Nursing a Grievance? The Role of Health Care Assistants in a Modernised NHS.

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The restructuring of employment and particularly the reform of work roles has comprised an integral feature of the Labour government’s modernisation agenda. In the NHS, policy attention has been directed at reshaping the nursing workforce to deliver more patient focused care and the contribution of health care assistants has become a more prominent feature of these reforms (Department of health [DH] 1999: 24-25). For trust managers, the requirement to deliver more timely and personalised care, measured against central government targets, is encouraging changes in professional boundaries. A further impetus for the reform of workforce structures stems from fiscal pressures to deploy staff effectively, reinforced by well publicised shortages in key health professions such as nursing (Royal College of Nursing 2004). The proliferation of assistant roles in the public services and their greatly increased numbers is viewed as integral to taking forward this reform agenda because ‘with the blurring of professional boundaries, there is scope for more creativity’ (DHa2005: 15). By contrast: ‘At its worst, the NHS has a very hierarchical tradition with professional divides …these can get in the way of good patient care’ (DH 2005a: 24).

Occupational groups affected by this modernisation agenda, including nursing, have sought to influence government reforms and recalibrate their relationship with the state to enhance their influence. It has long been suggested that in its quest for professional status nursing has modelled its professionalisation project on medicine (Ackroyd 1998). This attempt to establish occupational closure appeared to be bolstered by the election of a Labour government which encouraged nurses to extend their mandate, undertaking tasks formerly confined to doctors. Nurses’ jurisdiction was extended to enable them to prescribe drugs and manage their own clinics and the creation of nurse consultants was a tangible sign of the enhanced status of nurses. These reforms raise questions about the evolution and boundaries between different occupational groups. There has been a long-standing interest in the shifting boundary between the work of nurses and doctors (e.g. Wicks 1998), but less attention has been directed at exploring the division between the jurisdiction of nurses and support workers, termed health care assistants (HCAs). Some studies have examined the changing shape of nursing practice, including the role of HCAs, but the focus has been primarily on the consequences for nurses (e.g. Allen 2001). Health care assistants, however, are the most rapidly expanding staff group in the NHS, with an estimated 223,000 HCAs (seventeen per cent of the workforce) employed in the NHS (DH 2005b). This growth in HCA numbers has started to stimulate increased consideration of the HCA role in the nursing literature, but there remain relatively few studies of the impact of the modernisation agenda that place the HCA at the centre of the analysis (for an exception see Spilsbury and Meyer 2004).

Drawing on data from two NHS acute hospital trusts, this paper examines the role of health care assistants, the manner in which the boundaries between the role of HCAs and nurses is delineated and the consequences of the HCA role for the assistants themselves and nurses. This paper argues that the fluidity in the boundary between HCA and nurse roles potentially jeopardises the mandate of registered nurses. In a context in which the government’s modernisation agenda is seeking to erode occupational controls the development of the HCA workforce is reinforcing tensions.
with nursing staff as nurses seek to maintain their jurisdictional claims and reinvigorate the nursing professionalisation project.

**Professional Boundaries**

An increasingly dominant concern within the study of occupations, stimulated by the influential work of Abbott (1988), has been a concern with the fluidity and contested nature of occupational boundaries. The health sector with its plethora of competing occupations has been a fruitful arena in which to explore the strategies used by competing occupations to jostle for influence and legitimacy (Norris 2001; Timmons and Tanner 2004). The increased sensitivity to boundary disputes amongst public service occupations reflects the degree to which employers and policy makers are actively promoting more flexible employment practices designed to erode strict demarcations between occupational groups.

Nurses have been acutely aware of the consequences of altered nursing practice for their jurisdiction. Davies’s (1995) observed that in seeking a more technical role, nurses have discarded their long-standing focus on delivering essential patient care. She used the analogy of a polo mint with nursing represented as the hole in the middle. Nursing confronts a catch 22 dilemma because ‘anybody can do nursing because we cannot define what is special about it, but we cannot demonstrate its specialness, because many different people are doing it’ (Davies 1995: 90). The implication is that not only are other staff – especially health care assistants – filling the vacuum left by nurses, encroaching on their mandate, but this is much more likely to occur amongst occupations whose boundaries are hard to discern.

It has been suggested that despite an emphasis on the erosion of the status of professions, numerous occupations, such as nursing, are claiming to be professions and using an appeal to professionalism to advance their interests (Evetts 2003). She argues that it is important to distinguish two distinct traditions in analysing the appeal of professionalism: the normative and the ideological. The normative approach views professionalism as a system of altruistic values subscribed to by practitioners whose behaviour in adherence to professional values ensures a positive outcome for society. For much of the post war period policy makers assumed that these type of values animated public service professionals who subscribed to a public service ethos. This normative tradition has also been integral to nursing’s identity as ‘angels’ who selflessly focus on caring and who place the patient’s physical and emotional welfare at the centre of nursing practice (Davies 1995). Friedson (2001: 12 ) has been the most prominent advocate of the normative approach. He suggests that ‘professionalism’ is a distinct logic in comparison to markets or bureaucracies because it ‘refers to institutional circumstances in which members of occupations rather than consumers or managers control work’. Professionalism reflects a commitment to doing good work rather than securing economic gain. Friedson (2001: 209-210) has therefore expressed concern that the ‘assault on the professions’ by the state and employers is designed to reduce the cost and independence of the professions, which he predicted would result in many tasks being reassigned to less qualified workers.

This normative approach to professionalism has been subject to extensive criticism and professionalism as ideology has become the dominant perspective. The starting
point is less benign and assumes that in general professions are powerful and self-serving, encouraging other occupations to emulate and usurp the power and status of the traditional professions. Parkin (1979) drawing on Weber’s notion of social closure suggests that occupations embrace dual closure strategies based on usurpatory and exclusionary dimensions. Academic and professional qualifications what Parkin terms ‘credentials’ are a key mechanism used by occupational groups to restrict access to rewards and privileges. As applied to nursing (see Witz 1992) this dualism involves usurping the role of medical dominance, whilst seeking to exclude other groups, such as HCAs from below.

Many of these accounts which view the appeal to professionalism as a form of occupational control have been influenced by Larson’s (1977) analysis of the evolution of medicine and law. She termed the concept ‘the professional project’ to capture how by restricting labour supply and gaining public respect medicine and law became professions. Abbott (1998) extended the analysis of the professional project, placing inter-occupational competition for what he terms ‘job jurisdictions’ at the centre of his analysis. What unites these disparate accounts is an emphasis on the fluidity and contested nature of occupational boundaries and the strategies used by occupations to enhance their status. These writers, however, concentrate on the traditional professions, omitting consideration of lower-status assistant roles.

The role of the state in bolstering or undermining a professional project is assigned a relatively minor role in many of these predominantly US accounts. Abbott (1998: 63), for example, suggests that a legal mandate from the state follows long after public recognition. By contrast analysis of the new managerialism has centred on the degree to which state-sponsored managerial reforms have undermined the mandates of occupations such as nursing (Traynor 1999). Many of these accounts are far from sanguine about the extent to which occupations can maintain their jurisdictions in a shifting frontier of control between professional discretion and management prerogative (Broadbent and Laughlin, 2002), but they do not directly consider the type of assistant roles explored in this paper.

Ironically, despite these threats to public service professions, a discourse of professionalism is becoming more prevalent within organisations. Fournier (1999) suggests that as work becomes more flexible and indeterminate ‘the appeal to professionalism’ is being marshalled by employers and managerial groups within organisations as an indirect form of control. The idea of professionalism is used to inculcate appropriate work values within occupations not traditionally associated with the professions. Abbott and Merebeau (1998: 15-16) make a similar point that in being ‘professional” nurses are expected to be selfless but can also utilise the idea of professionalism to police the actions of those who aspire to professional status. The implication is that nurses’ behaviour is both shaped by notions of professionalism and they may use the appeal to professionalism to exert control over the work identities of other employees, such as HCAs. The degree to which nurses utilise such strategies in conjunction with forms of boundary work relate to the wider status of nursing within the health system.
The Changing Shape of the Nursing Workforce: the Search for Professional Status

The uncertain status of nursing has been examined in an extensive debate about the degree to which the professional project of nursing has been successful (Davies 1995; Savage 1985). In the past nurses have often been characterised as semi-professions because their training is shorter, their status and expert knowledge is less legitimised and they have less autonomy from supervision of their work than the medical profession (Etzioni, 1969). A key landmark was the 1919 Nurses Registration Act which gave nurses a protected title, but failed to achieve closure, because registration was not a pre-requisite for employment as a nurse (Dingwall et al. 1988: 88). Non-registered nurses remained a crucial component of the workforce and confronted with continuous recruitment crises throughout the 1930s the nursing professionalizers were unable to prevent the establishment of a lower level nurse, the State Enrolled Assistant Nurse, which achieved statutory recognition in 1943. Alongside enrolled nurses there was also an unplanned growth in nursing auxillaries, a grade with no formal training requirements, that was nationally recognised in 1955. The post war growth of nursing auxillaries and enrolled nurses as a proportion of the workforce contributed to grade dilution but also signalled that the division between nursing and non-nursing duties was fluid and the knowledge requirements of nursing remained contested (Thornley 1996: 165-166).

The reforms of nurse education at the end of the 1980s, termed Project 2000, was an integral component of a professional project because it resulted in a change from an apprenticeship model of training towards a university based model. Student nurses became supernumerary and it was envisaged that registered nurses would comprise up to 70 per cent of ward based staff. Project 2000 raised the qualification levels for nurses and by placing nurse training within universities distanced nurse training from the immediate service priorities of hospital managers. This was at a time when the power base of nursing was under threat from the new public management reforms of the Conservative government, introduced under the guise of general management (Bach 2004; Humphreys 2000).

Project 2000 was initially greeted as a triumph of occupational closure because it not only raised the credentials required of trained nurses, but also included the abolition of the enrolled nurse grade, by allowing conversion to registered nurse status. But the Conservative government was concerned at the compatibility of the proposals with the maintenance of adequate staffing levels because of the planned expansion in nurse numbers and the cost associated with such an increase (Humphreys 2000). Restrictions in funding ensured that health authorities were unable to replace their traditional student workforce with either the numbers or skill mix anticipated in Project 2000 and there were signs that this shortfall was being filled by the expansion of health care assistant staff (Elkan et al. 1994: 420).

The emergence of health care assistants

The role of assistants envisaged in Project 2000, termed ‘aides’ was heavily circumscribed as indicated by the opening sentence outlining the aide role: ‘In an ideal world, most would wish to see registered practitioners giving all the care needed’ (UKCC: 1986: 42). Continuing from this initial premise the term ‘aide’ was used because ‘assistant nurse’ was viewed as misleading and the emphasis was on the
‘notion of being a helper and not a practitioner’ (p.43). The idea that the helper grade could form the first step to practitioner status was forcibly rejected and anticipating subsequent uncertainties about role boundaries the UKCC suggested that it was ‘incumbent upon us to be clear about the boundaries of the practitioner role’ (p43) but provided no further illumination on this issue.

The Conservative government rejected this limited vision for assistants and proposed a much larger role for a trained cadre of assistants who would contribute directly to clinical care and could ultimately enter nurse training. To take this agenda forward the government established the National Council for Vocational Qualifications (NCVQ) to award NVQs to assistants (retitled health care assistants). A substantial further boost to the integration of HCAs in the NHS arose from the establishment of local pay in the early 1990s. Trust managers were encouraged to appoint them on local terms and conditions of employment with HCAs becoming the first grade of staff that were not subject to nationally determined pay and conditions. In a context of nurse shortages and tight budgets trust managers expanded the HCA workforce and reassessed traditional demarcations between registered and non-registered nurses (Bach 2004; Grimshaw 1999). Conservative governments therefore encouraged the reform of working practices, geared primarily to reduce costs through dilution and work intensification (Kendall and Lissauer, 2003: 9).

The Labour government’s workforce reform agenda has been more ambitious linked to attempts to make wholesale reforms of working practices. The Changing Working Programme, part of the NHS Modernisation Agency, was established to redesign staff roles underpinned by pay modernization which is intended as a catalyst for changes in working practices. The reduction of working hours for junior doctors and government initiatives to boost the status of nurses by the creation of nurse consultants has led to many tasks being delegated to nurses that were previously undertaken by junior doctors. Regulatory frameworks have been altered to accommodate enhanced roles, for example, nurse prescribing. These changes are taking place in a context in which ward based staff are under increased pressure to achieve a variety of government targets.

Cumulatively these changes have had important consequences in raising the profile of the HCA workforce. By establishing NVQ programmes for HCAs and with employers increasingly establishing an expectation that HCAs would attain NVQs, HCAs could no longer be stereotyped as an ‘untrained’ or ‘unskilled’ workforce (Thornley 2000: 455). For the government and employers HCAs present an opportunity to increase workforce capacity by growing its own professional workforce. Improved workplace based training along structured pathways could enable many HCAs to become registered nurses. The formalisation of training has also directed attention at the role that HCAs perform within the workplace. It has become widely acknowledged that HCAs undertake many of the activities such as observing and monitoring patients, and more technical tasks such as performing ECGs and applying wound dressings that are associated with the work of registered nurses. This suggests that at ward level the boundaries between nursing and HCA work is frequently blurred (Allen 2001; Spilsbury and Meyer 2004; Thornley 2000). The scope for such blurring of roles is increased because work organization is not Taylorised with ward managers having considerable discretion over the allocation of tasks (Ackroyd 1998). Finally as awareness has grown of the crucial role that HCAs perform at ward level, there has
been a vigorous debate about whether HCAs should be regulated and the form that any such regulation should take.

Overall, the fluctuating fortunes of the nurse professionalisation project can be calibrated in relationship to the shifting boundaries of registered/non-registered workforce and the increased numbers and prominence of the HCA role. Nursing has been more effective at encroaching into terrain vacated by medical staff than preventing usurpation from below. The Project 2000 reforms represented a hollow victory for nursing because it enabled the establishment of the HCA grade that did not fall within the remit of the nursing regulatory body (UKCC) or the nurses’ pay review body. The transfer of work previously undertaken by trainee and/or enrolled nurses to HCAs also represented a potential diminution of the control of nursing work at ward level (Humphries 2000). Moreover, the establishment of an NVQ training system for HCAs, controlled by employers rather than nurse training organizations, enabled greater control to be exercised over HCA work at trust level and by establishing transferable qualifications opened up a route into nursing, undermining attempts to establish an all graduate nursing profession.

These developments pose dilemmas for nursing which has become increasingly reliant on HCAs, but remains concerned that these trends represent a form of dilution which may undermine their quest for professional status. The unease amongst nursing elites at the current challenges to nurse status is reflected in redoubled efforts to define the core of nursing and to articulate its appeal to professionalism. The Royal College of Nursing has established a vision of the future nurse (RCN 2004) and it clearly delineates the contribution of the registered nurse:

‘Not all nursing is undertaken by qualified nurses...other people who ‘do nursing’ include ...a variety of care assistants and support workers. Their contribution to care is invaluable, but it is different from that of the professional nurse’ (RCN 2002: 3).

Similarly many nursing writers continue to assert that the role of ‘untrained nurses’ is ‘hugely different’ and this emphasis on difference seems motivated by concerns that the work of nurses is being devalued (see Hart 2004: 1).

This review of the literature and evolving role of the nursing workforce suggests that there has been relatively little consideration of the HCA role, which has been neglected by the new managerialism and the sociology of occupations literatures. Nurses continue to search for professional status to differentiate between nursing work and nurses’ work in a context in which the modernisation agenda has boosted the prominence of HCA roles. This paper examines the interface between HCAs and nurses by exploring three questions. First, what is the role of HCAs and what are the influences that shape the HCA role? Second, where is the boundary between the HCA and nurse role and how is this boundary established? Third, what are the consequences of the HCA role for the assistants themselves and for the nurses that they work with. For nurses do HCAs constitute a threat to professional identity and status, or an opportunity to focus on more technical components of the nursing role?
The Study

The research forms part of a larger ESRC-funded research project that examines the growth of assistant roles in education, health and social services. The research for this paper was undertaken in two London acute NHS trusts between June 2004 and July 2005, termed ‘Metro’ and ‘Tower’ to preserve anonymity. Full ethical consent was obtained from the appropriate Local Medical Ethics Committees.

The NHS trusts consisted of several hospitals as each trust had been through several mergers and amalgamations. Both trusts had achieved 2 star ratings in the government’s NHS performance ratings until 2005, when their rating declined primarily because of difficulties in achieving financial targets. In 2003-04 Metro had an income of almost £250 million and approximately 900 beds. Tower’s income was just over £300 million which supported 1000 beds. Both trusts committed a similar level of expenditure to staffing with wage bill at each trust comprising approximately £175 million. Metro employed almost 4,500 staff and this staffing profile includes approximately 575 medical and dental staff, more than 1500 nurses and midwives, and almost 300 HCAs. In 2003-04 staff turnover was 23 per cent. Tower employed 4,700 staff with a higher proportion of registered nursing staff than at Metro. The staff profile included more than 650 medical and dental staff, over 1500 nursing, midwifery and health visiting staff and almost 200 HCAs.

Because the trusts were in adjacent London boroughs, it enabled certain socio-economic and demographic conditions to be held relatively constant. Both trusts were located on the boundaries of inner and outer London, but both paid outer London weighting placing them at a disadvantage with inner London trusts. In particular recruitment and retention difficulties for registered nursing staff was a concern at both trusts, although it was a somewhat more prominent issue at Metro, impacting on the number and role of HCAs employed at the trusts. In the absence of HCA regulation, employers are able to shape the HCA role to their local circumstances and this can result in variations in HCA roles between medical and surgical specialties, for example, a distinctive role in intensive care has been identified (see British Association of Critical Care Nurses 2003). For this reason, in both trusts the sample was drawn from medical specialties, focusing on the care of the elderly wards, in which the largest number of HCAs were employed.

There were also strong similarities in the background and characteristics of the HCAs interviewed at each trust (Table 1). There were no significant statistical differences between the trusts despite the large differences on some of the variables in raw percentage terms. The percentage differences were most marked in terms of educational differences. Interviews with respondents indicated that at Tower, a significant minority of HCAs were from overseas, but despite having non-health related professional qualifications, they had frequently been unable to gain employment in their chosen field and had entered HCA employment.

The main fieldwork technique was interviewing. In total 60 interviews were conducted at the two NHS trusts, divided equally between the two trusts. This comprised interviews with 34 HCAs and 26 staff nurses, sisters and senior nurses.
Each interview lasted between 25 and 90 minutes and was recorded digitally on an MP3 player. Interviews were uploaded to a computer and transcribed using the open source software ‘Transcriber’. The interviews were supplemented by a short questionnaire that gathered structured information from HCAs on their background, qualifications and length of service. Relevant documentation was also collected on job descriptions, personnel practices and trust level policies.

The Role of HCAs

The HCA role has to be placed within the context of the organization of work on each ward. Wards contained between 22-28 beds divided approximately equally between male and female patients. Staffing patterns varied, with lower staffing levels for all categories of staff at night compared to the day. The care of the older person wards used a higher proportion of HCAs than other ward areas. A day shift comprised 7 staff usually 4 HCAs and 3 nurses at Metro and the reverse at Tower (3 HCAs and 4 nurses), reflecting the richer skill-mix at Tower. Sickness absence or annual leave, however, sometimes led to wards operating with a crew of 6 rather than 7. By comparison in other ward areas there were usually 2 HCAs on during the day in conjunction with 3-5 qualified staff. Student nurses were also sometimes present on the ward. The main role of HCAs is outlined in Table 2.

In the main duties listed in the HCA job description (Table 2), it is items associated with observation that are listed first. Observations were a crucial part of their job, which involved taking blood pressures, recording temperature, checking blood glucose levels and recording fluid intake and output. Food intake and output was also monitored on food charts. The intervals between observations varied depending on the dependency level of the patient, with some patients checked hourly whilst others were on four hourly observations. This role was viewed as pivotal by the registered nurses because as several HCAs explained:

“Well basically how I see it, we are the eyes and ears of the qualified nurses’ (HCA1M: 9.3).

Because HCAs interacted with patients more frequently than the registered nurses, an important role of HCAs was to alert them in a timely manner of any concerns or changes that they noticed:

‘they spend, I think, the majority of their time with the patients so they're able to spot things that sometimes if you're a trained nurse you can't because you're doing dressings, you're doing drugs, you're doing a million and one things. Whereas they have the time to, you know, speak to patients, they find out problems, they alert the nurses to them’ (RGN7T: 12:6).

‘I've just come back from a meeting there and we were saying HCAs, that their main role is observations… as nurses we should be doing it as well and checking on it. But we don't do it, and we don't have the time sometimes to do it’ (RGN5M: 3:17).

The ability of HCAs to be alert to changes in patients’ conditions and there sense of urgency and initiative in communicating any concerns to registered nurses was an important criteria that nursing staff used in evaluating the effectiveness of HCAs.
HCAs often referred to how busy registered nursing staff were, reinforcing the importance of their role in drawing attention to the changing circumstances of individual patients. It was the use of tacit or informally acquired skills, often derived from experience, that were frequently highlighted in describing this role:

‘I’ll go and say to the nurse in charge that the patient is very ill. I can see because he or she is not eating and they’re not responding to me very politely like they do, they’re normally a bit agitated so, so you know instantly, yes’ (HCA1M: 14.4).

The registered nurses acknowledged this key role of HCAs, although they sometimes expressed reservations about the level of responsibility placed on HCAs.

A substantial proportion of an HCAs workload involved supporting the personal needs of patients. This involved assisting with personal hygiene, washing, including mouth care, feeding, assisting them with mobility and assistance to avoid bed sores. HCAs would assist patients that needed help with feeding. They were also involved in helping patients to fill in the menu card. As an HCA explained:

‘the main thing is the patient, to take care of the patient, wash them, you know, take care of their daily activities of living, feed, the people that cannot eat, you have to help to feed them. Then you make their beds, everything about the patient’ (HCA4T: 6:32).

HCAs provided a substantial proportion of the hands-on care for patients and had more opportunities to talk to patients than registered nurses, providing important emotional as well as physical support to patients:

‘... we've had some patients who haven't had a visitor in three months, four months, so in a way we've had to try and fill up that void, so to speak, that gap and... and it's not easy at times, I mean you have to show some degree of understanding...that only comes from listening’ (HCA12T: 33:25).

In addition to their role undertaking observations and personal care, HCAs were involved in a variety of more specialised tasks. At both trusts there was a clear sense that HCAs responsibilities had increased in recent years and a presumption that HCAs should be encouraged to develop within their role. Nonetheless, it was in relation to these more specialist activities that there was greater variation, with the HCA role more extended at Metro than at Tower. There was also some variation in both trusts in the degree to which HCAs undertook more specialist tasks. HCAs highlighted tasks that they were involved in, which usually required additional training off the ward and subsequent supervision to ensure that they were competent to undertake the task. The main activities mentioned included:

- Maintaining the ward environment, for example, checking suction apparatus.
- Escorting patients to other departments.
- Documenting patient property.
- Answering the phone and passing on queries to nurses.
- Assisting nurses with dressings and medications.
- Taking blood from patients (only at Metro).
- Measuring ECGs (only at Metro).
Although a significant proportion of HCAs undertook a number of these tasks, particularly at Metro, it was a much less central part of their work than personal care and observations.

Explaining variation

The overall increase in the centrality of the HCA role masked differences in the breadth of the HCA role between the trusts, despite the majority of HCAs interviewed across both trusts working within the same medical specialty of elder care. A second source of variation within each trust arose from the personal attributes of individual HCAs and related to the degree that nurses viewed particular HCAs as ‘good’ HCAs.

In terms of the variation between trusts, Tower has a reputation for innovation. This dates back to its experimentation with patient focused care in the early 1990s which has continued with its development of clinical protocols and its involvement in the Changing Workforce Programme. The trust also faced a challenging environment in terms of recruitment and retention of registered nurses that increased the premium placed on an extended role for HCAs. It is located in an area of significant economic deprivation, with an unenviable reputation for crime, and a caseload which includes many patients that are reluctant to be in hospital. There are a number of flagship hospitals located within a 5-10 mile radius of the site which are perceived to be more attractive employers. Countering these disadvantages the trust was viewed as relatively non-hierarchical with an innovative nursing culture. Nurse managers suggested that it attracted forward looking staff that often trained at Metro and continued to work there for a lengthy period, reflecting the more general commitment towards a ‘grow your own’ workforce strategy. This ethos resulted in a willingness to allow HCAs to extend their role. As one of the ward managers explained:

‘I mean the [trust name] way has always been to challenge whatever it is and see if you can do it better... an awful lot of stuff that we do, you know, it's a suck it and see approach, if it works that's fine and we'll continue with it... We've seen a clinical need for somebody to be able to do this task and ...let's train you [an HCA] to do it instead. Fantastic’ (RGN8M: 38:28).

At Tower, nurse managers were also supportive of the development of the HCA role and had developed training programmes to facilitate HCAs becoming nurses. Although the trust also faced challenges in recruiting and retaining nurses, it had invested heavily in overseas nurses and employed more registered nursing staff than at Metro, Nurse managers suggested that the nursing culture was relatively formal and hierarchical and that there was some reticence amongst ward managers and registered nurses to delegate more specialist tasks to HCAs. One nurse manager in comparing the less extended role at Tower to the previous trust she worked at suggested that:

‘I think here as well people are quite conscious of roles and responsibilities and perhaps a little anxious about giving up some of the more extended roles to non-professional qualified staff (TM1T: 2.38)

A second source of variation within each trust related to the personal attributes and conduct of individual HCAs. The degree to which HCAs adhered to a set of
professional values was a key criteria that nurses used to distinguish the ‘good’ HCA from the ‘bad’ and this influenced the degree to which they were willing to delegate responsibilities and trust particular HCAs. At Tower these norms were made explicit as one of the duties within the HCA job description was to ‘Behave in a manner that is professional, positive and polite’. The ‘good’ HCA was therefore characterised as:

’an attitude of caring, wanting to be in this environment...obviously honest, open and reliable. I think they need to be practical, they also need a degree of initiative, you know, because a qualified nurse is not always by there side, and a good communicator’ (WMT: 31.54).

Good HCAs were viewed as possessing a set of caring and empathetic skills that indicated they adhered to the same professional values as nursing staff. Other attributes that reflected adherence to a similar set of professional values concerned a willingness ‘to muck in’, to take the initiative and to work relatively unsupervised. This enabled HCAs to significantly ease the workload of nursing staff. These attributes clearly mirror the emphasis within nursing of placing the patient-nurse relationship at the centre of nursing practice; distinguishing the nursing model of ‘care’ from the medical model of ‘cure’. The inclination to recruit from within the hospital environment or to seek out HCAs that had formal or informal experience of caring work can clearly be linked to the emphasis on these tacit skills.

By contrast it was the absence of professionalism that led to criticism and a reluctance to delegate more complex tasks to HCAs. At both trusts nurses identified a ‘tail’ of demotivated HCAs that nurses were unwilling to trust. In some cases this stemmed from a sense that HCAs were not competent to undertake the responsibilities they were delegated, could not be relied upon, or because they challenged nurses about the tasks allocated to them. Although nurses were sometimes reluctant to put a figure on it, at Tower, one registered nurse stated that about 60 per cent of HCAs could be relied upon. Nurses were especially critical if HCAs did not demonstrate a commitment to professional values:

‘what makes them bad is when they just don’t care’ (RGN6M: 12.37).

Overall, nurses valued HCA input greatly, and taking account of the workload pressures generated by government targets and staff shortages, the majority of nurses acknowledged that wards would not function in the absence of HCAs. It was the assistance that HCAs provided in relieving them of many aspects of routine patient care that was mentioned most frequently:

‘without Health Care Assistants I think, you know, my job would be so much, it would double, my workload would double’ (RGN7T: 31:35)

If we didn't have them, you know, you'd be working at a fifty percent slower rate (RGN8M: 42.8).

Boundaries between HCA and Nurse Roles

The increased reliance by nurses on the contribution of HCAs brought into sharp relief the question of where the boundary between the role of HCA and nurses is
drawn. Although this was not the dominant perspective, some nurses acknowledged that they could see little differentiation between their role and that of HCAs:

‘we’ve got exactly the same responsibility, and …it’s difficult to answer to be honest with you. We basically…I’d say we are qualified, I don’t know we’ve got a pin number and we can do a lot of things that the healthcare assistants cannot, like IV, medication, you know. But what’s the difference? I’d say that apart from the qualification I can’t see much, some of, most of the healthcare assistants work harder than we do, to be honest with you. But what’s the difference? It’s just a few things that we can do and they can’t’ (RGN1M: 15.44).

‘well some of our Healthcare Assistants now can do practically as much as some of our junior staff, it's just the fact that they don't have a degree or a diploma under their belt to say that I am a nurse. But you find that we have two Healthcare Assistants here who are just as good as any of our junior staff” (RGN7M: 16:42).

This created dilemmas for nurses, however, in that taking account of the fragile professional status of nursing too close an association between the work of nurses and HCAs could serve to undermine the professional project of nursing staff. At the same time nurses recognised their reliance on HCAs and highlighted the interdependence of HCAs and nurses and that ‘we can’t do without each other’. Whilst acknowledging the contribution of HCAs, nurses sought to maintain a differentiation between their work and that of HCAs and this created tensions in the relations between nurses and HCAs. In a context of considerable overlap between roles, nursing staff engaged actively in establishing the boundaries between their work and that of HCAs.

First, an integral element in this attempt at boundary work concerned defining HCAs as primarily supportive of the nurses role:

‘Well they are our assistants’ (RGN1M: 3.31).

‘They are effective helpers, very effective' (RGN2M: 1.43).

This contrasted with the perspective of HCAs who defined their role as distinct from nurses and emphasised the patient orientated nature of their work rather than primarily assisting nursing staff:

‘And basically our job here is, as far as I concerned, do everything that you would do for yourself for the patient, and that’s the way I see it’ (HCA7M: 4.22).

‘I work with the patient, not to the nurse, because we have our own role in this ward’. (HCA13T: 4:39).

Second, nurses highlighted the credentials they possessed which they suggested resulted in higher standards of patient care. Credentials associated with professional workers, especially higher standards of knowledge, a more holistic overview of patient care rather than being ‘task orientated’ and an awareness of the importance of undertaking particular tasks in a timely manner were used as illustrations to explain the difference between the care given by HCAs and nurses. Ward managers and staff nurses expressed a preference for a higher ratio of registered to unregistered staff and
in some cases favoured an all trained workforce which they argued would produce better standards of care:

‘in care for the elderly you have a high proportion of Health Care Assistant...research have shown sometimes if you have more qualified, you know, probably, they will probably deliver higher level of care’ (WM1T: 22:35).

‘If I had my way and money was no object, then I would have qualified nurses throughout the wards.... they're trained and they're registered, they're accountable’. (RGN3T: 28:2).

Third, nursing staff pointed out that just because HCAs and nurses undertook many of the same activities it was erroneous to conclude that their role was interchangeable. Nurses argued that they undertook tasks from a vantage point of a higher level of knowledge and understanding and these credentials had important implications for patient outcomes. Various examples were cited of the limitations of HCAs which differentiated the contribution of nurses and HCAs:

‘the qualified nurses would be able to do a lot more, you know. Because like I said, the Health Care Assistant is very limited in what they can do...[if a relative is asking] ...why the patient are on antibiotic.... why are they going for an investigation. I mean a qualified nurse would really answer this question, and you can't expect the Health Care to’ (WM1T: 23:45).

‘They do ECGs but they, obviously they don't know how to interpret them, but they would know what a normal one was. And if something is different, they'd come and show you’ (RGN5M 5:49).

Finally, nurses reminded HCAs that their role was different from that of the registered nurse and sought to reinforce their own mandate and areas of jurisdiction. Nurses reminded HCAs of what they could and couldn’t do, referred to their own registered status and emphasised that they were subject to a professional code of conduct. Ultimately they could lose their ‘pin’ (their nurse registration) if HCAs transgressed:

‘you have to keep on reminding them you've got some limitations and you need to know your limitations. Because some of them wouldn't really know what their limitations are, and if you're just being a bit tricky and ask them do you mind to just give this medication, and they would do it, and you would just say actually you're not meant to do that, you know,(RGN4T: 3.46)

A staff nurse at Metro made a similar point:

‘they do go a bit too far, and you have to pull them up on it and go, why did you do that?’ (RGN5M: 22.51).

Nursing staff were supported in their attempts to distinguish between the role of nurses and HCAs by nursing management, especially at Tower. At both trusts the management of HCAs was being formalised and they were subject to annual appraisal, encouraged to access training and could also consult their job descriptions to clarify their role. Several respondents alluded to their remit by referring to their job
description and outlining the functions and boundaries of the HCA role was an important aspect of HCA training:

‘one of the first sessions we do on the [HCA] course is around roles and responsibilities, I mean we literally have tick box lists of what they think they should do and what they think qualified nurses should do. And it's quite interesting seeing the crossover and, you know, the arguments, if you like, the debate that arises from that. But actually it's good because it raises awareness about what the different roles are and why they are different as well’. (TMIT: 41:32).

HCAs were mindful of their jurisdiction in responding to patients:

‘Sometimes he's asking oh can, nurse I am in pain, can you give him painkiller. I said look, I'll call my colleague because he's in charge, I'm not allowed to give you, you know, painkillers’ (HCA6M: 16:51).

‘I would not do it, yes, especially if it's not in my powers, yes, or out of my boundary to do what the patients ask [e.g. dealing with their money]. I'd always highlight it to the nurse in charge or the Charge Nurse, yes, I would never take it onboard myself... (HCA1M: 19.1).

Consequences of HCA roles

For HCAs

The increase in the number of HCAs and the extension of their role indicates that a number of actors have a stake in the development and effectiveness of HCAs. The majority of HCAs expressed satisfaction with their role and in particular HCAs enjoyed the contact with patients and the opportunity to talk to them when they were assisting them with washing and feeding. HCAs cherished the distinctive relationship they developed with patients:

‘you know, they will tell you any little thing, that you go and sit with them if Staff Nurse are busy...you have more time with the patient, you know, and sometime you can reassure them. If they're going down to have a procedure done and you see them look down or, you know, upset, you'll go and ...sit down with them a little and listen to what they've got to say...they trust you and they will tell you anything. The doctor just leave them and they don't tell the doctor that they've got a headache, they see you [and] say 'oh I've got a headache’. (HCA11M: 23.9).

‘Looking after the patients, I love looking after the patients, washing them and talking to them and having a laugh with them, you know, I love that, and feeding them’, (HCA4M: 10:55).

At both trusts many HCAs commented on the positive atmosphere at ward level in which ‘everyone mucks in’ and another HCA commented that ‘the manager wash patient to’. HCAs also valued the encouragement they received to undergo further training and often spoke warmly of the management style of their ward manager. Nonetheless although there was some variation between HCAs, high workloads and the stressful nature of HCA work resulted in tensions between HCAs and nurses.
Frustration amongst HCAs related to workload distribution between them and registered nurses which they viewed as inequitable, a dislike of their lowly status on the ward environment, and a perception that their work and that of registered nurses differed little in practice. This also gave rise to resentment at their relatively poor pay. Some registered nurses believed that HCAs had limited insight into what their role entailed and felt uncomfortable about the influence that some HCAs could exert at ward level.

The starting point for considering these issues concern HCA views of the role of registered nurses. HCAs acknowledged that nurses undertook a wider variety of tasks, especially in relation to administration of medication, IVs and paperwork, but they tended to view the role of nurses as essentially similar to their own job:

‘The only thing is that we don’t do, that’s medicine, but you do everything else as a nurse’ (HCA15M: 5.9).

‘It's, it's the same, we do the same thing, it's just that they, they do like, they do medication, we don't, they do what is that? ECG, well, we are being taught to do that anyway’ (HCA9T: 25:4).

Because HCAs argued that their role was very similar to nursing staff and they had limited awareness of the role of nursing staff, they expressed frustration about the distribution of work:

‘some of the nurses do help, you know, if a patient want a bed pan they just go and grab it instead of calling. But some, they don’t want to do it no matter what, full stop’ (HCA13M: 6.6).

‘because there's some nurse that they're not helping, they'll always say busy, busy, but sometimes they are writing, they are taking their time in writing their cardex’ (HCA13T: 9.46).

HCAs were sensitive not only to the amount of work they were allocated, but also the type of work they were expected to perform and resented having the most unpleasant tasks always allocated to them:

‘I was the only Healthcare and I was looking after a patient and there was two qualified nurses standing right there, and this guy is asking for the commode...they had to call me all the way from the top, leave the other patient and come down to get the commode. And I got really angry that morning, because I mean that was really unfair, it wasn't nice at all’ (HCA16M: 18.31).

For HCAs these type of occurrences signified a lack of respect for the role they fulfilled and this was given concrete expression in the low wages they received with most HCAs placed on Grade A (£10,710 - £13,022) compared to higher earnings of newly qualified D grade nurses (£17,610 - £19,437). A number of staff, both HCAs and nurses, suggested that HCAs did not feel good about themselves and an HCA graphically eluded to his sense of invisibility within the hospital hierarchy:
'you know what hurts me most...an you believe that I stopped greeting the doctors, they don't respond to your greetings...: I mean over the years I've realised it and I don't say hello anymore. Now, such thing play on your intelligence’ (HCA9T: 47:45)

Other HCAs referred to numerous slights that they experienced in their working lives as nursing staff sought to reinforce occupational boundaries, for example, by stating ‘that they were not meant to wash patients’. A frequently mentioned example was that nurses often referred to the HCA grade in a pejorative manner stating ‘you’re just an A grade’. Nursing staff directed some of their most acerbic comments at HCAs that overstepped the boundary of what was viewed as acceptable conduct, for example, pointing out poor nursing practice brought immediate sanction:

‘they will take offence and say imagine an A grade... no, it wouldn't be like this it would be [louder]: ‘imagine Tony imagine the A grade telling me, you know, to do this, or maybe to wash my hands ...imagine the audacity of an A... it wouldn't be Tony any more, an A grade...’(HCA9T: 37:26).

For nurses

For nurses the increase in the centrality of HCAs had implications for their working lives. Although it is often suggested that HCAs are a neglected and invisible workforce (Thornley 2000: 452), registered nurses suggested that HCAs had little conception of the additional responsibilities they undertook and the manner in which they spent their time, when not engaged in direct patient care. These activities were largely invisible and hidden to HCAs. RGNs detailed some of the demands on their time:

‘we have to you know see to the doctors’ demands, relatives, we have to answer queries...we have to go to meetings’ (RGN2M 10.6).

‘Discharge planning, we do an awful lot or trying to link up with social services and getting people out of here’ (RGN5M: 9.32).

Registered nurses expressed some frustration that many HCAs didn’t recognise the difference between their job and that of an HCA which could lead to tensions:

‘some of them would be, would be arguing about their job because they would start counting their jobs. They would just say, I've washed a patient, I've done obs, I've done blood sugar, I've done monitoring and stuff, but for a nursing job, we've done more than that, and I think they don't seem to recognise that there’s a big difference between, between the nurse and the A grade’ (RGN4T: 5:54)

As this quotation illustrates, some of the dynamics between nurses and HCAs were reinforced by the different criteria used to judge their own contribution at ward level. HCAs tended to highlight the number of tasks that they had undertaken in terms of the number of patients washed etc. Nurses emphasised, in keeping with a professional ideology of ‘holistic care’ and an emphasis on teamwork, that overall patient outcomes were most important.

It was difficult in practice, however, for nurses to sustain the emphasis on ‘holistic care’ when nurses had delegated a sizeable proportion of their role in direct patient
care to HCAs. Nursing staff had mixed feelings towards HCAs providing more hands-on care and developing close relationships with patients, mirroring wider debates about the appropriate roles that nurses should occupy within a modernised health service. There were quite polarised views between nursing staff. For some nurses patient contact and other aspects of basic care were viewed as not essential and could be delegated to HCAs. Other nurses, however, expressed anxieties about the degree to which they were becoming distanced from direct patient care. A staff nurse argued that patient care ‘is becoming Americanised’ by which he meant that substantial amounts of time were being taken up with forms of audit, documenting procedures and other forms of administration (e.g. chasing social services). He concluded that ‘quality patient care is going down’. A ward manager expressed similar sentiments:

‘They have more patient contact, unfortunately something I don’t particularly like because I think staff nurses should work with the HCA in terms of washing and dressing and basic hygiene in order to perform teaching and ensuring that standards are kept up to date, but it doesn’t always work out that way’ (WM1M: 19:3).

Other ward managers were more pragmatic about the shift in nursing practice and tried to capitalise on the empathy that HCAs established with patients which was attributed to HCAs being more ‘down to earth’ than other staff. These managers valued the information about patients’ concerns that HCAs uncovered. Ward managers were also acutely conscious of the requirement to meet government targets. This meant that activities had to be completed in a timely manner and as HCAs were less likely to be called away to do other things, some ward managers viewed it as logical for HCAs to do the bulk of washing and personal care.

Finally, some nurses also alluded to the influence of HCAs. For them it was HCAs rather than qualified staff that wielded too much influence at ward level because of the length of service and intricate knowledge that HCAs had gained of ward routine. Other nurses stated that some more recently qualified or younger nurses were hesitant in directing long-serving HCAs. In some cases this was attributed, rightly or wrongly, to cultural factors with the example being provided of the reluctance of Filipino nurses to direct the activities of older HCAs because of cultural norms of deferring to the older generation. These perspectives were reflected in the comments of nurses:

‘I think it is actually the Healthcare Assistants that manipulate the nurses’ (RGN6M: 13.44).

‘you'll find that the Healthcare Assistant will end up kind of ruling the younger juniors. So that's when you kind of have to kind of stab it in and just give them, the nurses, the younger ones that is, just that bit more of a push and kind of say look, don't be afraid to be a bit bossy, it's all part and parcel of the job’ (RGN7M: 15.2)

Summary and Conclusions

This paper has examined the evolution of the nursing workforce and how the Labour government’s modernisation agenda has increased the prominence of the health care assistant role. This paper has examined the structure and content of the HCA role and the boundaries with the work of nurses. In considering these questions the review of the literature indicated that the new public management literature has given scant
attention to assistant roles focusing on the interface between managers and professionals. The literature on the sociology of occupations has highlighted the prominence of professional projects and more recently emphasised the appeal to professionalism as a wider range of occupations try to attain professional status and to bring other occupational groups, such as HCAs, under their sphere of control. For nursing the ‘professional project’, epitomised by the revamp of nurse education termed Project 2000, has failed to achieve occupational closure. This has made nurses acutely sensitive to their occupational jurisdiction and the threat to their mandate posed by HCAs. Nursing elites have redoubled their attempts to differentiate the work of registered nurses from other staff that provide nursing care, but in a context in which the Labour government is attempting to blur the boundaries between occupational groups in the NHS.

This paper examined the role of HCAs in two acute hospital trusts. HCAs were delivering a substantial proportion of hands-on care and had a key role in observations, personal care and in undertaking more specialist activities. There was some variation between the trusts with a more extended role for HCAs at Metro, reflecting the reliance placed on HCAs at Metro. There were also some variation within each trust in the role of HCAs. These variations were linked to the personal attributes and ‘professionalism’ of individual HCAs which affected the degree to which nurses were willing to delegate responsibilities to HCAs.

At the workplace nurses had ambivalent attitudes towards HCAs because they recognised that HCAs fulfilled an invaluable role and made their workload more manageable, but at the same time they were concerned about the consequences of an expanded HCA workforce. There was a high degree of consensus amongst nurses that HCAs had a crucial role in the delivery of physical and emotional care on the wards. There were differences between nurses in the degree to which they observed this shift in roles with equanimity or concern. It was clear, however, that all nurses felt more comfortable with this shift in boundaries if they trusted the HCAs they worked with and believed that HCAs endorsed the professional values and vocationalism that are associated with nursing.

Because the boundary between the work of nurses and HCAs is relatively fluid, nurses had to spend time articulating and reinforcing the boundary between their role and that of HCAs and were critical of HCAs that transgressed this divide. Nurses actively engaged in seeking to differentiate their role from that of HCAs by defining HCAs as assistants to them, highlighted their credentials in comparison to HCAs, and suggested that even if similar tasks were undertaken by HCAs and nurses, nurses had a more complete understanding of the needs of patients. This attempt at boundary work produced tensions between HCAs and nurses. HCAs often saw little differentiation between their role and that of registered staff and this reinforced a sense of grievance at being allocated high workloads and the most unpleasant tasks. This reinforced HCAs sense of their own lowly status within the hospital environment.

This paper has highlighted that many nurses feel anxious about the prominence of the HCA role to a much great degree than, for example, teachers in relation to teaching assistants (see Bach et al. 2006). This indicates a degree of continuity in terms of nurses’ sense of anxiety about their professional status, but it may also signal other
wider influences: the degree to which the absence of the regulation of HCA roles provides scope for substitution; the degree to which the ideology of holistic care, which is prominent in the professionalisation project of nurses, is difficult to sustain when HCAs are undertaking much of the hands-on care at ward level, and the competition between multiple occupations within the hospital environment. For policy makers, however, effective health care delivery at ward level needs to give more consideration to the implications of an expanded HCA workforce. In particular the degree to which nurses have adequate training in supervising and delegating tasks to HCAs and greater awareness that a more prominent role for HCAs has consequences for the status and professional identities of nurses.
References


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### Table 1: Summary data: Personal and employment characteristics of HCAs (per cent)

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Source: Proforma data Metro and Tower trusts
### Table 2 Main duties of HCAs

1. Giving and receiving reports on the conditions and progress of patients and making known patients wants, needs and views.
2. Taking and recording temperatures, pulse, respiration and weighing patients and blood glucose monitoring, venepuncture and cannulation, recording of ECG.
3. Testing, measuring and recording urine/stool output.
4. Collecting blood from blood bank.
5. Collecting sputum, urine and stool specimen for investigation.
6. Bathing patients, assisting with their personal hygiene, elimination, mobility and maintenance of healthy pressure area.
7. Assisting with serving of meals and beverages, feeding patients and helping with menu cards, allocation of supplements and monitoring of naso-gastril feeds.
9. Participate in bed making.
10. Assists with Ward Clerk duties in his/her absence.
11. Escort patients to other areas or departments.
12. Assisting the trained nurses in carrying out nursing procedures.
13. Assisting doctors with medical examination.
14. Participate in the admission and discharge of patients.
15. Participate in ensuring a safe & healthy environment for patients, staff, visitors.
16. Willingness to undertake any other relevant training as well as duties including phlebotomy and ECG.

Source: Metro Trust