the Member State level, it was decided (in consultation with the European Commission and based on Directive

2013/55/EU) that participants in the CC4HCA Delphi study should either be representatives of a 'competent authority' for HCAs at Member State-level and/or representatives of Ministries of Health and/or representatives of national professional organisations. The scheme below was used to select participants in each EU Member State:



An extensive description of the selection procedure can be found in Appendices D and E.

3.3.3 Participants in the Delphi study

High participation rates were obtained for all Delphi rounds, for instance through the use of phone and regular e-mail reminders for those who had not yet completed the Delphi study. Only two Member States that were invited did not participate in any of the Delphi rounds: Austria and Malta. All other MSs have participated in at least one of the three rounds.

Table 3.2: Participation in the three Delphi rounds

	No. of competent authorities invited	**No. of Member States invited**[1]	**No. of competent authorities that completed the survey**	**Response rate**	**No. of Member States represented**
Round 1	27	22	27	100%	22
Round 2	33	26	29	87,9%	25
Round 3	33	26	31	93,3%%	25

[1] *As some countries have multiple competent authorities for healthcare assistants (HCAs), the number of competent authorities invited is greater than the number of Member States represented.*

The results of the Delphi study are described in Part III of this report, 'Exploration of a common training framework for HCAs'.

3.4 CC4HCA study workshops

3.4.1 Goals of the CC4HCA workshops

At the start of the CC4HCA study, one CC4HCA workshop was envisioned with the aim of discussing the desirability of a potential CTF for HCAs, and its core set of knowledge, skills

and competences with all EU Member States. These discussions would start from a *national point of view*, taking into account the current definition, position and situation of HCAs in the different countries.

The CC4HCA workshop was organised on 6-7 April 2016 in Brussels (Belgium). For this workshop, competent authorities from all EU Member States and a number of European experts and stakeholder organisations were invited to participate in an open discussion and almost all agreed to come. However, due to the tragic terrorist attacks in Brussels in March 2016 and the subsequent limited operation of Brussels Airport, many flights were cancelled and a significant number those invited were unable to attend. In consultation with the EC, it was decided to go ahead with the workshop and organise an additional online workshop at a later point in time for those participants who could not come. After all, it is a fundamental aim of the CC4HCA study to get a full and complete overview of the position of competent authorities of *all* EU Member States, and of all relevant European stakeholders. This online workshop took place on the 10 June 2016. While both workshops had largely the same aim, structure and discussion questions, for the sake of clarity we will discuss them separately in this methodology section.

3.4.2 Starting point of the Brussels workshop

To '*set the scene*' for the Brussels workshop, the consortium prepared a list of starting points for the discussion that were also shared with the workshop invitees and complemented by the Commission's presentation. The starting points read:

- The desirability and feasibility of a CTF for HCAs at the European level is *explored*. Hence, during this workshop, no actual CTF will be proposed nor is the actual decision to propose a CTF for HCAs decided upon or proposed;
- A CTF for HCAs at the European level contains *several elements* (i.e. requirements) that participants are invited to discuss;
- A CTF is part of Directive 2013/55/EU (amending Directive 2005/36/EC), focusing on automatic recognition of the basis of common training principles. This is one of the first studies concerning this instrument;
- A CTF for HCAs at the European level is legally binding for all EU Member States, but MSs can opt out if this is adequately substantiated; which *in any case* calls for a thorough discussion about the advantages and disadvantages of a CTF;
- A CTF shall not replace national training programmes unless a Member State decides otherwise under national law;
- For those not complying with the CTFs, the general system of recognition of professional qualifications will continue to apply;
- Labour regulations of the host Member State prevail;
- 'HCAs' is used as an *umbrella term* throughout the CC4HCA study as well as in the workshop; it is recognised (and described in the project reports) that there are a large variety of professional titles, education and training in the various countries;

- The aim of the workshop is to discuss a potential CTF for HCAs and its various/potential core competences *from the point of view of national situations*, in particular the definition, position and situation of HCAs in the various countries;
- All participants are invited to discuss the desirability and feasibility of a CTF for HCAs and its requirements, while recognising the standpoints *of other EU Member States*, as well as the *stakeholders at the European level*.

3.4.3 Programme and documentation of the Brussels workshop

Prior to the workshop and in consultation with the EC, the consortium prepared a programme for the workshop. All invitees received a discussion paper allowing them to prepare for the various discussion rounds, including the programme of the day (see Appendix F). During the workshop, the input from all stakeholders was documented by at least two members of the research team at the same time. Moreover, rapporteurs were appointed for each round two subgroup discussion, responsible for documenting the discussions and summarising them.

3.4.4 Participation in the Brussels workshop

The Brussels workshop was attended by 15 participants from 14 EU Member States and 6 participants from 4 European-level organisations (see Table 3.3).

Table 3.3: Overview of participating organisations in the CC4HCA workshop 6-7 April

Country	**Organisation**
Austria	Federal Ministry of Health (Bundesministerium für Gesundheit)
Belgium	Federal Public Service Health, Food Chain Safety and Environment
France	The Directorate-General of Healthcare Provision (DGOS - La direction générale de l'offre de soins)
Germany, Lower Saxony	Ministry of Education and Cultural Affairs in Lower Saxony
Greece	Greek Regulatory Body of Nurses
Ireland	Office of Nursing and Midwifery Services Director, Health Service Executive (HSE)
Italy	National Federation of Colleges of Nursing (Ipasvi -Federazione Nazionale Collegi Infermieri professionali)
Lithuania	Lithuanian Nurses Organisation
Luxembourg	Ministry of Health
Malta	Regulation and Standards Directorate
Netherlands	Cooperation Organisation for Vocational Education, Training and the Labour Market (SBB)
Portugal	National Agency for Qualification and Vocational Education and Training (ANQEP, I.P.)
Sweden	Kommunal
UK	Health Education England (HEE)
European representation	ESNO - European Specialist Nurses Organisations
European representation	HOSPEEM - European Hospital & Healthcare Employers' Association
European representation	EPSU - European Federation of Public Service Unions
European representation	EFN - European Federation of Nurses Associations

In total 27 people from 18 countries and 6 people from 6 European organisations were not able to attend the event.

3.4.5 Online workshop

Those invitees who could not attend the Brussels workshop were invited to participate in an online workshop. The online workshop was designed in two stages:

1) First, the invitees received a *Summary Document* (see Appendix G) that informed them about the discussion questions and results of the subgroup discussion rounds that took place during the two-day workshop in Brussels. Participants were invited to share the document with their colleagues and other stakeholders in their country.

2) Second, the representatives were invited to participate in an *online group workshop*. This online teleconference was held in two subgroups of 6 to 7 participants on Friday 10 June 2016. Each participant was assigned to one of the two subgroups and thereby to a timeslot in the morning or the afternoon of Friday 10 June.

Each web group conference took 2.5 hours. With this online workshop, we aimed to consult all participants through a group discussion that was as similar as possible to the workshop subgroup meetings we held in Brussels in April.

3.4.6 Programme and documentation of the online workshop

The programme of the online meeting consisted of three parts:

1. A general introduction to the CC4HCA study by DG SANTE of the European Commission, a presentation on the common training framework by DG Internal Market, Industry, Entrepreneurship and SMEs (DG Growth) and an overview of the CC4HCA study design and results so far. Slides were presented through the web application.
2. After the presentations, there was time for questions and answers from all participants.
3. All participants were then asked to contribute to a group discussion. All participants were invited to express their views and positions regarding two main discussion questions. The two questions were described in the Summary Document and are similar to those posed in the Brussels workshop. Input and comments were documented during the session. The aim was to provide an open atmosphere for all participants to express and exchange opinions..

During the online workshop, the input from all stakeholders was documented by at least two members of the research team at the same time.

3.4.7 Participation in the online workshop

The web conference was organised through a (simple) online system for which each participant received a link and logon details. The online workshop was attended by 13 participants from 13 countries and 2 participants from 2 European level organisations (see table 3.4).

Table 3.4: Overview of participating organisations in the CC4HCA online workshop 10 June 2016

Country	**Organisation(s)**
Bulgaria	Ministry of Health
Croatia	Croatian Nursing Council (Hrvatska komora medicinskih sestara)
Czech Republic	Czech National association of Nurses
Estonia	Estonian Nurses Union
Finland	The Finnish National Board of Education; the Ministry of Social Affairs and Health
Hungary	Chamber of Hungarian Health Care Professionals (MESZK)
Poland	Ministry of Health, Department of science and higher education
Romania	Romanian Nursing Association (RNA)
Slovenia	Nurses and Midwives Association of Slovenia
Slovenia	Faculty of Nursing Jesenice
Spain	Ministry of Health
UK, England	Health Education England
UK, Northern Ireland	Department of Health Social Services and Public Safety
European representation	FEPI - European Council of Nursing Regulators
European representation	EPSU - European Federation of Public Service Unions

3.5 Preparation of the final report

After the workshop and web conference, the study consortium processed the outcomes from all steps into this final report. In order to produce a report that accurately reflects the outcomes of the study, we invited the Member States and European organisations that participated in the workshops to provide comments on a draft version of the report. They were invited to check whether the facts were correct and whether the findings and conclusions reported reflected the discussions and conclusions during the workshops. For this consultation, representatives from 24 Member States and 5 European organisations were invited. We received responses from 16 Member States 4 European organisations. The feedback was taken on board in this final version of the report.

Part II:

The role, knowledge, skills and competences of HCAs in the EU Member States

4 Healthcare assistants: definitions, job descriptions and statistics

In this chapter we describe the position of HCAs in all 28 EU Member States in terms of the following aspects:

- definition and occupational title
- number registered and employed
- age, gender, employment/unemployment rate, annual wages
- cross-border mobility
- areas of employment

Various data sources have been used for this and the subsequent chapters. The primary sources are the data collected by the CC4HCA study on 14 EU Member States and the data that were previously collected by the Contec pilot study on the 14 other Member States, which was updated, extended and complemented by the CC4HCA study where possible. In addition, other internationally acknowledged data sources were used.

4.1 Definitions and occupational titles

4.1.1 Internationally applied definitions and classifications of HCAs

The definitions and classifications of healthcare assistants that are commonly used internationally are based on the International Standard Classification of Occupations (ISCO, 2008 revision), a system for classifying and aggregating occupational information obtained by means of population censuses, (labour) statistical surveys, as well as administrative records. The three ISCO codes presented in Table 4.1 correspond the profession of healthcare assistants (code 5321 and 5322), or are closely related to the HCA profession (code 3221).

Table 4.1: ISCO-08 codes with relevance to the HCA profession

ISCO code	Occupation group	Definition	Examples of occupations
ISCO-codes corresponding with the profession of healthcare assistants			
5321	Health care assistants	Health care assistants provide direct personal care and assistance with activities of daily living to patients and residents in a variety of health care settings such as hospitals, clinics and residential nursing care facilities. They generally work in implementation of established care plans and practices, and under the direct supervision of medical, nursing or other health professionals or associate professionals	▪ Birth assistant (clinic or hospital) ▪ Nursing aide (clinic or hospital) ▪ Patient care assistant ▪ Psychiatric aid
5322	Home-based personal care workers	Home-based personal care workers provide routine personal care and assistance with activities of daily living to persons who are in need of such care due to effects of ageing, illness, injury, or other physical or mental conditions, in private homes and other independent residential settings	▪ Home birth assistant ▪ Home care aide ▪ Nursing aide (home) ▪ Personal care provider

ISCO code	Occupation group	Definition	Examples of occupations
ISCO-codes closely related to profession of healthcare assistants			
3221	Nursing associate professionals	Nursing associate professionals provide basic nursing and personal care for people in need of such care due to effects of ageing, illness, injury, or other physical or mental impairment. They generally work under the supervision of, and in support of, implementation of health care, treatment and referrals plans established by medical, nursing and other health professionals	▪ Assistant nurse ▪ Associate professional nurse ▪ Enrolled nurse ▪ Practical nurse

ISCO-codes corresponding with the profession of healthcare assistants
When reporting on HCAs, the main international statistical organisations combine ISCO-08 codes 5321 and 5322 as can been seen in the 'Joint Questionnaire on Non-Monetary Health Care Statistics' (OCED/Eurostat/WHO). This questionnaire combines codes 5321 and 5322 and does not collect separate data for the separate codes. The main argument behind this is that home-based personal care workers (5322), according to the ISCO definition, are doing essentially the same things as health care assistants (5321), with the main difference being they are providing their services in the home of patients rather than in institutions. Both ISCO codes are combined in the Joint Questionnaire and are used to measure the following two variables:

- The number of 'Practising caring personnel (personal care workers)', that includes both health care assistants in institutions (ISCO-08 5321) and home-based personal care workers (ISCO-08 5322) providing services for patients, and
- The number of 'Professionally active caring personnel (personal care workers)', that includes professionally active caring personnel include practising caring personnel and other caring personnel for whom their education is a prerequisite for the execution of the job (covering ISCO-08 codes 5321 and 5322).

ISCO-codes related to the profession of healthcare assistants
As stated before, this study built upon the results of the Contec study conducted in 2011/2012. In the Contec study, healthcare assistants were defined by the ISCO-08 codes 5321 (healthcare assistants) and 3221 (nursing associate professionals), but not by the ISCO-08 code 5322 (home-based personal care workers). Compared to the current state of international data (collection), ISCO-08 code 3221 is not part of the profession of healthcare assistants but – as shown by Tabel 4.1 – it is closely related to the HCA profession. Therefore, and to maintain comparability with the data from the 14 Member States covered by the Contec study, we decided to similarly use ISCO-08 code 3221 and 5321 to define HCAs in the 14 Member States covered by this study.

4.1.2 Occupational titles of HCAs as reported by country informants

Table 4.2 provides an overview of the occupational titles belonging to HCAs as identified through country informants in all 28 EU Member States. The first half of Table 4.2 is based on the information collected through CC4HCA country experts, the second half is based on information collected through the Contec study. We asked the country informants of the 14 Member States covered in our study to describe the "(…) appropriate occupational name or title for HCAs" in their national language. In order to maintain comparability with the Contec study, the ISCO-08 code 5321 and 3221 were presented to the informants as a starting point (see Appendix A). Given this, the country experts were requested to describe in free format the occupational titles for healthcare assistants in their country and language. All information sources provided by the informants that support the occupational title and job description of HCAs within the Member States can be found in Appendix J.

Table 4.2 shows that the occupational title and terminology for HCAs – as translated from the national languages back into English by the study consortium – differs considerably between Member States. In some countries, HCAs appear to be broader or at least more extensively described than in others (e.g. ward or dentists assistants in Cyprus, versus a range of titles in Malta). In a number of countries, e.g. Greece and Latvia, the term explicitly refers to HCAs being assistants to nurses. In other countries, this is left unspecified, implying that HCAs can also work under supervision of e.g. GPs or other doctors. For Germany, it should be noted that the information provided in Table 4.2 concerns only the HCA in the federal state of Lower Saxony. The occupation of the HCA in Germany varies at the federal state (Bundesland) level. Job titles in other states include *Krankenpflegehelfer / Krankenpflegehelferin* (certified nursing assistant) and *Altenpflegehelfer / Altenpflegehelferin* (certified assistant in elderly care).

Table 4.2: Occupational titles of HCAs in national language and English (back)translation in 28 MSs, provided by CC4HCA country informants in 2015 and Contec country informants in 2011/2012

	Occupational title	**English (back)translation**
Member States consulted by CC4HCA country informants in 2015		
Croatia [a]	Medicinska sestra; medicinski tehničar	Nurse; nurse technician
Cyprus	Βοηθός Θαλάμου; Βοηθός Οδοντιατρείου	Ward assistants dentist assistant
Estonia	Isikuhooldustöötajad; Hooldustöötajad tervishoius;Hooldajad tervishoiuasutustes	Care worker, healthcare assistant
France	Aide soignante hospitalière; aide à domicile	Hospital and home healthcare assistant
Greece	βοηθοί νοσηλευτών or νοσοκόμοι	Nurse's assistants
Hungary	Ápolási asszisztens	Nursing associate professional
Latvia	Māsas palīgs	Assistant of nurse
Lithuania	Slaugytojo padėjėjas	Nurse assistant
Luxembourg	Aide-soignant	Care assistant

	Occupational title	English (back)translation
Malta	Nursing Aides, Health Assistants, Paramedic Aides, Carers, Assistant Carers, Care Workers, Assistant Care Workers, Care and Support Workers, Social Assistants	Ibid
Portugal	Técnico Auxiliar de Saúde	Technical Health Assistant
Romania	Infirmiera	Healthcare assistants
Slovakia	Zdravotnícky asistent	Healthcare assistants
Sweden	Undersköterska, vårdbiträden	Assistant nurse, nursing assistant
Member States consulted in the Contec pilot study in 2011/2012		
Austria	Pflegehelfer; Heimhelfer	Care assistant, home helper
Belgium	Aide Soignante, Zorgkundige, Pflegehelfe [a]	Healthcare assistant
Bulgaria	Sanitaries	Health Assistants
Czech Republic	Not reported	Medical Assistants
Denmark	Social- og sundhedsassisten	Social/ Healthcare Assistant
Finland[c]	Lähihoitaja	Practical nurse
Germany (Lower Saxony)	Staatlich geprüfter Pflegeassistent	Certified Care Assistant
Ireland	Health care Assistant	Ibid
Italy	OSS – Operatore Socio-sanitario	Auxiliary Staff, Social and Health Auxiliary Workers
Netherlands	Verzorgende IG, Helpende zorg en welzijn, Zorghulp	Individual healthcare carers, health and welfare assistants, care assistant
Poland	Opiekun medyczny	Medical Carer
Slovenia[b, d]	Not reported	Nurse assistant, healthcare technician, practical nurse
Spain	Técnico en cuidados auxiliares de enfermería	Nursing assistants
UK[b, e]	Healthcare Assistants, Health Care Support Workers, Nursing Assistants, Nursing Auxiliaries, Clinical Support Workers	Ibid-

[a] The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

[b] Updated after the Contec pilot study.

[c] This is how the HCA was defined in the pilot Contec study. Updated information after the pilot study showed that the HCA in Finland can be defined as "hoiva-avustaja" (Care Assistant). The care assistant only follows a part of practical nurse training.

[d] Slovenia started with reform of education on secondary level in 2014. Competences of the Practical Nurse will be reduced and the title will be changed. The new title proposed by the National Council for Nursing is Healthcare Assistant (HCA).

[e] In the United Kingdom, the Healthcare Assistants form the occupational group in focus of this project because they work under the supervision of RNs as indicated in the definition of the target group. In terms of working tasks performed, Assistant Practitioners (who are a level above the HCAs) are also relevant and comparable to examples given from other countries. Assistant practitioners work with greater independence and may in some cases even supervise HCAs.

The Contec study and our consultation of the country informants provided information about protection of the occupational title of HCAs as well. From Table 4.3 it can be seen that country informants in 11 of the 28 EU Member States reported that the professional names of HCAs are protected. For a total of 10 out of 28 Member States, it is unknown whether the job title is protected (i.e. this was not reported by country informants) while 7 Member States do not protect the occupational titles of HCAs.

Table 4.3: Title protection of HCAs in 28 MSs, as (not) reported by CC4HCA informants in 2015 and Contec country informants in 2011/2012

Protected	Not protected	Not reported
• Croatia[a]	• Estonia	• Austria
• Cyprus	• Germany (Lower Saxony)	• Belgium
• Finland	• Ireland	• Bulgaria
• France	• Malta	• Czech Republic
• Greece	• Portugal	• Denmark
• Hungary	• Romania	• Latvia
• Italy	• Sweden	• Poland
• Lithuania		• Slovenia
• Luxembourg		• Spain
• Netherlands		• United Kingdom
• Slovakia		

[a] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

4.2 Statistical information on HCAs

4.2.1 Numbers of HCAs

To describe the number of HCAs in all 28 MSs, we start by presenting the statistics of the international statistical reporting bodies and offices. As explained in paragraph 4.1.1, the OECD/Eurostat/WHO 'Joint Questionnaire on Non-Monetary Health Care Statistics' combines ISCO-08 codes 5321 (healthcare assistants) and 5322 (home-based personal care workers) to measure two variables:

- The number of 'Practising caring personnel (personal care workers)', and
- The number of 'Professionally active caring personnel (personal care workers)'.

Table 4.4 shows the most recent OECD/Eurostat statistics on practising caring personnel and professionally active caring personnel. It shows that the variation between countries for the two variables is very large. For example, Austria, Croatia, Bulgaria and Greece have fewer than 60 practising caring professionals per 100,000 inhabitants, while the Netherlands and Finland have 1,441 resp. 2,063 practising caring professionals per 100,000 inhabitants.

For reasons of comparison with the Contec pilot study, we also included a third column in Table 4.4 with the numbers of practising nursing associate professionals (ISCO 3221). Looking at the statistics for this professional category, we note that the variation between countries in terms of number of practising nursing associate professionals per 100,000 inhabitants is considerable (e.g. 16 in Cyprus and 667 in Denmark) – but still smaller compared to the cross-national variation for the two caring personnel variables.

Table 4.4: Statistics on practising caring personnel, professionally active caring personnel and practising nursing associate professionals, in numbers and per 100,000 inhabitants

	Practising caring personnel (ISCO-08 5321 and ISCO-08 5322)[1]		**Professionally active caring personnel (ISCO-08 5321 and ISCO-08 5322)[2]**		**Practising nursing associate professionals (ISCO-08 3221)[1]**	
Country	**No.**	**No. per 100,000 inhabitants**	**No.**	**No. per 100,000 inhabitants**	**No.**	**No. per 100,000 inhabitants**
Austria	4,561	53	.	.	10,312	121
Belgium	.	.	114,209	1,014	.	.
Bulgaria	139	2	.	.	0	0
Croatia	455	11	.	.	19,473	460
Cyprus	.	.	.	.	140	16
Czech Republic	25,048	238	.	.	.	.
Denmark	51,663	.	54,041	962	37,442	667
Estonia	3,569	272	.	.	0	0
Finland	111,704	2,063	141,346	2,611	24,673	456
France	.	:	403,856	609	.	.
Germany	.	.	.	.	164,000	203
Greece	6,389	59	.	.	15,398	141
Hungary	27,457	278	.	.	14,685	149
Ireland	23,938	505	.	.	.	.
Italy	.	.	625,464	.	.	.
Latvia	2,102	105	2,102	.	0	0
Lithuania	7,015	239	.	.	0	0
Luxembourg	3,415	591	3,468	616	0	0
Malta	3,058	708	.	.	0	0
Netherlands	243,000	1,441	.	.	.	.
Poland	.	.	.	.	0	0
Portugal	28,103	270	.	.	.	.
Romania	60,647	305	.	.	111,599	561
Slovakia	4,935	91	8,894		.	.
Slovenia	3,976	193	4,016		12,628	612
Spain	426,533	918	432,233		0	0
Sweden	.	.	.	.	.	.
UK	675,532	1,046	.	.	94,926	152

[1] Source: Eurostat (online data code: hlth_rs_prsns); [2] Source: OECD.Stat (code: Professionally active caring personnel), data retrieved on 24 October 2016 for the most recent years available (2010-2015); . = Data not available.

We close this section by comparing the total number of employed HCAs as reported by our country informants with the number of (1) practising caring personnel, (2) professionally active caring personnel and (3) practising nursing associate professionals as provided OECD/Eurostat and collected by their Joint Questionnaire. Table 4.5 presents the results of this comparison, that can be made for 9 Member States. Great caution is needed, however, in interpreting these numbers. The numbers in Table 4.4 (copied in the last three columns in Table 4.5 for the 9 Member States) concern the number of practising caring personnel, professionally active caring personnel and practising nursing associate professionals as provided by the statistical offices and agencies of the Member States. The numbers in the first column of Table 4.5 are reported by our country informants.

Table 4.5: Comparison number of HCAs as reported by country informants and classified as practising caring personnel, professionally active caring personnel and practising nursing associate professionals

Country	No. of HCAs as reported by country informants	No. of practising caring personnel (ISCO-08 5321 and ISCO-08 5322)[1]	No. of professionally active caring personnel (ISCO-08 5321 and ISCO-08 5322)[2]	No. of practising nursing associate professionals (ISCO-08 3221)[1]
Croatia	23,000[a]	455	.	19,473
Cyprus	376	.	.	140
Estonia	3,465	.	.	.
Greece	14,617	6,389	.	15,398
Luxembourg	3,300	3,415	3,468	.
Malta	918	3,058	.	.
Portugal	26,040	28,103	.	.
Romania	60,130	60,647	.	111,599
Slovakia	2,352	4,935	8,894	.

[1] Source: Eurostat (online data code: hlth_rs_prsns); [2] Source: OECD.Stat (code: Professionally active caring personnel), data retrieved on 24 October 2016 for the most recent years available (2010-2015); . = Data not available.
[a] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

For some countries, the numbers as reported by country informants are quite close to the numbers of caring personnel or practising nursing associate professionals as reported in the Eurostat and OECD database. But for Member States such as Cyprus, Malta and Slovakia the differences are considerable, which might be a result of other definitions and classifictions applied for HCAs by the country informants. This demonstrates the strong influence of

definition and sources on this type of statistics, and the importance of obtaining agreement on them, within and between countries.

4.2.2 Additional information provided by country informants

We asked our country informants to provide a number of additional statistics on HCAs as well, but the data which we received was often incomplete and not all countries could provide this information. The annual wages of HCAs (either as a range or an average) and unemployment rates of HCAs could not be provided by all country informants, as Table 4.6 shows. The numbers presented in the table show a large variation between countries, but this should be interpreted with caution. Numbers are presented in absolute terms and not corrected for e.g. size of the population (as in the Eurostat/OECD statistics in Table 4.4) or gross national income (in relation to their annual wage).

Table 4.6: Unemployment rates and annual wages of HCAs as reported by country informants

Country	Unemployment rate	Annual wage
Croatia [a]	6%	EUR 12,000-24,000
Cyprus	.	EUR 8,172 -8,820
Estonia	.	EUR 5,592
France	.	EUR 16,920
Greece	82%	EUR 6,600 – 12,000
Hungary	approx. 10%	EUR 4,080 – 7,200
Latvia	.	.
Lithuania	.	.
Luxembourg	.	EUR 33,156 – 57,000
Malta	.	EUR 8,000 -13,000
Portugal	.	.
Romania	.	EUR 2,400 -2,600
Slovakia	.	.
Sweden	.	EUR 22,832 -32,600

.= Data not available

[a] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

Table 4.6 shows that the unemployment rate was reported or estimated for only three Member States. The annual wage is reported for more countries, showing (again) considerable differences between e.g. Sweden (over 22,000 euros) and Romania (about 2,500 euros).

Additional statistical information collected through the country informants (not presented in Table 4.6) concerns a small number of countries. For example, the average age of HCAs is known for three countries: in Croatia it is 42, in Cyprus 50 and in Estonia it is situated in the age category 50-59. The three countries that were able to provide information on gender

distribution also indicate that the profession is strongly female-dominated; in Croatia the proportion of women working as HCAs is 95%, in Cyprus it is 90% and in Estonia 95%. This is most likely also the case in other countries. A final statistic, which is only known for two countries, is the number of graduates per year: in Croatia it is 1,200 and in Slovakia 1,250.

4.2.3 Mobility of HCAs, indicated by mobility statistics on 'second-level nurses' in the EU Market Regulated Professions Database

One driver of a potential common training framework (CTF) for HCAs is that EU Member States can collaborate on the training, recruitment and the mobility of HCAs. Indicators for the mobility of HCAs are not available from the Eurostat/OECD statistics, nor could these be retrieved through our country informants in a comparable and reliable manner.

As an alternative, figures from the EU Single Market Regulated Professions Database, governed by DG Growth, can be used. In this database, healthcare assistants are not included under the title 'healthcare assistants'. The profession that *partly* corresponds with the occupational title and definition of healthcare assistants is the 'second-level nurse'. 'Second-level nurses' as defined in the EU Single Market regulated professions database under Directive 2005/36/EC are part of the general system of recognition (primary application).

To demonstrate the correspondence between HCAs and 'second-level nurses', a specific job title or category in the EU database, Table 4.7 provides a comparison between the translations of 'second-level nurse' according to the regulated professions database and 'healthcare assistants' for the CC4HCA database in the countries for which data is available. As can be seen, the professional titles are identical for 8 of the 16 countries (indicated in green). Slight deviations are found for 5 countries: for Austria and the Netherlands, the definition in the CC4HCA study is broader, while for Finland, Germany (Lower Saxony) and Slovakia, the definition in the Regulated Professions Database is broader (indicated in yellow). For the remaining three countries it could not be decided if the definitions are comparable.

Table 4.7: Comparison between translations of 'second-level nurse' (regulated professions database) and 'healthcare assistant' (CC4HCA study)

	Translation of 'second-level nurse' (regulated professions database)	**Translation of 'healthcare assistant' in the CC4HCA study**
Austria	Pflegehelferin / Pflegehelfer	Pflegehelfer; Heimhelfer
Belgium	Aide-soignant,	Aide-Soignant, Zorgkundige, Pflegehelfer
Czech Republic	Ošetřovatel; Sanitář; Zdravotnický asistent	Medical Assistants
Denmark	Social- og sundhedsassistent	Social- og sundhedsassisten
Finland	Lähihoitaja/ Närvårdarea	Lähihoitaja

France	Aide soignant	Aide soignant
Germany (Lower Saxony)	Kranken-pflegerhelfer/in; Rettungsassistent	Staatlich geprüfter Pflegeassistent
Greece	Assistant nurse	Nurse's assistants
Italy	Assistente sanitaria	OSS – Operatore Socio-sanitario
Latvia	Māsas palīgs	Māsas palīgs
Luxembourg	Aide soignant	Aide soignant
Malta	Registered nurse (second level); State enrolled nurse	Nursing Aides, Health Assistants, Paramedic Aides, Carers, Assistant Carers, Care Workers, Assistant Care Workers, Care and Support Workers, Social Assistants
Netherlands	Verzorgende individuele gezondheidszorg (formerly ziekenverzorgende)	Verzorgende IG, Helpende zorg en welzijn, Zorghulp
Slovakia	Sanitár; Zdravotnícky asistent	Zdravotnícky asistent
Spain	Auxiliar de enfermería	Técnico en cuidados auxiliares de enfermería
United Kingdom	Nurse Admitted to Sub-Part 2 of the Register maintained by the Nursing & Midwifery Council	Healthcare Assistants, Health Care Support Workers, Nursing Assistants, Nursing Auxiliaries, Clinical Support Workers

Green: Same definition; yellow: (slight) deviations; white: unknown

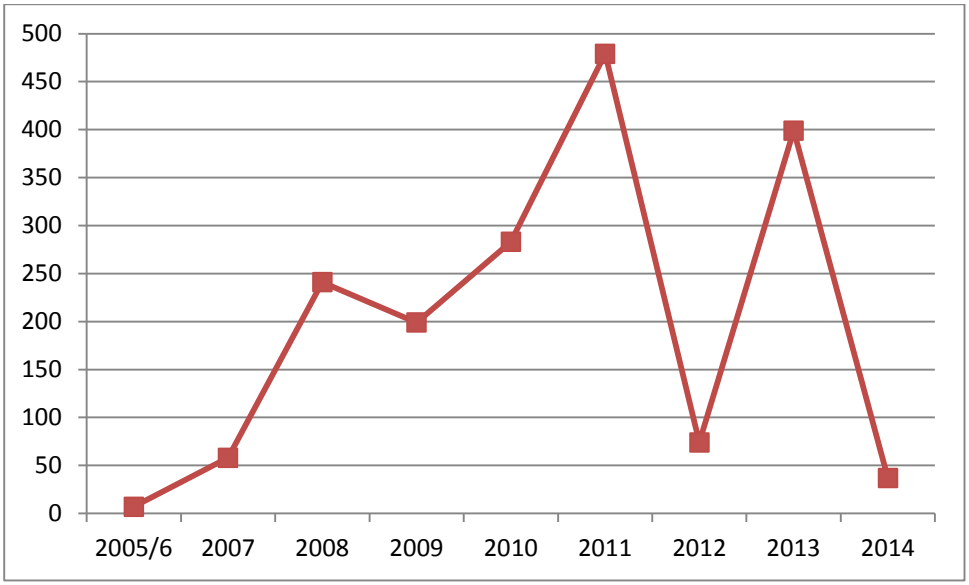
[a] Updated information after the Contec pilot study: hoiva-avustaja

Taking these similarities and differences into account, the numbers on mobility as provided in the Regulated Professions Database can be used as *an indicator* for the mobility of HCAs for the majority of countries.

The first number that can be shown is the number of second-level nurses who were permanently established in another EU Member State between 2005 and 2014. Figure 4.1 shows that this number fluctuated between 7 in 2005/2006 to 479 in 2011. There is no clear trend of increase or decrease of mobility visible for this professional group.

Figure 4.1: Number of second-level nurses from EU Member States who were permanently established in another MS between 2005 and 2014[3]

[3] Source: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm.



Next, Table 4.8 and figures 4.2 and 4.3 show the countries where the second-level nurses obtained their qualifications between 2005/6 and 2013/2014. The highest absolute number of second-level nurses settling in other countries comes from Germany (1,022 nurses), Belgium (974 nurses) and France (778 nurses). The German second-level nurses mostly settled in Austria, Luxembourg and Denmark. Almost all second-level nurses from Belgium who emigrated settled in France and a large proportion of French second-level nurses settled in Belgium or Luxembourg. Countries which serve the most as host countries are Austria (1,516 nurses), France (1,431) and Belgium (1,074). The fact that Austria, Germany, France and Belgium share common languages is a possible explanation for the higher mobility numbers between these four countries.

Table 4.8: Permanent settlement of second-level nurses in 26 EU Member States in 2005-13, sorted by number of number of nurses from the country of origin [4]

	Recognition in host country:											
Qualification obtained in:	Austria	Belgium	Czech Republic	Denmark	France	Germany	Greece	Luxembourg	Malta	Slovakia	UK	**Total**
Germany	365	61	1	129	13	0	21	414	0	0	18	**1,022**
France	1	523	0	0	0	12	0	241	1	0	0	**778**
Sweden	5	7	0	648	6	7	2	0	1	0	6	**682**
Slovakia	331	0	88	1	0	10	0	0	0	0	0	**430**
Slovenia	423	1	0	0	0	2	0	0	0	0	0	**426**
Romania	92	77	0	5	81	41	1	1	2	0	6	**306**

[4] Source: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm > Second level nurses > Establishment > Geography of mobility > 2005-2013 > In all EU Countries, retrieved 2015

Netherlands	3	251	0	13	10	2	0	1	0	0	3	**283**
Poland	100	43	0	14	24	67	0	2	1	1	0	**252**
Italy	11	43	0	1	122	7	0	0	1	0	0	**185**
Spain	3	32	0	0	117	13	0	0	0	0	7	**172**
Hungary	106	3	0	4	3	42	0	1	1	0	1	**161**
Bulgaria	19	9	0	0	5	6	1	0	13	0	36	**89**
Czech Republic	48	1	0	1	6	8	1	1	2	2	1	**71**
Finland	0	3	0	6	2	0	1	0	0	0	48	**60**
Greece	4	1	0	0	1	31	0	0	0	0	17	**54**
UK	1	7	0	3	31	3	0	0	5	0	0	**50**
Portugal	0	8	0	0	30	0	0	0	0	0	0	**38**
Austria	0	1	0	0	5	21	0	2	1	0	0	**30**
Lithuania	2	1	0	9	2	5	0	0	2	0	2	**23**
Latvia	0	0	0	6	0	3	0	0	3	0	2	**14**
Denmark	0	0	0	0	4	4	0	0	0	0	0	**8**
Ireland	0	1	0	0	2	0	0	1	1	0	0	**5**
Luxembourg	0	1	0	0	1	3	0	0	0	0	0	**5**
Cyprus	0	0	0	0	2	0	0	0	0	0	0	**2**
Estonia	0	0	0	0	0	1	0	0	0	0	1	**2**
Malta	0	0	0	0	0	0	0	0	0	0	2	**2**
Total	**1,516**	**1,074**	**89**	**840**	**1431**	**288**	**27**	**671**	**35**	**3**	**150**	**6,124**

Figure 4.2: Country of qualification of permanently settled second-level nurses in 25 EU Member States, 2005-14[5]

[5] Source: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm > Second level nurses > Establishment > Geography of mobility > 2005-2013 > In all EU Countries, retrieved 2015.

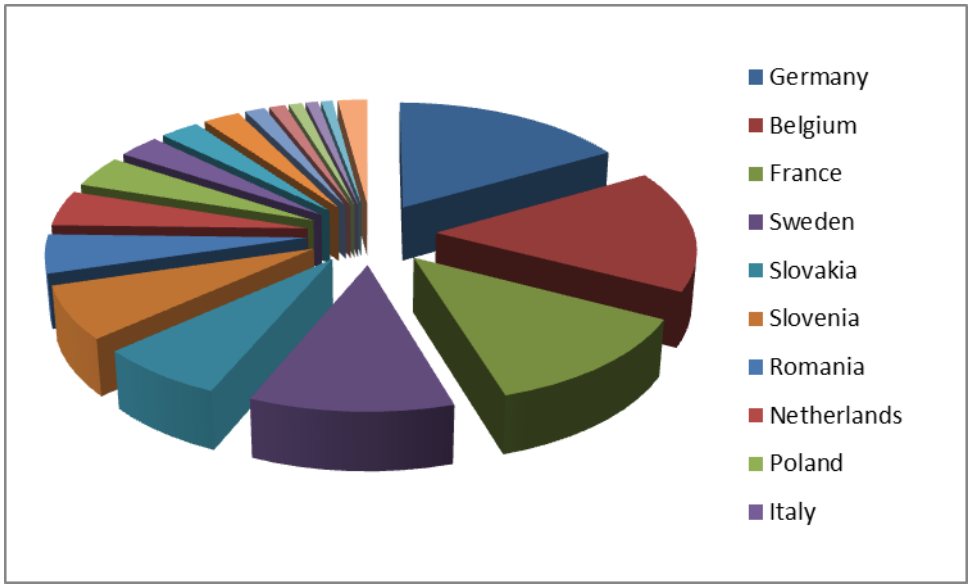
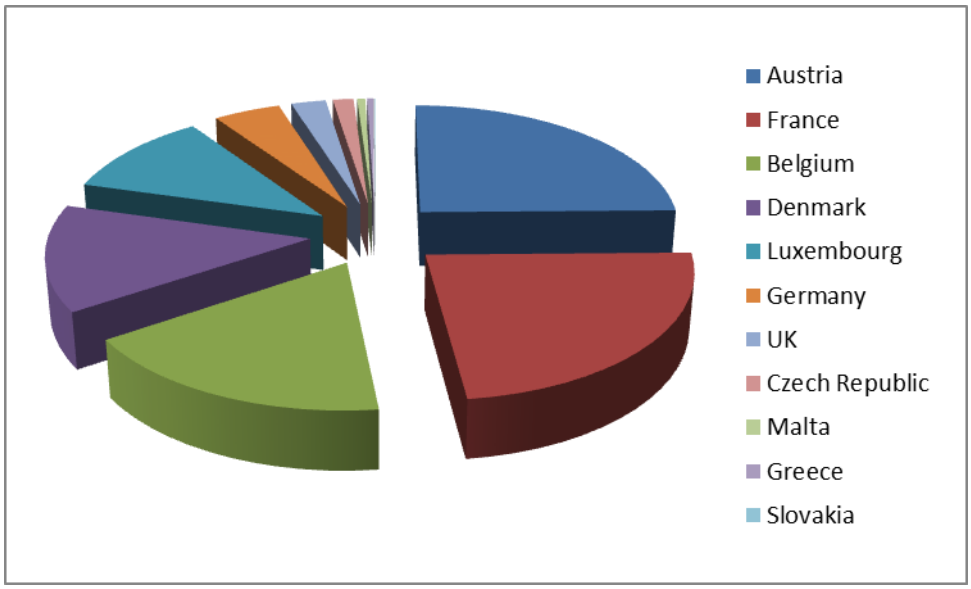


Figure 4.3: Host countries of HCAs permanently settled in other countries 2005-2014



Another indicator providing insight into the mobility of second-level nurses in the EU Market Regulated Professions Database is the number of decisions taken on recognition of professional qualifications for the purpose of permanent settlement within the EU Member States. These decisions are taken by host countries on professionals qualified in one country who apply for recognition in another country to practice there on a permanent basis. Limited to intra-EU mobility in the period 2005-2015 (i.e. since Directive 2005/36/EU came into existence), data that can be retrieved from the EU Single Market regulated professions Database shows that 62% (n=5341) of the decisions with regard to second-level nurses taken by host countries were positive (8% were negative (n=660) and 30% were neutral (n=2558)). When we compare these numbers with the intra-EU mobility numbers for nurses, as a comparable profession over the same period, we see that the percentage of positive decisions is higher at 89%. While this difference could have several causes, it is likely that

this is related to the fact that automatic recognition has been established for nurses, but not for second-level nurses (in particular by Directive 2005/36/EU).

5 Education and training systems

This chapter describes the variation in the position of HCAs in terms of education and entry requirements in the EU Member States. The descriptions are mostly limited to the 14 countries for which new data was collected (Croatia, Cyprus, France, Greece Hungary, Latvia, Lithuania, Luxembourg, Malta, Portugal, Romania, Slovakia and Sweden), but an additional description has been provided of the results of the pilot study where available (Braeseke *et al.*, 2013), in order to provide an EU-wide overview of the variation between Member States.

For all these 14 Member States, it was stated that the geographical level of the curriculum is the national level. Currently, only Malta has no curriculum defined. In the pilot study this was the case for the UK and Germany, as both countries are regulated at the regional rather than national level. In the third round of the Delphi study, participants were also asked to answer questions relating to their national qualification framework. Of the 25 participating Member States, 22 indicated that they had a national qualification framework. In 19 of these Member States HCAs' education is effectively linked to this framework. In most cases (n=15), these national qualification frameworks are linked to the European Qualifications Framework. Sometimes this is a direct link, such as in Bulgaria, but sometimes the link can be indirect, as is the case for Hungary, where the national qualification framework level 5.2 is comparable to EQF level 3.

There is a wide variation in entry requirements for education between the 14 Member States. This varies from no entry requirements in Latvia to high school or secondary school in e.g. Cyprus and Lithuania. The minimum age for starting education as an HCA also varies widely between the countries. In Cyprus, Greece and Portugal there is no minimum age, whereas in other countries the minimum age varies between 15 and 18. The variation in the minimum age was also found in the pilot study, with Ireland, the Netherlands and the UK having no minimum age requirements. It should be noted that the variation in age may be related to the variation in entry requirements regarding previous education. The age requirement may be less important than the education requirement.

Finally, differences can be found in the extent to which continuous professional development is required. In Croatia, Estonia, France, Latvia, Luxembourg, Romania and Slovakia, HCAs are obliged to do some form of CPD, whereas in the other countries this is optional or not mandatory (information for pilot countries unavailable).

Table 5.1: Definition of curricula and entry requirements for the education of HCAs in 14 Member States (data based on the CC4HCA mapping study only)

Country	Geographical level of curriculum	Qualifications framework to which HCAs are linked[a]	Entry requirement for education	Min. age	CPD
Croatia[b]	National	No	Elementary school (planned)	15	Yes
Cyprus	National	Not reported	Secondary school	No	No
Estonia	National	A national qualifications framework	Basic education (9 yrs) or secondary education (12 yrs)	18	
France	National	A national qualifications framework	Before high school diploma or "baccalauréat"	17	Yes
Greece	National	No	Basic education (12 years)	No	No
Hungary	National	A national qualifications framework, EQF (level 3)	Elementary school	16	No
Latvia	National	No	No entry requirement	18	Yes
Lithuania	National	A national qualifications framework	After secondary school	18	Optional
Luxembourg	National	A national qualifications framework	Finalisation of a 9th grade class, a favourable opinion to a healthcare profession in the 9th grade class; entry test of competences	15	Yes
Malta	No curriculum defined[c]	N/A	N/A	N/A	N/A
Portugal	National	EQF (level 4)	9 years of school	No	Optional
Romania	National	No	Graduate of eight classes minimum	16	Yes
Slovakia	National	EQF (level 4)	Basic school + entrance exam or high school	15 for fulltime, 18 for part-time	Yes
Sweden	National level with regional differences in special courses	A national qualifications framework	No	No	No

N/A= Not Applicable

[a] Source: Delphi study, round 3.

[b] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

[c] Since the time of data collection (September 2015) a set of national minimum standards for training has been established. The standards essentially note that training for HCAs needs to be at least EQF level 3. Requirement for education remains unidentified and so are age and CPD (source: https://activeageing.gov.mt/en/Documents/NMS_ENG.pdf)

Table 5.2 gives an overview of some characteristics of the training and education programmes of HCAs in the 28 EU Member States, i.e. including the 14 pilot countries. In more than half of European Member States (n=15), the education of HCAs is publicly

funded. In five more countries there is the option of choosing between publicly or privately funded education or a mix. In Romania, Lithuania and the UK, funding is mainly private. In the UK, funding can also be covered by the employer. There is a high variation between the countries in the duration of the education programmes. In Romania, the duration is shortest with 3 months or 360 hours and in Latvia the main programme has a duration of 6 years. Depending on the country, there are also differences in the minimum percentage or number of hours from the total period of education when HCA students have to be trained in practical situations. In France, Malta, the Netherlands and the UK, the minimum number of hours to be spent in practical work is not defined. In the other countries, the percentage is up to around 60% of the total duration of the education. It is worth noting that these dimensions are related, i.e. the duration of educational programmes tends to be shorter in countries with private funding of education.

Table 5.2: Education/ training programmes for HCAs

Country	**Funding education**	**Duration of main programme(s)**	**Percentage spent in practical work**
Member States consulted by our country informants in 2015			
Croatia [a]	Public	Not reported	Not reported
Cyprus	Mixed	1 or 2 years	Not defined
Estonia	Public	2 years	20%
France	Mixed	11 months	Not defined
Hungary	96% public	2 years, 1100-1400 hours	50%
Latvia	Public	6 years (from the age of 15)	Not reported
Lithuania	Mostly private	9 weeks, 360 hours	>60%
Luxembourg	Public	3 years	>50%
Malta	Public	6 months (EQF level 1), 1- 2 years (EQF 2-4)	Not defined
Portugal	Mixed	3 years	420 hours
Romania	Private	3 months (360 hours)	240 hours
Slovakia	Public	4 years, 4224 hours	Varying per year
Sweden	Public	120 weeks	12.5%
Member States consulted in the Contec pilot study in 2012			
Austria	Public, private or mixed	1600 hours	50%
Belgium [b]	Public or private	1 year	Not defined by law, generally 50%
Bulgaria	Public	Not reported	Not defined
Czech Republic	Public	4 years	33%
Denmark	Public	86 weeks *(approx. 1,5 year)*[c]	62%
Finland[d]	Public	3 years	All parts of the curricula are divided into practical and theoretical periods.
Germany (Lower Saxony) [b]	Public	> 2,220 hours *(approx. 2 yrs)*[c]	> 960 hours (43%)
Ireland	Public	Not reported	Not reported
Italy	Mixed	1000 hours *(approx. 6 months)*[c]	45%
Netherlands	Public	1, 2 or 3 years	Not defined
Poland	Public or private	880 hours *(approx. 4-5 months)*[c]	18%
Slovenia	Public or private	2718 hours *(approx.16 months)*[c]	37%
Spain	Public or mixed	1400 hours *(approx. 8 months)*[c]	31%

UK	Private or employer	Information not availabe	Not defined

[a] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

[b] Updated after the Contec study

[c] Own calculations, assuming a 40-hour/week

[d] Updated information after the Contec study: The training for the care assistant is only a part of practical nurse training. Normally it is 2 modules ('Support and guidance of growth' and 'Rehabilitation support') from practical nurse training plus a free choice module from some other vocational qualification or further qualification. Care assistant is not a qualification.

6 Main tasks and duties of HCAs

This chapter describes the main tasks and duties of HCAs within the EU Member States. Appendix H provides an extensive description of HCAs' tasks, collected by the current CC4HCA study and the Contec pilot study. Table 6.1 below lists the most common tasks and duties of HCAs across Europe and the number of countries where they are part of the role of HCAs. There are a number of core tasks that belong to the tasks and duties of HCAs in most Member States. These are mainly related to monitoring and measuring patients' vital signs, providing non-medical care for patients (e.g. preparing and serving food and drinks, sanitary care support), applying safety, quality and hygiene techniques, and providing some 'basic care'. The latter task is often not further specified. Another important task of HCAs in the majority of Member States is assisting other healthcare professionals. In a minority of countries, HCAs provide first aid to patients, assist in moving and transferring patients and provide support in activities of daily living (ADL). Tasks and duties that HCAs perform in just a few countries are supporting patients' relatives and providing education, supervision and professionalisation. When evaluating these texts, it appeared that a number of tasks are identified in most countries. These concern tasks that relate to supporting activities such as applying cleaning and washing techniques for equipment, monitoring and measuring vital parameters and preparing and serving food and drinks to clients/patients.

Table 6.1: Main tasks of HCAs in each country

Tasks and duties	**Part of HCA role in N countries**
Monitor and measure vital parameters	21
Apply cleaning and washing techniques (manual and mechanical) for equipment	16
Prepare and serve food and drinks to clients/patients	16
Apply quality and safety procedures	15
Support other health professionals	15
Apply hygiene techniques	14
Sanitary care support for patients	14
Communicate clearly in interacting with patients/clients	13
Provide basic care	13
Apply cleaning and washing techniques (manual and mechanical) for patients	9
Preventive care and first aid	9
Assist in moving and transferral of patients	8
Support in activities of daily living	8
Patient intake/discharge and documentation of care	6
Provide education/supervision/professionalisation	5
Support for relatives	3

The health professionals to which HCAs are accountable in practice varies between countries. In all countries, nurses are among the professionals to which HCAs are accountable, indicating the strong linkage between he professions. In seven countries, reference is made only to nurses, while in other countries the list of professionals to whom HCAs are accountable is broader, also including medical professions.

Table 6.2: Professionals to whom HCAs are accountable in practice (data based on the CC4HCA mapping study only)

Country	**HCAs accountable to**
Croatia	Head nurse of the department or physician
Cyprus	Ward assistants: to a personnel lead of the hospital; Dentist assistants: to the dentist
Estonia	Head nurse of staff nurse*
France	Mostly a nurse for clinical practice, but also a doctor if they work at the hospital.
Greece	Nurses*
Hungary	A healthcare assistant works under the supervision of nursing staff *
Latvia	Nurses, chief nurses, head of nursing*
Lithuania	Chief nurse/ nursing administrator of the department or unit of healthcare institution. Direct supervision of nurse who is implementing nursing plan*
Luxembourg	Doctors, chef nurses, nurses, physiotherapist, ergo therapist, diet assistants, speech therapists social worker, assurance dependence evaluators
Malta	Accountable to the qualified nurse working in the same context. In the absence of a nurse, such as at a radiology department or a social work clinic, the HCAs are accountable to the health professional present in the specific context.
Portugal	Nurses*
Romania	Nurse in charge or the chief nurse*
Slovakia	Nurses, midwives, doctors
Sweden	Not reported

* Only refer to nurses as the profession HCAs are accountable to

7 Knowledge, skills and competences of HCAs

The central question addressed in this chapter concerns the common set of fields of knowledge, skills and competences of HCAs: can this common set be defined and what does it look like? Based on the feedback from the country experts from all 28 Member States, a common set of the main knowledge, skills and competences of HCAs could indeed be constructed. To do this, the various terms and vocabulary provided by the country experts were interpreted, classified and allocated into different knowledge areas, skills and competences. In total, we identified 18 items related to knowledge, 16 related to skills and 4 related to competences. The skills of HCAs in practice were discussed in Chapter 6.

Table 7.1a shows the list of the 18 extracted common fields of knowledge of HCAs. It can be seen that "support in activities of daily living (ADL)" and "clerical/administrative/planning knowledge" are identified as part of the curriculum in most of the Member States. Other items of knowledge that were identified in at least 10 of the MS are "communication and interaction with patients and co-workers", "patient rights and rights and duties of HCAs", "legislation that falls within the scope of HCAs", "end-of-life and post-mortem care", "ethical principles of care provision", "positioning, lifting and transportation of patients (manually and mechanically)" and "inter-professional healthcare and teamwork". Items that are mentioned in four countries only (France, Latvia, Luxembourg and Portugal) are "knowledge of cleaning equipment" (manual and mechanical) and "specific patient groups".

Table 7.1a: Overview of knowledge items of HCAs commonly mentioned by country informants as being part of the HCA curriculum

Knowledge	**Part of curriculum in N countries**	**Part of curriculum in countries**
Support in activities of daily living (basic and instrumental)	19	AT, BE, BG, CY, DE, DK, EE, ES, FR, HU, IE, IT, LV, LU, NL, PL, PT, RO, UK
Clerical/administrative/planning knowledge	17	AT, BE, BG, CY, CZ, DE, EE, ES, HR, LU, LV, MT, PL, PT, SK, SI, UK
Communication and interaction with patients and co-workers	14	BE, CY, EE, DE, FR, HR, HU, IT, LU, LV, PL, PT, SI, UK
Patient rights and rights and duties of HCAs	12	BE, DE, ES, FR, HR, LV, LT, LU, PL, PT, RO, UK
Legislation that falls within the scope of HCAs / healthcare system knowledge	11	AT, DE, ES, FR, HR, IE, LV, LU, PL, PT, SK
End-of-life and post-mortem care	11	AT, FR, LV, LT, LU, MT, NL, PL, PT, RO, SI
Ethical principles of care provision	10	AT, BG, CY, EE, FR, HR, LV, PL,

Knowledge	Part of curriculum in N countries	Part of curriculum in countries
		PT, SI
Positioning, lifting and transportation of patients (manually and mechanically)	10	AT, BE, BG, CY, FR, HU, IT, LV, LU, PT
Interprofessional healthcare and teamwork	10	EE, DE, FR, HR, IT, LU, LV, PL, PT, SK
Human anatomy, physiology and pathology	8	BG, CY, EE, FR, HU, LV, LT, PL, PT
Cultural/gender/personal sensitivities	8	BE, CY, EE, ES, IT, LV, LU, PT
Hygiene rules and procedures in patient care	8	AT, BE, BG, FR, HU, LV, LU, PT
Pharmacology and non-pharmacological treatments	8	AT, CZ, EE, LT, LU, MT, SK, UK
Storage and organisation of equipment and materials	8	BG, CY, CZ, GR, LU, LV, MT, PT
Safe practice environment	7	AT, BE, FR, HR, HU, PL, PT
Specialist areas of care	5	CY, FR, GR, LU, PT
Cleaning equipment (manually and mechanically)	4	FR, LV, LU, PT
Specific patient groups	4	FR, LV, LU, PT

Table 7.1b provides an overview of the skills of HCAs that were extracted and classified from the country informant information. Among the many items, “monitor and measure vital parameters”, “prepare and serve food and drinks to clients/patients” and “support other health professionals” are common skills within the curriculum in a larger set of countries. Even though knowledge of the activities of daily living (ADL) was identified as the most common item of knowledge in the majority of countries, it is not necessarily identified as a skill in all of these countries.

Table 7.1b: Overview of skills items of HCAs commonly mentioned by country informants as being part of the HCA curriculum

Skills	Part of curriculum in N countries	Part of curriculum in countries
Monitor and measure vital parameters	21	AT, BE, BG, CZ, EE, ES, FR, GR, HR, HU, IE, IT, LU, LV, LT, MT, NL, PL, SK, SI, UK
Prepare and serve food and drinks to clients/patients	16	AT, BE, CZ, EE, HR, HU, IT, LU, LV, LT, MT, NL, PL, PT, RO, SK
Support other health professionals	15	AT, CZ, DE, EE, ES, FR, HR, IE, LT, LU, MT, PL, RO, SK, SI
Apply quality and safety procedures	14	BE, CY, EE, FR, HR, IE, IT, LU, LV, MT, NL, PL, PT, SK

Skills	Part of curriculum in N countries	Part of curriculum in countries
Apply cleaning techniques (manual and mechanical) for equipment	14	AT, BE, CZ, ES, GR, IE, LV, LU, MT, NL, PL, PT, RO, SK
Sanitary care support for patients	14	CZ, FR, GR, HR, HU, IT, LU, LV, LT, MT, PL, PT, RO, SK
Basic care	14	AT, BE, CZ, ES, GR, HR, LT, LU, MT, NL, PL, SK, SI, UK
Apply washing techniques (manual and mechanical) for patients	13	AT, BE, CY, CZ, EE, FR, GR, HU, IT, LV, LU, MT, UK
Apply hygiene techniques	13	AT, BE, CZ, EE, ES, FR, LU, LV, LT, PL, PT, RO, SK
Communicate clearly when interacting with patients/clients	13	BG, DE, HR, CZ, FR, HU, IE, IT, LU, MT, PT, RO
Preventive care and first aid	10	AT, BE, CY, EE, ES, HR, LV, LU, PL, SK
Assist in moving and transferring of patients	8	AT, LU, LV, LT, MT, PL, RO, SK
Support in activities of daily living	8	AT, DK, FR, HR, HU, LU, LV, RO
Admission, discharge and transfer (ADT) of patients and documentation of care	6	AT, BE, CZ, HR, IE, NL
Education/supervision/professionalisation	5	DK, HR, LU, LV, NL
Support for relatives	3	EE, FR, LT

Finally, Table 7.1.c presents the four common HCA competences identified regarding a “care plan”, “patient needs”, “patients’ safety and autonomy” and “communication”. These competences were only identified in 4 or 5 countries.

Table 7.1c: Overview of competence items of HCAs commonly mentioned by country informants as being part of the HCA curriculum

Competences	Part of curriculum in N countries	Part of curriculum in countries
Care plan	5	BE, BG, FR, LT, LU
Patient needs	4	BE, FR, LT, PT
Patients’ safety and autonomy	4	BE, BG, FR, PT
Communication	4	BG, FR, PT, LU

8 Regulation and registration of the HCA profession and education

In this chapter we answer the following questions:

- Is the HCA profession regulated and registered in the Member States? And if so, how is it regulated?
- Is this registration voluntary or obligatory, and if the first applies, what is the estimated registration coverage of healthcare assistants?
- How can the details and conditions of this regulation be described?

Directive 2005/36/EC defines a 'regulated profession' as follows:

> *"A professional activity or group of professional activities, access to which, the pursuit of which, or one of the modes of pursuit of which is subject, directly or indirectly, by virtue of legislative, regulatory or administrative provisions to the possession of specific professional qualifications; in particular, the use of a professional title limited by legislative, regulatory or administrative provisions to holders of a given professional qualification shall constitute a mode of pursuit. Where the first sentence of this definition does not apply, a profession referred to in paragraph 2 shall be treated as a regulated profession"*
>
> Directive 2005/36/EC, article 3, paragraph 1a

This definition is also used in the European Commission's regulated professions database, which contains information on the regulated professions covered by Directive 2005/36/EC. As explained in Chapter 4, the regulated professions database uses "second-level nurse" as the generic name referring to healthcare assistants. A comparative analysis between the national names for the HCA profession as reported by countries in the regulated professions database and the names as submitted by our country informants showed a high level of correspondence (see also Table 4.4 in this report). Based on the data in this database, we conclude that the HCA profession is regulated in 14 EU Member States, namely Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Italy, Latvia, Luxembourg, the Netherlands, Slovakia and Spain. While Malta is also included in the database, the database also notes that its level of recognition under Directive 2005/36/EC needs to be checked. For the moment, we have therefore considered the HCA profession as unregulated in Malta. It is worth noting that for a CTF to be possible, one of the conditions that have to be fulfilled is that "the profession or the education and training leading to the profession should be regulated in at least one third of Member States (Directive 2013/55/EU, Article 49a, paragraph 2, amending Directive 2005/35/EC). Looking at the regulation rules in the 28 MSs, this criterion would be fulfilled.

In addition, the CC4HCA study also examined how many countries entry to the profession is regulated in. For the 14 countries (Croatia, Cyprus, France, Greece Hungary, Latvia, Lithuania, Luxembourg, Malta, Portugal, Romania, Slovakia and Sweden) that were the subject of the mapping study, we see that entry into the HCA profession is regulated in eight. In five countries it is not and for one country (Latvia) the information is not available.

Table 8.1: Regulation and registration HCAs into practice in 14 Member States (data based on the CC4HCA mapping study only)

Country	**Entry regulation**	**Re-entry regulation**	**Regulation coverage**	**Registration body**	**Insurance requirements**
Croatia[a]	Yes	Yes	100%	Croatian Nursing Council (CNC)	Voluntary
Cyprus	Yes	No	90%	Ministry of Health	No
Estonia	No	-	-	No	No
France	Yes	No	N/A	No	No
Greece	Yes	No	100%	No	No
Hungary	Yes	Yes	100%	Chamber of Hungarian Health care Professionals + Health Registration and Training Centre	TBC
Latvia	-	-	-	Health Inspection	No
Lithuania	No	-	-	No	Voluntary
Luxembourg	Yes	Yes	N/A	Ministry of Health	No
Malta	No	-	-	No	No
Portugal	No	-	-	At the institutional level, by the employer	Yes
Romania	No	-	-	No	No
Slovakia	Yes	No	N/A	Slovak Chamber of Medical and Technical Staff	No
Sweden	Yes	No	-	-	No

- : Information not received or not available.

[a] Applies to 'Medicinska sestra; medicinski tehničar'. The Crotian Ministry of Health states that 'caregiver' is close to healthcare assistants, in Croatian translated „njegovatelj/njegovateljica", who are employed in the social welfare system for homes of elderly people and persons with disabilities. In addition, 'ordely' („bolničar/bolničarka") are close to healthcare assistants, who perform tasks in the hospitals. Both occupations are not health professions however, and not regulated. It should finally be noted that 'healthcare assistants' as such currently do not exist in Croatia, but the MoH is considering introducing them in the health system as 'assistant profession to nurses'.

Part III:

Exploration of a common training framework for HCAs

9 The views on the content of a potential CTF for HCAs

In the previous part of this report, a common set of knowledge, skills and competences of HCAs was investigated and defined, based on survey and consultation rounds among informants and representatives of the 28 EU Member States. The following three chapters describe the results of the Delphi study and the workshops for identifying whether there is a shared view for establishing a common position on a set of knowledge, skills and competences: what willingness is there across the EU to take this common set of core competences and follow a roadmap to start working on a suggestion for a CTF for HCAs? What is the desirability and feasibility of a CTF for HCAs within the EU?

The research questions related to this aim are:

- What are the visions of the representatives of the organisations identified, and representatives of other EU Member States?
- What consensus emerges from group discussions on a potential CTF and its components, in terms of applicability, usefulness, desirability and feasibility to implement?
- What is a common position on the minimum set of knowledge, skills, and competences of HCAs?
- What are further steps that should be taken to reach consensus on a minimum set of knowledge, skills, and competences that could support a CTF proposal at the EU level?
- To what extent did the workshops lead to a common position on the minimum set of knowledge, skills and competences of HCAs?
- What are the views of stakeholders who were not present on this position, and could consensus among them be achieved?
- If no common position can be determined that is shared by a minimum of one third of the Member States, what steps need to be taken in additional Member States to reach such a position?
- What are the next steps for a suggestion for a CTF, including a feasible timescale, a relevant legal framework and a plan for including relevant organisations or authorities?

To answer these questions, Chapter 9 focuses on the views of the EU Member States and European organisations regarding the content of a potential CTF for HCAs, while Chapter 10 goes into the views of these stakeholders regarding the desirability and feasibility of a CTF as a legal instrument to facilitate recognition of qualifications and examines the drivers and barriers that were identified. Chapter 11 focuses on the last two research questions mentioned above by discussing the potential further steps for exploration of a CTF for HCAs that can be taken by interested representative European, national professional organisations or competent authorities.

9.1 The level of support for a common set of knowledge, skills and competences for HCAs

To explore the level of support for a common training framework - a common set of knowledge, skills and competences - for healthcare assistants, the Delphi study and the workshops asked representatives from all EU Member States about their views on this matter. Article 49a of Directive 2013/55/EU, amending Directive 2005/36/EC, explains that a CTF "combines the knowledge, skills and competences required in the systems of training applicable in at least one third of the Member States". On this basis, we took the threshold of one third of the Member States, i.e. 10 Member States, to denote a sufficient level of support for a knowledge, skills or competence item to be potentially included in a CTF. As will be explained in detail below, this threshold was exceeded for all knowledge, skills and competence items that we asked about, showing a high level of agreement among competent authorities from the Member States about the content of a potential CTF for HCAs.

9.1.1 Results from the Delphi study

In the first two rounds of the Delphi study, competent authorities from 26 Member States were asked to indicate what knowledge, skills and competence items should or should not be included in a potential CTF for healthcare assistants. In total 48 items were presented and participants also had the option of adding additional items themselves. In Table 9.1, all items addressed in the Delphi are ranked according to the number of Member States that indicated they would *include* it in a CTF.

Table 9.1: Proposed CTF items in the Delphi rounds sorted by level of agreement to include them in a CTF (Category: S=skills item, K= knowledge item, C=competence item)

Category	Label of the item
S	Apply cleaning techniques (manual and mechanical) for equipment
S	Apply washing techniques (manual and mechanical) for patients
S	Attend to sanitary needs of clients/patients
K	Cultural, gender and other personal factors of the patient that impact upon patient care
K	Ethical principles in healthcare and awareness of these principles
K	First aid in emergency situations
K	Hygiene and infection rules and procedures in patient care
K	Manually and mechanically cleaning equipment
K	Principles of (manually and mechanically) positioning, lifting and transportation of patients
K	Rights and duties of HCAs
K	Supporting patients/clients in activities of daily living (basic and instrumental)
C	Work under the supervision of other healthcare professionals to assist them in care provision
S	Apply body hygiene procedures in patient care
S	Apply quality and safety procedures in patient care
S	Assist other healthcare professionals and have the required S to do so (depending on the type of other
S	Communicate clearly in interacting with clients/patients and family
K	Communication and interaction with patients and co-workers
K	Cooperation in a multi-professional team
K	Health and safety in the workplace and quality management systems
K	Legislation that regulates the professional activities of HCAs
S	Move and transfer patients
K	Patient rights
S	Prepare and serve food and drinks to clients/patients
S	Support patients in activities of daily living, including hygiene, comfort, mobility and feeding needs

C	Take responsibility for their actions and justify them professionally and ethically
S	Apply first aid in emergency situations
S	Conduct basic care activities
K	Storage and transportation of equipment and materials
K	The national health system and social insurance system
K	Basic knowledge on public health
K	Human anatomy, physiology and pathology
S	Support patients'/clients' relatives in patient care related activities
K	Specific patient groups, e.g. elderly
S	Conduct (delegated) activities related to ADT (admission, discharge, transfer) and documentation of care
K	ICT use and use of technological applications
S	Monitor and measure vital parameters and overall patient condition
C	Assess basic patient vital signs and care needs and requirements without supervision and report to other
S	Carry out social activities for specific age groups
K	Palliative care and pain management and post-mortem care provision
K	Chronic disease management
K	Specialist areas of care, e.g. diabetes care, at basic level
C	Assess the need for basic healthcare assignments without supervision
K	Clerical, administrative and care planning issues
K	Psychological support
K	Pharmacology, administration of medicines and non-pharmacological treatments
C	Show entrepreneurship
C	Carry out care assignments according to a care plan without supervision
S	Supply and distribute medicines

There was *much agreement* among Delphi respondents on the knowledge requirements that should be part of a potential CTF for healthcare assistants at the European level. Moreover, individual respondents' views on this remained consistent and few changes were observed between the various Delphi rounds. All knowledge requirements that we asked about exceeded the threshold of a minimum of 10 Member States (i.e. one third of the Member States), which implies that it could be part of a potential CTF for HCAs. In Table 9.2, an overview is given of all knowledge requirements that were surveyed. A significant number of respondents made a distinction between the *levels* of knowledge that HCAs should have on certain issues. For some requirements they indicated 'basic knowledge', for others they stated 'in-depth knowledge'.

There was *considerable agreement* among Delphi respondents on the skills requirements that should be part of a potential CTF for HCAs. Similarly to the knowledge requirements, individual respondents' views remained consistent through the various Delphi rounds and all skills requirements exceeded the threshold of a minimum of 10 Member States (see Table 9.3). Most respondents indicated that the skills requirements in a potential CTF for HCAs should stem from the duties that HCAs have in their everyday practice. More frequently and explicitly than for the knowledge requirements, respondents commented that the skills requirements should be further specified in terms of 'basic activities' or 'specialised activities'.

The degree of agreement among Delphi respondents on the competence requirements that should be part of a potential CTF for HCAs was *lower* than for knowledge and skills, and respondents showed little inclination to change their views. However, all competence requirements that we asked about exceeded the threshold of a minimum of 10 Member States agreeing that it should be part of a potential CTF for HCAs (see Table 9.4 below).

Table 9.2: Results of the CC4HCA Delphi rounds 1 and 2 for the minimum set of knowledge requirements for Healthcare Assistants

		ROUND 1	ROUND 2	ROUND 1	ROUND 2	CHANGE
	HCAs should have knowledge about....	**N of MSs that said 'yes'[6]**	**N of MSs that said 'yes'[7]**	**% of Delphi respondents who said 'yes'**	**% of Delphi respondents who said 'yes'**	**Between R1 and R2[8]**
Most consensus	Rights and duties of HCAs	22	24	100	100	=
	Ethical principles in healthcare and awareness of these principles	22	24	100	100	=
	Cultural, gender and other personal factors of the patient that impact upon patient care	22	24	100	100	=
	Principles of (manually and mechanically) positioning, lifting and transportation of patients	22	24	100	100	=
	Supporting patients/clients in activities of daily living (basic and instrumental)	22	24	100	100	=
	Hygiene- and infection rules and procedures in patient care	22	24	100	100	=
	First aid in emergency situations	*Not asked in R1*	24	*Not asked in R1*	100	N/A
	Legislation that regulates the professional activities of HCAs	22	24	96,3	96,6	+
	Manually and mechanically cleaning equipment	21	24	96,3	100	+
	Communication and interaction with patients and co-workers	22	23	100	96,6	–
	Cooperation in a multi-professional team	22	23	100	96,6	–
	The national health system and social insurance system	19	23	88,9	93,1	+
	Patient rights	21	23	96,3	96,6	+
	Health and safety in the workplace and quality management systems	21	22	96,3	93,1	–

[6] Member states with multiple competent authorities were aggregated to 'one vote'. We applied the following rule: if ≥ 50% of the competent authorities in a MS ticked 'yes', the answer for the MS as a whole was considered 'yes'.

[7] Member states with multiple competent authorities were aggregated to 'one vote'. We applied the following rule: if ≥ 50% of the competent authorities in a MS ticked 'yes', the answer for the MS as a whole was considered 'yes'.

[8] Key: = unchanged, + increase, – decrease

		ROUND 1	ROUND 2	ROUND 1	ROUND 2	CHANGE
	HCAs should have knowledge about....	**N of MSs that said 'yes'[6]**	**N of MSs that said 'yes'[7]**	**% of Delphi respondents who said 'yes'**	**% of Delphi respondents who said 'yes'**	**Between R1 and R2[8]**
	Storage and transportation of equipment and materials	19	22	92,6	93,1	+
	Basic knowledge of public health	*Not asked in R1*	21	*Not asked in R1*	89,7	N/A
	Human anatomy, physiology and pathology	17	21	77,8	86,2	+
	Specific patient groups, e.g. elderly	19	20	88,9	86,2	–
	ICT use and use of technological applications	18	19	85,2	79,3	–
	Palliative care and pain management and post-mortem care provision	16	17	77,8	72,4	–
	Specialist areas of care, e.g. diabetes care, at basic level	15	16	74,1	69	–
	Clerical, administrative and care planning issues	14	14	70,4	58,6	–
	Chronic disease management	*Not asked in R1*	13	*Not asked in R1*	65,5	N/A
	Psychological support	*Not asked in R1*	13	*Not asked in R1*	65,5	N/A
Least consensus	Pharmacology, administration of medicines and non-pharmacological treatments	12	12	59,3	55,2	–

Threshold for CTF

Threshold for CTF

Table 9.3: Results of the CC4HCA Delphi rounds 1 and 2 for the minimum set of skills requirements for Healthcare Assistants

		ROUND 1	ROUND 2	ROUND 1	ROUND 2	CHANGE
	HCAs should be able to….	**N of MSs that said 'yes'[9]**	**N of MSs that said 'yes'[10]**	**% of Delphi respondents who said 'yes'**	**% of Delphi respondents who said 'yes'**	**Between R1 and R2[11]**
Most consensus	Apply washing techniques (manual and mechanical) for patients	22	24	100	100	=
	Attend to sanitary needs of clients/patients	22	24	100	100	=
	Apply cleaning techniques (manual and mechanical) for equipment	20	24	92,6	100	+
	Communicate clearly in interacting with clients/patients and family	22	23	100	96,6	–
	Apply quality and safety procedures in patient care	21	23	96,3	96,6	+
	Move and transfer patients	21	23	96,3	96,6	+
	Support patients in the activities of daily living, including hygiene, comfort, mobility and feeding needs	21	23	96,3	96,6	+
	Prepare and serve food and drinks to clients/patients	20	23	92,6	96,6	+
	Assist other healthcare professionals and have the required skills to do so (depending on the type of other healthcare professionals)	20	22	92,6	93,1	+
	Apply body hygiene procedures in patient care	20	22	92,6	93,1	+
	Conduct basic care activities	18	22	85,2	89,7	+
	Apply first aid in emergency situations	20	21	92,6	89,7	–
	Support patients'/clients' relatives in patient care related activities	16	21	77,8	89,7	+
	Monitor and measure vital parameters and overall patient condition	15	18	74,1	75,9	+
	Conduct (delegated) activities related to ADT (admission, discharge, transfer) and documentation of care	15	18	74,1	79,3	+
	Carry out social activities for specific age groups	*Not asked in 1*	17	*Not asked in 1*	72,4	N/A
Least consensus	Supply and distribute medicines	*Not asked in 1*	12	*Not asked in 1*	51,7	/A

Threshold for CTF

Threshold for CTF

[9] Member states with multiple competent authorities were aggregated to a single vote. We applied the following rule: if ≥ 50% of the competent authorities in a MS ticked 'yes', the answer for the MS as a whole was considered 'yes'.

[10] Member states with multiple competent authorities were aggregated to a single vote. We applied the following rule: if ≥ 50% of the competent authorities in a MS ticked 'yes', the answer for the MS as a whole was considered 'yes'.

[11] Key: = unchanged, + increase, – decrease

Table 9.4: Results of the CC4HCA Delphi rounds 1 and 2 for the minimum set of competences for Healthcare Assistants

		ROUND 1	ROUND 2	ROUND 1	ROUND 2	CHANGE
	HCAs should be able to….	**N of MSs that said 'yes'[12]**	**N of MSs that said 'yes'[13]**	**% of Delphi respondents who said 'yes'**	**% of Delphi respondents who said 'yes'**	**Between R1 and R2[14]**
Most consensus	Work under the supervision of other healthcare professionals to assist them in care provision	21	24	96,3	100	+
	Take responsibility for their actions and justify them professionally and ethically	20	23	92,6	96,6	+
	Assess basic patient vital signs and care needs and requirements without supervision and report to other healthcare professionals as appropriate	15	14	70,4	58,6	–
	Assess the need for basic healthcare assignments without supervision	14	13	66,7	58,6	–
	Show entrepreneurship	11	11	55,6	51,7	–
Least consensus	Carry out care assignments according to a care plan without supervision	10	10	51,9	48,3	–

Threshold for CTF *Threshold for CTF*

[12] Member states with multiple competent authorities were aggregated to a single vote. We applied the following rule: if ≥ 50% of the competent authorities in a MS said 'yes', the answer for the MS as a whole was considered 'yes'.

[13] Member states with multiple competent authorities were aggregated to a single vote. We applied the following rule: if ≥ 50% of the competent authorities in a MS said 'yes', the answer for the MS as a whole was considered 'yes'.

[14] Key: = unchanged, + increase,– decrease

9.2.2 Results from the workshops

Based on the outcomes of the Delphi study, a common set of skills, knowledge and competence items that could be considered as the 'core' for the HCA profession was explored further during the Brussels workshop in April 2016 and online workshop in June 2016. During these workshops, not only were Member State representatives present, but representatives of a number of relevant European organisations participated in the discussions as well. As a basis for the discussions, we used the broad set of knowledge, skills and competence items that resulted from the Delphi study. The first main question addressed during the workshop was to explore if this list of knowledge, skills and competences (see Table 9.5 below) can indeed be considered as a 'core' for the HCA profession. In a round table setting, the participants were invited to share their viewpoints and answer the following questions:

- Can you point out items that definitely should be included in a CTF – why?
- Can you point out items that definitely should not be included in a CTF – why not?

Table 9.5: Proposed CTF items in the Delphi rounds sorted by level of agreement for including them in a CTF (Category: S=skills item, K= knowledge item, C=competence item)

Category	Label of the item
S	Apply cleaning techniques (manual and mechanical) for equipment
S	Apply washing techniques (manual and mechanical) for patients
S	Attend to sanitary needs of clients/patients
K	Cultural, gender and other personal factors of the patient that impact upon patient care
K	Ethical principles in healthcare and awareness of these principles
K	First aid in emergency situations
K	Hygiene and infection rules and procedures in patient care
K	Manually and mechanically cleaning equipment
K	Principles of (manually and mechanically) positioning, lifting and transportation of patients
K	Rights and duties of HCAs
K	Supporting patients/clients in activities of daily living (basic and instrumental)
C	Work under the supervision of other healthcare professionals to assist them in care provision
S	Apply body hygiene procedures in patient care
S	Apply quality and safety procedures in patient care
S	Assist other healthcare professionals and have the required S to do so (depending on the type of other
S	Communicate clearly in interacting with clients/patients and family
K	Communication and interaction with patients and co-workers
K	Cooperation in a multi-professional team
K	Health and safety in the workplace and quality management systems
K	Legislation that regulates the professional activities of HCAs
S	Move and transfer patients
K	Patient rights
S	Prepare and serve food and drinks to clients/patients
S	Support patients in the activities of daily living, including hygiene, comfort, mobility and feeding needs
C	Take responsibility for their actions and justify them professionally and ethically
S	Apply first aid in emergency situations
S	Conduct basic care activities
K	Storage and transportation of equipment and materials
K	The national health system and social insurance system
K	Basic knowledge on public health
K	Human anatomy, physiology and pathology
S	Support patients'/clients' relatives in patient care related activities
K	Specific patient groups, e.g. elderly
S	Conduct (delegated) activities related to ADT (admission, discharge, transfer) and documentation of care
K	ICT use and use of technological applications
S	Monitor and measure vital parameters and overall patient condition
C	Assess basic patient vital signs and care needs and requirements without supervision and report to other
S	Carry out social activities for specific age groups

K	Palliative care and pain management and post-mortem care provision
K	Chronic disease management
K	Specialist areas of care, e.g. diabetes care, at basic level
C	Assess the need for basic healthcare assignments without supervision
K	Clerical, administrative and care planning issues
K	Psychological support
K	Pharmacology, administration of medicines and non-pharmacological treatments
C	Show entrepreneurship
C	Carry out care assignments according to a care plan without supervision
S	Supply and distribute medicines

The discussions in the two workshops showed that in general the participants agreed that items ranked highest on the list are essential elements in a potential CTF. As the workshop was intended to let participants exchange their views and experiences in an open atmosphere, no voting was organised to actually 'measure' the number of participants agreeing with the CTF list and its various items. In fact, this was already done during the two Delphi study rounds. The aim of the workshop was to have a more in-depth discussion of the items. Various reasons why certain items should not be included or needed redrafting could be identified:

- Many participants indicated that they thought certain items should not be included, because they fall under the responsibility of other professions. These were generally the items at the bottom of the list (see Table 9.5). For example, many country representatives stated that HCAs in their country do not administer medicines. On the other hand, in some countries HCAs are expected to carry out this task. In other countries there are differences in the administration of medicines according to the settings in which HCAs work: in some settings HCAs are allowed to do this, in others not. Another example of an item that was considered to be outside the responsibility of HCAs was 'monitoring the overall patient condition' which is only done by nurses in certain countries. Various participants considered chronic disease management to be too specialised for HCAs.
- A second main reason for excluding or redrafting items was that they were considered to require too high a level of knowledge or to be at a specialised level. This, for example, applied to having specific knowledge of human anatomy. Other participants indicated that they thought HCAs needed to have only a basic level of knowledge in this field. 'Showing entrepreneurship' was also not considered to be an appropriate competence for HCAs by various stakeholders.
- Thirdly, it was also stated that certain items could only be included when the tasks were performed under supervision. Views on the level of autonomy of HCAs, however, varied between stakeholders. In some countries, for example 'carrying out care assignments according to a care plan without supervision' is out of the question and HCAs should always be supervised. Another example is that HCAs in one of the countries work under the supervision of nurses or other healthcare professionals for at least three years. Also, it can be the case that HCAs work without supervision, but only performing delegated tasks.

Various points were also raised that needed further specification in the view of the participants, for example:

- Conduct basic activities

- Clerical, administrative care planning issues
- Preparing meals: one participant indicated that if this includes cooking then it's not part of the training, but if the task is just to assemble and heat the food, then it is.

Sometimes the meaning was not clear to the participants of the workshop: e.g. one of the participants wanted to know what was meant by "mechanical cleaning".

In addition, some further issues for discussion were raised related to the content of a potential CTF:

- There was a general consensus that the core objective of a CTF should be patient safety and quality, besides promoting mobility;
- In line with the previous point, participants pointed out that if a potential CTF is set at too low a level, this may threaten patient safety. On the other hand, if the set of knowledge, skills and competences is at too high a level, this may be a barrier preventing countries from supporting a CTF;
- The items included in a potential CTF should be mutually coherent;
- Additionally, participants stated that a list of knowledge, skills and competence items should take account of:
    - The legal regulations at the country level with regard to knowledge, skills and competences. For example, in various countries there is legislation about which healthcare professionals are allowed to diagnose and prescribe.
    - The sectors in which HCAs are active, e.g. the hospital sector, home care, long-term care and, to a lesser extent, primary care and psychiatry.
    - Initial professional training and continuous vocational training
    - Patient perspective, including patient empowerment

The participants also raised a number of questions that may need further exploration:

- Should the items be categorised as having a low, average or, high level of complexity?
- Does the framework focus on general or specific settings, patient groups, levels and legislation?
- There is a need for further definition of what HCAs are, given the range of different definitions across the EU, and what CTFs are.

9.2 Support for additional criteria to be included in a CTF

A common training framework (CTF) is not limited to a minimum set of knowledge, skills and competences, but may include other additional criteria as well. We asked the Delphi participants to indicate which other criteria should be part of a potential CTF for HCAs (e.g. entry requirements for HCA education, language proficiency, and so on). There was a *high level of agreement* among Delphi respondents about the minimum set of other CTF criteria for Healthcare Assistants and all requirements that we asked about exceeded the threshold

of a minimum of 10 Member States agreeing that it should be part of a potential CTF for HCAs.

Table 9.6: Results of the CC4HCA Delphi round 1 on the minimum set of other criteria for HCAs

	Criterion should be part of CTF?	**% of Delphi respondents who said 'yes'**	**N of MSs that said 'yes'**[15]
Most consensus	3. Duration of HCA education	92,6	21
	6. Appropriate level of national language proficiency	88,9	19
	4. Theory-practice ratio of HCA education	85,2	19
	1. Entry requirements for HCA education	77,8	17
	2. Minimum age to enter HCA education	77,8	17
Least consensus	5. Continuing Professional Development requirements for HCAs	77,8	17

Threshold for CTF

Threshold for CTF

Duration of HCA education

92,6% of the Delphi respondents, representing 21 EU Member States, believed that a potential common training framework for healthcare assistants at the European level should include the duration of HCA education. There was little agreement between the respondents who agreed with this statement on what that duration should be; durations mentioned ranged from 3 months to 48 months, with an average of 17,4 months. The most frequently mentioned duration was 12 months (N=7), closely followed by 24 months (N=6).

Appropriate level of national language proficiency

88,9% of the Delphi respondents, representing 19 EU Member States, believed that a potential common training framework for healthcare assistants at the European level should include the appropriate level of national language proficiency which HCAs should have. There was little agreement among the respondents who agreed with this on what that level should be, based on the Common European Framework of Reference for Languages. The threshold of 10 Member States agreeing was exceeded for none of the levels (see below).

Level based on the Common European Framework of Reference for Languages	**N (%) of Delphi respondents who said 'yes'**
A1- Basic	0 (0%)
A2- Elementary	1 (4,2%)
B1- Intermediate	7 (29,2%)
B2- Upper intermediate	5 (20,8%)
C1- Effective operational proficiency or advanced	6 (25%)

[15] For member states with multiple competent authorities, we applied the following rule: if ≥ 50% of the competent authorities said 'yes', the answer for the MS as a whole was considered 'yes'.

C2- Mastery or Proficiency	1 (4,2%)
Don't know	4 (16,7%)
Total who believe that a CTF should include level of national language proficiency	**24 (100%)**

Theory/practice ratio of HCA education

85,2% of the Delphi respondents, representing 19 EU Member States, believed that a potential common training framework for healthcare assistants at the European level should include the theory/practice ratio that HCA education should have. There was little agreement among the respondents who agreed with this on what the ideal ratio between the theoretical and practical components in the education/training for HCAs should be. Eight respondents preferred a 50-50 ratio. A small majority of respondents (N=10) believed that the practical part should be greater than the theoretical part, but there was variation in the exact ratio, ranging from a 90:10 ratio to 60:40. Only a small minority (N=3) believed the theoretical part should be more extended.

Entry requirements for HCA Education

77,8% of the Delphi respondents, representing 17 EU Member States, believed that entry requirements for HCA education should be part of a potential common training framework for healthcare assistants. All respondents who agreed with this were asked to specify their answer:

	Entry requirements that should be part of a potential CTF for HCAs at European level	**N Delphi respondents who said 'yes'**	**%**	**No. of MSs that said 'yes'**
Most consensus	Secondary school graduation	18	85,7	16
	Successfully passing a health check	15	71,4	13
	Successfully passing an entry test	15	71,4	13
	Elementary school graduation	13	61,9	11
	Graduation at other school level	10	47,6	9
Least consensus	Relevant work experience	5	23,8	3

Threshold for CTF

Threshold for CTF

Most respondents agreed that elementary and secondary school graduation should be entry requirements, just as successfully passing of a health check and entry test. For graduation at other school levels and work experience, the threshold of one third of all Member States agreeing was not exceeded.

Minimum age for entering HCA education

77,8% of the Delphi respondents, representing 17 EU Member States, believed that a potential CTF for healthcare assistants at the European level should include a minimum age for entering HCA education. Among the respondents who agreed with this, there was considerable agreement on what age this should be. The most frequently mentioned age

was 18 (N=12), exceeding the threshold of 10 Member States agreeing. However, answers provided ranged from age 15 to 20, with an average of 17,3..

Continuing professional development requirements for HCAs

77,8% of the Delphi respondents, representing 17 EU Member States, believed that a potential CTF for healthcare assistants at European level should include Continuing Professional Development (CPD) requirements for HCAs. Ideas about what these CPD requirements should look like vary. While most respondents opt for learning credits to be obtained per time period, there are different ideas about the minimum number of credits and what time period should be used, ranging from 8 hours of CPD per year to 50 hours per year.

9.3 EQF level of a potential CTF for HCAs

Another condition that a common training framework should fulfil, according to Directive 2013/55/EU, amending Directive 2005/36/EC [16], is that it is based on European Qualification Framework levels. We therefore also asked our Delphi respondents at which EQF level a potential CTF for HCAs should be positioned. Even though a potential CTF would only have one EQF level, we asked respondents for the desired EQF levels for knowledge, skills and competences separately, as we expected there could be differences in their views on these dimensions (see Table 9.7). The degree of agreement among Delphi respondents on the appropriate EQF level was low for all three dimensions (i.e. knowledge, skills and competences). There was no common opinion about the 'right' EQF level. Respondents' views on EQF levels for knowledge and skills were most similar, with most respondents opting for either EQF level 3 or 4, but the degree of agreement was low with 41.4% being the highest percentage of respondents agreeing on any given EQF level. For the minimum set of competences, we found that more respondents would prefer a lower EQF level, but again there was no agreement on the exact level.

Table 9.7: Desired EQF level for the minimum set of knowledge, skill and competence requirements (based on round 2 of the Delphi study)

	EQF level 1	EQF level 2	EQF level 3	EQF level 4	EQF level 5	Total
EQF level for minimum set of knowledge	0 0%	2 6,9%	10 34,5%	11 37,9%	4 13,8%	29 100%
EQF level for minimum set of skills	0 0%	2 6,9%	12 41,4%	10 34,5%	5 17,2%	29 100%
EQF level for minimum set of competences	0 0%	7 24,1%	10 34,5%	6 20,7%	4 13,8%	29 100%

9.4 Conclusions on the content of a potential CTF for HCAs

Following the results from the Delphi survey and the CC4HCA workshops, various conclusions can be drawn regarding the views of the stakeholders consulted on the content

[16] The full Directive 2013/55/EU including all required conditions can be found here.

of a potential CTF. The Delphi study showed that there seems to be a general consensus among the competent authorities of the EU Member States about what the core knowledge, skills and competences of HCAs should be. This is most true for the knowledge items and least true for the competence items. Nevertheless, the threshold of one third of the Member States agreeing was exceeded for all three categories.

While there is a fair level of consensus on the content of a potential CTF, the level at which these content items should be situated was a topic of substantial discussion between Member States, with little agreement reached. First of all, there is the issue of whether the required knowledge, skills and competences should be formulated at a 'basic' or more specialised or in-depth level. Member States had different views on this. This became even clearer when looking at the second requirement for a CTF, that the knowledge, skills and competence items should be based on the levels of the European Qualification Framework. The degree of agreement among Delphi respondents on the appropriate EQF level was low for all three dimensions. Moreover, there were discrepancies between the views of the consulted stakeholders regarding the level of autonomy that HCAs should have and the required level of supervision, for example by nurses.

A final conclusion that can be drawn is that all stakeholders are of the opinion that a potential CTF should have additional requirements, for example concerning the theory/practice ratio in training and the language requirements, but again there is a lot of variation in the views on exactly what these requirements should be.

10. The desirability and feasibility of a CTF as a legal instrument

This chapter presents the views of EU Member States and European professional organisations on the desirability and feasibility of a common training framework for healthcare assistants as a legal instrument. Naturally, the desirability and feasibility of a CTF as a legal instrument are related to its content, as there is little point in discussing an abstract concept. However, the outcomes of the discussions presented here are at a broader level than merely the content of a CTF (as presented in Chapter 9). In the first section we will go into the drivers and barriers which were raised during two phases of the data collection (Delphi and workshops) as well as Member States' willingness to explore a CTF for HCAs further. Subsequently, we will outline what these findings mean for the feasibility and desirability of a potential CTF for HCAs.

10.1 Drivers and barriers for a CTF for HCAs

10.1.1 Barriers

From the Delphi study and the workshops, various barriers for a potential CTF for HCAs could be identified:

- One barrier is the lack of a uniform Europe-wide accepted definition of what an HCA is. This was often mentioned at the beginning of discussions and was acknowledged as a problem by all stakeholders. However, it did not prevent further discussions about a CTF from taking place.
- The main barrier seems to be the differences between and within countries concerning the level of HCAs and their education. During the workshop it was indicated that there are huge differences in the levels of education across Europe and this was seen as a major barrier to establishing a CTF. Participants expressed the view that they would not be able to agree to a CTF if it was not in line with their own national framework. Related to this, concerns were expressed that if a CTF were to be adopted with a very minimal set of knowledge, skills and competences and a low EQF level, this would downgrade the level of HCAs. This was mentioned by various workshop participants as a reason for not backing a CTF. In the Delphi study, 5 out of 31 participants indicated that if the final level of knowledge, skills and competences adopted in a CTF was too low compared to what there is now at the national level, this could even be a 'deal breaker' in terms of supporting a CTF for HCAs. On the other hand, the authorities from some countries were concerned that the level of requirements for HCA in their country could become 'too high', so that potential conflicts could arise with the nursing role.
- The potential threat of HCAs' knowledge, skills and competences overlapping with the scope of practice of other health professions, particularly nurses, was also deemed problematic and a potential barrier for a CTF. For example, one particular item that was mentioned in the workshop was the administration of medicines, which is often only done by nurses or doctors and not by HCAs. This is related to difficulties surrounding the need for definition of what an HCA is, in particular in terms of the level of autonomy and supervision. For three Delphi participants, it would be a 'deal breaker' if they were asked

to support a CTF that does not include the requirement that HCAs must work under nurse supervision or nursing quality control of their activities. Other participants also indicated that it is important that HCAs are supervised in their work, mainly by nurses. A related discussion point is that nurses might need new or additional supervisory skills to do this.

- Another potential barrier is the current educational and regulatory frameworks in various countries. These could potentially conflict with any CTF that is adopted. To study the level of discrepancy between the set of knowledge, skills and competences that country representatives could agree on and the current educational and regulatory frameworks, we included some questions about this in the final Delphi round. We found that for the complete set of knowledge, skills and competences, 15 to 17 Member States (depending on the specific item) indicated that their current educational and regulatory frameworks would match this set. Some 9 to 11 Member States indicated that there was a moderate or limited match and 1 to 4 Member States indicated that there would be no match with this set (for a complete overview of the results see Appendix I). Related to this, there were uncertainties about the future development of the HCA role at national level and how this would be affected by a CTF. Two participants also specifically indicated that legislation in their own country would need to be changed in order to be able to adopt the CTF.
- Before a CTF for HCAs could be adopted, a number of the Delphi participants indicated that consultation with all relevant stakeholders about a potential CTF would be needed. For two Delphi participants, not involving all stakeholders would be a deal breaker stopping support for a CTF. During the workshops, it was also emphasised that the views of HCAs themselves and patients on this issue should be considered as well. A difficulty is that there is no European level organisation exclusively representing HCAs.
- A final but important barrier that participants mentioned when discussing a CTF for HCAs was the uncertainty about the potential consequences once it is implemented. One of the uncertainties centres on the issue of cross-border mobility. As no CTF for any sector has been implemented yet, workshop participants expressed their concerns about whether a CTF would change mobility patterns or not. For countries where HCAs receive low salaries, this uncertainty is accompanied by concerns regarding an unintended increase in outflow and therefore a declining workforce. Related concerns regarded the traceability and quality control of HCAs working across borders, in particular if HCAs move from a state with no regulation to a state with regulation. Finally, uncertainties were discussed about the conditions for a country to opt out from a potential CTF and what the economic consequences would be.

10.1.2 Drivers

Apart from the barriers, most country representatives and some representatives from European organisations also saw multiple benefits of having a CTF and discussed various drivers needed for a CTF to come into existence.

- First of all, the development of a CTF was seen as an opportunity to improve the national situation regarding HCAs. For example, a CTF may create the possibility of upgrading and optimising skill mixes within countries. In other countries, where HCAs are not yet regulated, it was mentioned that national regulation processes could be accelerated and supported through a CTF. A couple of countries are also in the process of defining or redefining the role of HCAs or developing qualifications for HCAs, and these processes could be supported by a CTF as well.
- Benefits and drivers were also seen at the European level. As there is no clear vision yet on the role of HCAs at the European level, a CTF could create more transparency about what the standards are or should be across Europe. During the workshop, one participant indicated that there is a need for a European-level definition of HCAs: who they are, what they do, and the basic levels of those workers.
- Another important driver for a CTF to come into existence is its potential to facilitate cross-border mobility. As stated earlier in this report as one of the rationales, a CTF may contribute to cross-national collaboration and hence to a solution for healthcare assistant shortages in certain countries. At the same time, as was discussed earlier, a counter-effect may be that this leads to (greater) shortages in source countries.
- Finally, participants agreed that there is a growing need for healthcare assistants in many countries as a key healthcare profession. Awareness is high in all countries that more people need special care and the amount of chronic diseases is growing. This makes clarifying the position of HCAs in all MSs critical, in order to benefit fully from the HCA capacity in relation to the healthcare teams they are part of. This is an important result in its own right, regardless of the controversies as to whether a CTF is the right instrument at this moment for positioning the core competencies of HCAs and to exploring its development.

10.2 Willingness among EU Member States to explore a CTF for HCAs further

If there is one clear finding that stands out from this study, it is the willingness of Member States and European stakeholders to be involved in exploring a potential CTF for HCAs; however, there is as yet no common position on making a formal suggestion to the European Commission. This was evident from the high participation rates in the various steps of the study: the mapping exercise, the Delphi study and both workshops. In the final round of the Delphi study, we asked participants whether their country would be willing to engage in further exploration of developing a CTF for HCAs at the European level. Of the 31 respondents, 29 answered “yes”, one answered “no” and one did not reply. The respondents also indicated in what way their country would be willing to engage in further steps. The main ways they selected were:

- Further discussion about HCA regulation and education (n=7)
- Sharing experiences about HCA regulation and education (n=6)
- Via conferences, networking, workshops, etc. (n=5)
- Being involved in this and other studies on the same topic and play a ‘consultant role’ (n=5)

These results, from before the workshop discussions, indicated that the competent authorities across all MSs recognise the potential importance of a CTF for HCAs within the EU.

10.3 Conclusions

Based on the results of the Delphi study and workshops, there is still a large gap to be overcome when we explore the desirability of a CTF for HCAs on the one hand and its feasibility on the other hand. While there is a clear need for the role of HCAs across Europe to be strengthened (*inter alia* in view of the common challenges facing healthcare systems across Europe) and a CTF could make more transparent what the standards are or should be, many difficulties will have to be overcome before a CTF would actually be feasible. These difficulties are mainly related to the current differences between countries, especially in the level of education and autonomy of HCAs. Furthermore, there are a number of uncertainties with regard to a CTF that make countries hesitant to embrace the instrument at this moment. These are for example related to the potential effects of a CTF on mobility, as well as the legal consequences of a CTF and the option of opting out. A first important step that should be taken in further exploration of a potential CTF for HCAs is to include all stakeholders in the countries in the formal decision-making process, including HCAs themselves and hospital employers and trade unions, and to ensure that stakeholders are fully informed.

11. Further exploration of a CTF for HCAs and possible next steps

As described in this report, the CC4HCA study aims to explore the desirability and feasibility of a potential common training framework for healthcare assistants within the EU as perceived by all 28 EU Member States. As a final step in this exploration process, this chapter sketches a roadmap of what further exploration of a CTF for HCAs may entail and what issues may be encountered, should interested parties decide to undertake further exploration of a CTF for HCAs. It does this by first providing a short reflection on the willingness for such an exploration among the Member States versus their perceptions of the feasibility of a CTF for HCAs. Subsequently, we discuss potential further steps. To structure this discussion, we started from Directive 2013/55/EU, amending Directive 2005/36/EC, and the considerations that entered our study through various stakeholders.

It should be noted that this chapter and its discussion should not be considered as an actual first step on the road towards a formal CTF process. We would like to stress once again that the exploratory nature of this CC4HCA study means that it merely presents the possibilities and the building blocks from which an actual CTF process may potentially be started, should there be parties interested in doing so. In other words, an actual CTF development process should have a bottom-up approach and originate from the interested parties, namely either one or more Member States or European-level stakeholders.

We conclude this chapter with some reflections on the design and route of the CC4HCA study itself.

11.1 Starting point: willingness to explore a CTF for HCAs further

Based on the Delphi study and during the workshops, we observed willingness among EU Member States and European stakeholders to be engaged in further exploration of a potential CTF for HCAs. At the same time, as the previous chapters showed, the actual feasibility of a CTF for HCAs is challenged by a substantial list of barriers perceived by different authorities and stakeholders. This study shows that the desirability and feasibility of a CTF for HCAs are conditional and context-sensitive, and there is no full or integral consensus among all Member States on all elements for supporting a CTF for HCAs. As a final step in our exploratory study, we have sketched possible future steps in the development of a CTF for HCAs, should a number of organisations or authorities from different EU MSs be willing to start such a process.

11.2 Exploration of possible future steps in the development of a CTF for HCAs

To identify potential future steps in the development of a CTF for HCAs and the issues that interested parties may encounter, we started our exploration by analysing the formal conditions set out in Art. 49a of Directive 2013/55/EU, amending Directive 2005/36/EC. Because every common training framework must comply with the conditions set out in this

Directive, we analysed the extent to which 'building blocks' are in place that could be a starting point for fulfilling the formal requirements of the Directive in the case of healthcare assistants. Table 11.1 summarises the results of the CC4HCA study against the seven CTF requirements.

Table 11.1: Main study results and description of the building blocks for further CTF compliance/exploration already in place

A CTF must comply with the following conditions (Dir. 2013/55/EU, art. 49a):	**Main study results and description of the building blocks for further CTF compliance/exploration already in place:**
(a) The CTF enables more professionals to move across Member States	This cannot be predicted at the time. Some participants are concerned about the intended consequences of cross-border mobility of HCAs.
(b) The profession or the education and training leading to the professions is regulated in at least one third of Member States	The CC4HCA study found that: HCA profession is regulated in 14 EU MSs and HCA education is regulated in 22 EU MSs
(c) The CTF combines knowledge, skills and competences required in at least one third of the Member States	The CC4HCA study showed that there is consensus on what the knowledge, skills and competences of HCAs could comprise (> one third of the MSs agreeing), but the formulation of the level (basic versus specialised) and level of autonomy/supervision and other issues need further discussion.
(d) The CTF is based on European Qualification Framework levels	The CC4HCA study showed that it would currently not be feasible to reach agreement among the MSs on a single EQF level, but provided MSs with alternative interpretations of this condition. These could be explored further.
(e) The profession concerned is not covered by another CTF and does not benefit from automatic recognition under another system	HCAs are not covered by another CTF and do not benefit from automatic recognition under another system.
(f) Preparation of the CTF following a "transparent due process", including the relevant stakeholders from Member States where the profession is not regulated	The CC4HCA Study provided an initial building block for this by including representatives from all 28 EU Member States and a number of European professional organisations through the Delphi study and workshops.
(g) The CTF permits nationals from any Member State to acquire the professional qualification under such framework without being required to be a member of- or registered with any professional organisation.	This would be an effect of an actual CTF and cannot be determined at the time. Some participants are concerned about the representation of HCAs by professional organisations.

When looking at the formal requirements that every CTF must fulfil, we see that for two out of the seven conditions the building blocks for the HCA profession are already in place. This is the case for the conditions on regulation (b) and the lack of coverage by another automatic recognition system (e). These two conditions may be referred as "checkboxes", for which a clear answer can be provided. For the other five conditions, determining the extent to which building blocks are already in place is more complex. This is partly due to the fact that these conditions cannot be predicted (conditions a and g), are harder to quantify or judge (condition f), but also because the discussions during the workshops revealed a large number of complex discussion points associated with them (conditions c and d). Parties interested in starting a formal development process for a CTF for HCAs will therefore probably encounter difficulties with these conditions in the development process. We will therefore discuss the issues with regard to these particular conditions as found in our exploratory study on a CTF for HCAs.

Condition (a) The CTF enables more professionals to move across Member States
The nature of this condition precludes any comments being made about it, as the CTF itself is the legal instrument that (through automatic recognition) will enable more professionals to move across borders. This study did not investigate cross-border mobility as such, but we do note that there is discussion and specific doubts among stakeholders (notably among European-level organisations as well) about the intended or desired mobility of HCAs. These doubts are deepened by the lack of valid and reliable numbers on HCAs' mobility. As described in Chapter 4.3, mobility statistics are only available for 'second-level nurses', an occupational title that largely but not fully overlaps with the group of HCAs.

The lack of information about cross-border mobility as such does not necessarily have to be a barrier to creating a CTF. Still, it shows that is highly important to establish uniform data sources and statistics about HCAs across Europe to improve the monitoring of HCA mobility.

Conditions (c) The CTF combines knowledge, skills and competences required in at least one third of the Member States, and (d) The CTF is based on European Qualification Framework levels
We came across a number of discussion points among Member States and European level organisations about these conditions. The two main discussion points are:

- How should autonomy and supervision of HCAs be defined with regard to the set of knowledge, skills and competences that are selected for a potential CTF? And how are autonomy and supervision related to the other professions with which HCAs collaborate in practice?
- Can or should consensus be reached with regard to the qualification level of the knowledge, skills and competences of HCAs, if this is based on the European Qualification Framework? Can an 'appropriate' consensus-based educational level for HCAs at European level also be based on compliance with the MSs' national qualification system for HCAs and related professions?

With regard to these discussion points that most Member States are involved in, the CC4HCA report provides the basis from where these discussions can potentially be taken

forward. First, there is the set of knowledge, skills and competences that came out of the Delphi study, with more than one third of the Member States agreeing on their inclusion in a potential CTF. This list can be taken as a starting point for discussions at *both* the EU and national level about the qualification level, autonomy and supervision of HCAs. We found that discussions are pending in half of the Member States about the position of HCAs. This implies that national discussions should be taken into account, as qualifications and autonomy of occupations are determined by national-level legislation. In this context, it should also be noted that a CTF does not include or apply a certain level of autonomy. The level of HCAs' autonomy or supervision depends on the labour market in which they work. However, MSs and European stakeholders see this as a point to be kept in mind *already* when discussing/drafting a CTF. This is because it would make no sense to draft a core set of knowledge, skills and competences for HCAs if the required level of autonomy to actually use or put the content of this core set into effect is missing in practice. In other words, the current differences between countries in terms of the level of autonomy/supervision of HCAs are already *influencing* the discussion on the content of a CTF. This is why autonomy and supervision of HCAs is one of the issues to be discussed further, should parties be interested to work further on a CTF for HCAs. The outcomes of discussions at the European level and the exchange of practices among MSs may provide input for the discussions at the national level.

The CC4HCA study showed that the condition that a CTF should be based on the European Qualification Framework is a complex issue. The Delphi study showed us that there is a low level of consensus among Member States on defining the appropriate EQF level. It is also important to note that not all countries have a national qualification system that is linked to the EQF system. Moreover, during the course of the study, it also became clear that alternative interpretations of this condition for a CTF are possible, which makes the issue more complex. This issue will be explored further in the following section (11.3).

Condition (f) Preparation of the CTF following a "transparent due process", including the relevant stakeholders from Member States where the profession is not regulated

The CC4HCA study provides a starting point for fulfilling this condition if a CTF for HCAs would be proposedin future. It brought together representatives from all 28 EU Member States and a number of European stakeholders through the Delphi study and workshops. However, during the interactive discussions at the workshops it was also noted that a potential further exploration of a CTF for HCAs would require a broader involvement of stakeholders. This includes the national and European health employers and health employee organisations, patient organisations, and potentially healthcare insurers and Ministries of Health and Education, insofar as they are not (or do not overlap with) the competent authorities in each MS.

Condition (g) The CTF permits nationals from any Member State to acquire the professional qualification under such framework without being required to be a member of- or registered with any professional organisation

This condition is beyond the scope of the CC4HCA study. The condition implies the effect of a CTF that was not investigated and cannot be determined until a CTF for HCAs is actually prepared or proposed. This is a reminder that our study concerns the exploration of the pathway towards a potential CTF, including its desirability and feasibility.

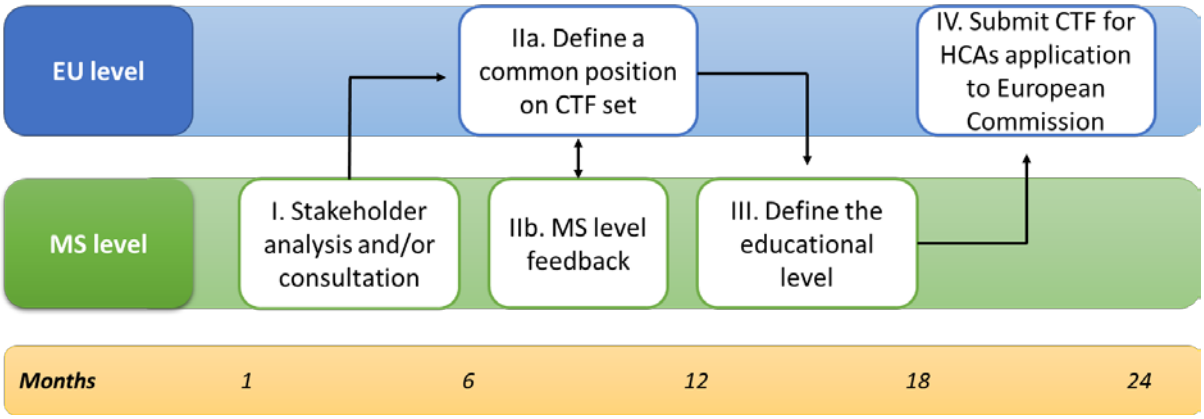
11.3 'Roadmap' fora potential suggestions for a CTF for HCAs

In this section we sketch out a 'roadmap' that may guide interested representative European or national professional organisations (or competent authorities) that may want to work on a suggestion for a CTF for HCAs. This roadmap forms the final step of the CC4HCA study's exploratory process and presents a number of recommendations.

At this point, it should be noted once again that these recommendations should not in any way be seen as the actual start of a formal CTF development process. The CC4HCA study remains exploratory, mapping out the position of HCAs in the EU Member States, and mapping out the positions of Member States with regard to the desirability and feasibility of a CTF for HCAs.

Figure 11.1 provides a schematic overview of the roadmap. Its elements will be described in more detail below. The timeline presents an estimate of the time the different steps (building blocks) would require. Experience of CTF proposals that are currently in preparation should confirm whether these estimates are realistic and feasible.

Figure 11.1 Schematic overview of roadmap to help guide interested parties that may want work on a suggestion for a CTF for HCAs



11.3.1 Major tasks

Based on the outcomes of the CC4HCA study, the roadmap recommends the following major tasks to be performed by interested parties to work on a suggestion for a CTF:

I. National-level stakeholder analysis and/or consultation

Before any further steps can be taken, a prerequisite is involvement of all relevant stakeholders at the *national* level in the development process of a CTF at the European level. This requirement was particularly emphasised by the European stakeholder organisations that participated in the study, stressing the point that the current and future position of

HCAs is often not solely defined by competent authorities. In many cases and practices, health employer and employee organisations are developing and implementing policies with regard to the training, occupation, allocation and development of HCAs. Competent authorities within each Member State should explore the need to consult and involve stakeholders in the development process of a CTF for HCAs. In those countries where the HCA profession and/or education are not regulated (on not yet), it will be critical that such a stakeholder analysis should be performed first to identify all the relevant parties. This also applies for Member States that have regions or countries with independent authorities for health policy and regulations (e.g. Germany, Italy, Spain, Sweden, UK). Obviously, stakeholder analysis at the national level will be more complex in Member States that have a decentralised or devolved healthcare system.

After all relevant national stakeholders have been identified, a stakeholder consultation process at national level can be conducted. Whether this is necessary, and whether it should have a formal or more informal character, will depend on the Member State situation. We recommend a stakeholder consultation to:

a. generally explore the willingness at Member State level to be engaged in a CTF development process, and
b. specifically explore the 'critical' conditions or a CTF (see section 11.2) and their implications for the national situation.

The first task recommended as part of the roadmap is ensuring that competent authorities and all other national stakeholders are fully informed and feel confident that they support the countries' standpoints at the EU level where applicable.

IIa. Define a common position on the knowledge, skills and competences as pre-defined learning outcomes

A second proposed step is that a common position is defined on the knowledge, skills and competences that a CTF should include. This consensus process should be initiated and supported by those representative European or national professional organisations or competent authorities that are interested in developing a CTF for HCA.

While this CC4HCA study actually found a high level of consensus on a set of generally defined knowledge, skills and competences of HCAs, the Delphi rounds and workshops also showed a critical discussion on the contextual factors that are relevant for the content of a CTF as well. This concerned the qualification level of the CTF elements, and the level of autonomy and supervision of HCAs. For example, while Member States agree that HCAs should have knowledge of the "principles of (manually and mechanically) positioning, lifting and transporting patients", there was no consensus on whether this knowledge should be at a basic level (to support other health professionals in the process) or more specialised knowledge (to independently transport all patient types). With regard to this second step of the roadmap, it can be noted that the list of knowledge, skills and competences resulting from this CC4HCA study is a useful base for further exploration. However, there is no common position among EU Member States on all elements of a CTF of HCAs.

To execute this second task of the roadmap, and to overcome the barriers found in this study, it is recommended that formulating *learning outcomes* for HCAs should also be an aim. Learning outcomes can be considered as a key pillar of the content of a CTF, from which the desired knowledge, skills and competences can subsequently be derived. It can be an alternative route for exploring whether EU Member States agree on the learning outcome definitions for HCAs in a potential CTF. If this is the case, these learning outcomes may be adjusted more easily to the national (legal) context of Member States. This might also lower the barriers with regard to the allocation of qualifications and the application of the EQF (see step III).

IIb. MS level feedback

Achieving a common position on the content of a CTF for HCAs should preferably be done iteratively. As noted before, it is critical that all representative actors at the European level and the national stakeholders are involved in this process. The desirability at the MS level of a CTF for HCAs should be monitored, as well as the feasibility of proposals made at the EU level. Continuous feedback to the MS level will allow problems or conflicts with national legislation to be identified at an early stage and taken back into the EU-level discussions.

III. Define the educational level of a CTF

If a common position on the knowledge, skills and competences has been defined, the qualification level of a CTF can be defined. It became clear from the Delphi rounds within the CC4HCA study that there is little agreement among the Member States on the EQF level that can (or should) be associated with the core knowledge, skills and competences of an HCA. Also during the workshop rounds, the assignment of an EQF level to the HCA profession and its core competences generated critical discussions. These centred around the risk of underemployment or overeducation of HCAs, the financial consequences for national healthcare budgets and healthcare employers if HCAs were to be 'upgraded', and unintended competition between professions on domains and positons. Again, the alignment between national and European qualifications was a general point of concern. In several countries, debates are currently ongoing on the risk of restructuring the national system of education (including health education), and the associated time and budgets that need to be allocated for European harmonisation.

One solution for overcoming this discussion that was discussed during the CC4HCA workshops is to interpret the requirement that a CTF should be based on European Qualification Framework levels in the following way:

- Make the CTF a reference for national qualifications;
- Link HCAs' national qualifications to a national qualification framework; and
- Link the national qualification frameworks to the European Qualification Framework (which is often already the case).

This allows the Directive's conditions for a CTF to be fulfilled, while each Member State's specific national context can be taken into account. Obviously this implies that the proposed roadmap explicitly changes between the MS and EU levels, as addressed in step IIb.

IV. Submit the application of a CTF for HCAs to the European Commission

After steps I to III have been completed, the interested parties can formally submit a proposal for a CTF for HCAs to the European Commission. A number of CTF applications are currently being prepared, as well as a further description of the guidelines that need to be followed. For this final step, it should be remembered that the results of this CC4HCA study are *not* aimed at actually submitting or preparing a CTF application for HCAs. The study provides information about (and insights into) the barriers actors can encounter when following the roadmap proposed in this section. The same needs to be remembered for the recommendations for overcoming these barriers based on the CC4HCA study results.

11.3.2 Recommendations for process management

The proposed roadmap consists of a number of core tasks to be undertaken, should interested parties be willing to start a formal CTF development process for HCAs. As this is a complex process including many stakeholders with different interests and acting at different levels, this needs to be managed if it is to succeed. The recommendations below are not part of the formal CTF process as such, but are listed to assist parties interested in developing a CTF for HCAs. The process management recommendations are based on the results of the CC4HCA study.

Ensure fully informed stakeholders to enable informed decision-making

An important barrier that was identified by the CC4HCA study was the uncertainty among stakeholders regarding a CTF as a legal instrument. Uncertainties were related to the potential effects of a CTF for HCAs and the legal and financial implications of CTF at the national level. This uncertainty can make Member States reluctant to explore a CTF, even if they could potentially agree on its content and educational level. Care must therefore be taken that as much detailed information as possible about a CTF is available for all stakeholders.

To achieve this, the European Commission could develop more in-depth background information on CTFs, apart from the (restricted) information that is available in Art. 49a of Directive 2013/55/EU, amending Directive 2005/36/EC, for example on the legal status of a CTF, opt-out possibilities for Member States and the possibility of adjusting a CTF to changing health workforce needs. At the national level, our study showed that stakeholders are uncertain about the financial consequences, consequences for national health systems, health workforce structures, and so on. National-level stakeholder consultations can only be organised effectively and better-informed decisions can only be taken about the implications of adopting a CTF for HCAs if the stakeholders are properly informed.

Ensure that potential language barriers are removed

A second important aspect of the CTF development process that was brought up by the CC4HCA study participants is language proficiency. The discussion about a CTF and the definition of a core set of knowledge, skills and competences may be very specific. In the CC4HCA study, stakeholders from 28 MSs participated, most of which do not have English as

a first language. During the Delphi rounds and the workshop, this sometimes hindered a thorough discussion of the meaning of knowledge, skills and competences sets and terms. In taking next steps for proposing a CTF and formulating its content, interpreters may need to be used at critical points in the process, e.g. in the formulation of learning outcomes.

Time management

Finally, time and momentum are essential and strategic conditions in the development process of new legal instruments such as a CTF. This is specifically the case for EU decision-making that take place in complex political and trans-national settings. As the CC4HCA study shows, it takes considerable time to collect all the relevant information for a CTF. Investment in networks and contacts is needed for identifying the right stakeholders and competent authorities for all Member States, and bringing them together to explore whether the conditions for a CTF can be met. This study shows what the current status and consensus are, but this can obviously change over time.

11.4 Reflections on the CC4HCA study

In terms of deliverables, the CC4HCA study had three main objectives:

1. To identify the representative national or European professional organisations (or competent authorities) that would be interested in working on a suggestion for a common training framework (CFT) for healthcare assistants (HCAs)
2. To set up a network that can establish a common position on a set of knowledge, skills and competences combining the knowledge, skills and competences required in at least 12 Member States.
3. To provide input (a common position on the set of knowledge, skills and competences and a feasible roadmap) for interested representative European or national professional organisations (or competent authorities) that might want to engage in working on a suggestion for a CTF for HCAs.

These objectives have been achieved to a large extent, but also appeared ambitious. This is largely due to the lack of standardised information about HCAs across Europe, the large diversity found across Member States, and the complexity of exploring all the relevant conditions for a potential CTF for HCAs.

Nevertheless, the CC4HCA study was successful in identifying and consulting the main country experts, competent authorities and relevant stakeholders in all EU Member States that exist specifically for healthcare assistants. This took a considerable time and it was not always clear who was the actual competent authority in a Member State, or for countries or regions within Member States. The actual 'measurement' of the two key concepts of the study – the 'desirability' and 'feasibility' of a CTF for HCAs among Member States –, was a challenging task. Different methods and sources were applied that led to the conclusions described in this report, but a number of options for additional research remain.

Another reflection at this stage is that it is hard to identify the network or a group of Member States that represents a common position for actually proposing a CTF for HCAs.

We have provided the *building blocks* and a roadmap for such a group or network, but, as noted in this report, the actual proposal or preparation of a CTF for HCAs is outside the scope of this study. We would like to stress once more that an actual CTF development process should have a bottom-up approach and originate from the interested parties, namely either one or more Member States or European-level stakeholders.

Reflections on the study approach

The approach taken by the CC4HCA study in exploring a potential CTF development process should not be considered as a 'golden standard' or 'blueprint' on how to conduct a CTF development process. Other approaches could also be taken and the choice of a certain approach depends partly on the profession concerned. For example, the European Association of Hospital Pharmacists is currently developing a CTF for hospital pharmacists and included an exercise for gathering existing evidence in their approach. This exercise includes an exploration of the experience and attitudes of hospital pharmacists to labour mobility (EAHP, 2016).

Finally, it should be remembered at this point that HCAs, as an occupation, have weak representation and limited organisational strength in many Member States and especially at the European level. The rationale of this study was to explore the desirability and feasibility of a CTF from a European and governmental perspective. Improving the position of all health occupations – including those that are poorly represented – is a collective responsibility.

Abstract

Background: This report presents the findings of the study 'Core Competences of Healthcare Assistants in Europe' (CC4HCA), which aimed to map out the position of healthcare assistants in all 28 EU Member States and explore the feasibility to adopt a common training framework for this professional group under Directive 2013/55/EU, amending the Professional Qualifications Directive (2005/36/EC), and interest among Member States for doing so.

Methods: Firstly, the roles of HCAs in all 28 EU Member States were mapped out, including identification of competent authorities and European stakeholder organisations. Next, a Delphi study of three rounds was organised with the competent authorities, followed by two interactive workshops with the Delphi participants and European stakeholder organisations.

Results: Country informants and Delphi participants from all 28 Member States actively participated in all parts of the study. The map of the current situation shows substantial variation between European countries in HCAs' roles in terms of education, regulation and the tasks they perform. There appears to be consensus among EU Member States on the need to define the role of HCAs across Europe. There was also consensus between EU Member States on the core knowledge, skills and competences of HCAs that could be included in a CTF, although further refinement would be required. At the same time, there was a great deal of discussion on the differences between Member States with regard to the qualification level that this set should have. In terms of feasibility of a CTF, Member States and European stakeholder organisations see barriers regarding a number of conditions that are formally required for proposing a CTF. There is also perceived uncertainty about a CTF as a new EU legal instrument and its potential consequences for national training, occupation and financing systems.

Conclusion: There is willingness among Member States and European stakeholders to be involved in further exploration of a potential CTF for HCAs. A possible roadmap has been sketched out for stakeholders at the national and European level who are interested in developing a CTF for HCAs.

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