PROFESSIONALS AND ASSISTANTS IN THE BRITISH HEALTH SERVICE: FRIENDS OR FOES?

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INTRODUCTION

Over recent years, the status and role of the public service professional in Britain have been subject to considerable debate and increasing challenge. The implications and consequences of this turbulent period have, however, been far from clear. Certainly the eighties and early nineties witnessed a fairly sustained and unambiguous public policy assault on the professional (Exworthy and Halford, 1999). The power of the professional was seen as intrinsic to the more general ‘producer control’ of public service delivery, which successive Conservative governments were intent on addressing as a means of re-asserting the ‘rights’ of the ‘customer’. This re-assertion of user control was to be achieved in a number of related ways. First, it was apparent in attempts to ‘marketize’ the provision of many public services. Seen as a means of giving effect to and deepening the scope for ‘customer choice’, markets were encouraged as a replacement for more bureaucratised forms of service delivery which had been founded upon a ‘custodial’ form of management giving professionals considerable discretion to make informed decisions on behalf of the users (Ackroyd et al, 1989). Second, it was reflected in the growth of a general management cadre in different parts of the public services, which was seen as a countervailing force to the professional and a means of delivering services more efficiently within the context of increased marketisation. Thirdly, a robust performance management framework was introduced based on measures and targets which tightened managerial control and placed considerable pressure on professionals and other public service employees at the workplace (Power, 1997).

The election of New Labour government in 1997 saw the adoption of a more nuanced approach to the public service professional (Kirkpatrick, Ackroyd, and Walker, 2005)
This still privileged the service user. Thus, in one of its earliest statements on public sector reform, New Labour proclaimed ‘we will deliver public services to meet the needs of citizen, not the convenience of service providers.’ (Cabinet Office, 1999:13). Indeed, the pursuit of user or ‘person’ centred services deepened and accelerated under New Labour. However, the approach has been more balanced, displaying greater sensitivity to the circumstances and needs of the professional, not at the expense of the user, but as a means of ensuring better customer service. As the NHS, proclaiming itself a ‘model employer’, noted, ‘A management style that is both involving and facilitating will result in NHS staff feeling more valued, which benefits patients in turn’ (www.dh.gov.uk).

Government attempts to address the situation of the professional within the context of ongoing public service modernisation have in large part centred on workforce structure and working practices. Public policy makers have addressed professional interests and aspirations by modifying the division of labour: re-distributing tasks and responsibilities between occupations. This has been seen as a way of reducing certain ‘burdens’ on professionals, so allowing them to focus on and develop ‘core’ professional tasks. But this has been at the cost of challenges to the labour market standing and well being. Professionals have been required to become more flexible in response to user needs, reflected in a possible breakdown of their control over certain activities. The role of the assistant, an employee working alongside and often supporting the professional, has been a central to this process. Such figures have emerged as teaching assistants in education, health care assistants in health, community support workers in the police force, and family support workers in social care. It is a role which embodies the ambiguities and possible difficulties generated for public service professionals by this more balanced government approach. The
assistant has been seen by national policy makers as the vehicle by which professionals might be relieved of apparently onerous and distracting tasks, but this has often been accompanied by a blurring and complication of relationships and responsibilities.

This paper explores the use and consequences of the assistant role in the British National Health Service from the perspective of the professional: does the assistant role represents a threat to or an opportunity for the professional? More specifically, attention will focus on the implications of the health care assistant role for the nurses in the secondary health sector. Data are drawn from a case study NHS hospital trust to assess how the HCA role is viewed and used by the nurse, and whether perceptions and practice combine to present the HCA as the nurses’ friend or foe. The paper is dived into four main parts: the first sets the context by presenting the public policy backdrop to the use of assistants and the literature exploring the relationship between assistant and professional; the second outlines our research approach; the third sets out our main findings; and the fourth discusses them.

**CONTEXT**

**Public Policy**

Over the last decade or so, New Labour governments have sought to re-invent the public service professional in the context of a broader public service modernisation agenda founded upon the pursuit of greater user choice and the development of person centred services. This has created a dilemma for public policy makers: on the one hand, the ‘empowerment’ of the user challenges a traditional deference to the decision-making authority of the professional, while on the other, giving meaningful
effect to such empowerment through the provision of high quality services, remains crucially dependent on the commitment and skills of the professional. It is a dilemma which has been reflected in the ‘Janus’ like presentation and treatment of the state professional by the government. At times, the government has appeared to keen to support professionals and nurture its relationship with them. As Tony Blair (2002) noted when he was Prime Minister:

‘Public service is not some vague notion. It is real. It is good. It is what binds our country together. It is the million of hours in unpaid overtime. It is the doctor willing to get out of bed in the middle of the night to see a young child. It is the teacher who in his spare time runs the school football team. It is the policewoman with the guts to take on a group of anti social kids yelling abuse on the street corner.’

At others, the government has sought to encourage the professions to adopt a more flexible approach to service provision and criticised them when they have been unwilling to do so. In the very same speech, for example, Tony Blair in calling for greater flexibility from the public service workforce stated that:

‘Flexibility means abolishing professional demarcations.’ (Ibid)

These tensions have been more tangibly manifest in government attempts to reform workforce structure in the public services and, particularly, in the emergence of the assistant role which has often been intrinsic to such attempts. The assistant role has been used as a vehicle for a number of public policy goals (Kessler et al, 2007): addressing shortages in the availability of professionals, with assistants often being central to organisational ‘grow your own’ strategies; containing labour costs as lower paid assistant have been used to replace professionals; reducing ‘burdens’ on professionals, reflected in assistants taking over their more routine tasks; and
contributing to the performance agenda, with assistants having capabilities which might be used to improve service quality.

For the professional, the use of the assistant in these ways has certain contradictory implications. This is most obviously the case in relation to the assistant as a ‘relief’, clearly seeking to reduce burdens on the professional, and as a substitute, where there is a danger of core professional activities being usurped. It is tension illustrated in the development of the teaching assistant role. More than perhaps any other assistant role, the teaching assistant has emerged as an explicit attempt by government to deal with the work pressures confronting the professional. An independent study confirming these pressures led to a Workload Agreement in 2003 between government and the relevant trades unions, which provided for the delegation of a range of tasks to teaching assistants. However, it also allowed for the creation a higher level teaching assistant role, which could take on whole-class responsibilities, the traditional preserve of the qualified teacher, a development which led to one of the teaching unions withdrawing from the agreement.

**Professionalisation and the Assistant**

The tensions between professionals and associated occupations have long been acknowledged in the literature on professionalisation. In recognising the ‘professional project’ as a social and political process by which an occupational group seeks to secure labour market privilege (Larson, 1977), this literature has shown considerable interest in inter-occupational group relations. Abbott (1988) has highlighted the way in which professions compete over jurisdictions, and the inherent fluidity of boundaries in the division of expert labour. A focus on the professions has positioned support roles as peripheral, but nonetheless important within this analytical schema.
Abbott (1988:72) views such roles as available to professionals to take on ‘dangerously routine work’ which otherwise might dilute claims to knowledge-based expertise. A similar development was noted by Hughes (1993:307) who in a healthcare context stressed that ‘The nurses, as they successfully rise to professional standing, are delegating the more lowly of their traditional tasks to aides and maids.’

For these authors the assistant role is presented as an unambiguous support in the pursuit of professional aspirations amongst particular sections of the workforce. It is a view founded on a conception of the professional project as a process of closure by which an occupational group successfully claims the exclusive provision of a range of technical tasks and the theory driven knowledge base which underpins them. However, an alternative view of this project suggests dilemmas, and perhaps dangers, for the professions presented by the involvement of assistants. For semi-professionals in particular, such as teachers, social workers and nurses, a key narrative underpinning claims to privileged status resides in the holistic provision of a service. Rather than acquiring and deepening a narrow set of specialist tasks, this claim rests more on engaging in the full range of activities, from the most basic to the more sophisticated, needed to address service users’ needs in the round. Such a model implies difficulties in distinguishing between marginal or routine tasks and core professional tasks. Indeed, more profoundly it suggests that in taking on more technical tasks and vacating more basic responsibilities, there is a risk of fragmenting the service and undermining the very holism which gave it a distinctive claim to labour market privilege in the first place. Stevenson (2007) highlights these difficulties in relation to teaching in the context of the Workload Agreement where it is suggested the delegation of ‘non-essential’ teaching tasks to assistants insidiously erodes the professional authority of the teacher. This is a dilemma which emerges
with even greater force for nurses as pressures have affected their position within the health care workforce and encouraged a changing role for the health care assistant.

**The Emergence of the HCA**

Nurse support roles have long been an established feature of the healthcare workforce, emerging under various jobs titles such as a nursing auxiliary or nurse assistant (Abel-Smith, 1960). These have been non-registered roles, in the main filled by those without formal nursing qualifications, although from the early 1940s a second tier nurse, the State Enrolled Nurse, was in place and founded upon two years accredited training (Allan and McLafferty, 1999, 8:6). The longstanding presence of such roles has encouraged debate over the years amongst researchers and policy makers on their relations with registered nurses, attention being drawn, in particular, to the use of support workers as nurse substitutes in times of financial pressure (Thornley, 1996). In addition, the ability for such ‘unqualified’ workers to take the tasks of registered nurse has sometimes been seen as threat to a nurse ‘professionalisation’ project, calling into the question the level expertise required to perform the nurse role (Johnson, 1978).

The nurse support role assumed new and increased importance in the 1990s and into twenty-first century in the context of a number of developments. First, a major restructuring of nurse training, entitled Project 2000, founded upon the move from on-the-job to ‘classroom’ based learning, saw the removal of students nurses from the ward. Accompanied by the withdrawal of the SEN role, this left the HCA as the main support for the nurse at the workplace level. At the same time a range of forces were encouraging a change in the nurse role. For example, the need to reduce the working time of junior doctors in line with European Union directives encouraged the
delegation of tasks such as canulation, taking blood and some prescribing, while also establishing opportunities for the creation of nurse specialist roles. Moreover, the increased regulation of healthcare, not least reflected in the growth of performance targets, promoted a heightened need for nurses to focus on administering systems and outcomes.

In combination these developments created a momentum for nurses to move away from the provision of direct and basic patient care, creating a space to be fulfilled by a support role. Indeed, the increased public policy importance attached to the role in these circumstances saw the government creating of a role with the designated ‘Health Care Assistant’ job title and authorising the determination of terms of employment at local, hospital level, outside of the national agreement traditionally regulating employment for healthcare workers. The pressures towards this flight from basic care by nurses might be seen support the nurse professional project, providing the opportunity for closure around a narrower set of expert technical tasks; at the same time it challenged a model of the professional based on the provision holistic care. As the NHS Chief Nursing Officer (2004) warned:

‘I believe that we are guilty of seeing caring as lower status as reflected in our keenness to delegate caring aspects of our role to others. Our action fail to legitimise the value of caring- as nursing develops we tend to take on the roles and tasks from the medical profession.’

While following a vote at the Royal College of Nursing Conferences in 2004 against devolving the caring component of nursing to the HCA, the organisation’s General Secretary stated:
'If I become too posh to wash, I should no longer be in the profession. We are doing more than that. We are assessing the patient, we are doing holistic care, we are checking their emotional state.' (http://news.bbc.co.uk/1/hi/health, 10 May 2004)

The emergence and development of the HCA role within the context of the broader modernisation of the public services and the more longstanding nurse professional project gives rise to a number of questions. The first general, overarching question is: how are HCAs viewed and used by nurses? More specifically, given the public policy emphasis on assistants reducing burdens on professionals, to what extent have HCAs been used and viewed by nurses in this way? Have HCAs been used in other ways by nurses and has their deployment in these various ways been regarded positively by nurses? Alternatively has the use of HCAs in new and different ways been perceived as a threat by nurses? Might the use of HCAs and their relationship with nurses vary and if so what factors might lead to such variation?

RESEARCH APPROACH

This paper seeks to address these questions by drawing on data from a case study hospital trust. The trust is a large teaching hospital in the south of England on three sites, with around 1,400 beds, employing over 9,000 (actual) employees and with a budget of close to £500 million (Annual Report, 2007). In total the trust employs just over 2,500 whole time equivalent nurses, (3,200 heads) and almost 700 whole time equivalent HCAs (980 heads). This gives a ratio of around one HCA for every four nurses (although precise skill mix varies by clinical area). The research concentrated on those nurses and HCAs working in acute general medical and surgical wards on two of the Trust’s sites. More precisely, 10 wards were covered, with each ward
employing between 6 and 8 HCAs. The contrast between different clinical areas was designed to pick on possible variation in the relationship in nurse-HCA relations given differences in patient conditions: age, dependency and acuity on these wards.

The paper draws mainly upon data from 60 interviews with nurses and HCAs spread evenly across the wards spread fairly evenly across wards and sites. The Table below sets out the full range of interviews. It can be seen that there was a balance between interviews with HCAs (30) and nurses including senior nurses such as sisters and matrons (30) Carried out at the end of 2007, the interviews generated two sorts of data: at the outset of each interview HCAs and nurses were asked to complete a pro forma, which asked a series of structured questions about personal background; this was followed by the interview itself, which was based on open questions giving the HCA and nurses a chance to talk more freely about each other. In addition, 12 observational sessions were conducted which involved shadowing a nurse and two HCAs on four wards. This paper focuses mainly on data from the 30 nurse interviews plus some of the observational material.

Table 1: Overview of case study interviews by location

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<th>Site 2 AGM</th>
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<td>3</td>
<td>6</td>
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<td>Total</td>
<td>60</td>
<td>14</td>
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1 Given the focus on workplace relationships, this paper does not present the results from the pro forma data on nurse/HCA personal backgrounds.

2 It should be noted that the ward sisters chose the HCAs and nurses for interview. They were encouraged to send a mix of HCAs and nurses in terms of background and experience, but some care needs to be taken in regarding the interviewees as fully representative.
FINDINGS

The findings are presented in three main parts: the first explores whether HCAs were viewed in a positive light by nurses and, if so, why; the second assesses whether nurses perceived any threat from working with HCAs; and the third consider the factors likely to influence the nature of nurse-HCA relationship. As a backdrop to this discussion, however, it is initially worth setting out the elements of nursing as a work process.

Nursing

Nursing on general surgical and medical wards comprises a wide range tasks. A key distinction can be made between patient-centred or team-centred activities. The team centred activities do not involve direct involvement with patients, but rather relate to the more general running of the ward, for example answering the telephone and undertaking clerical work. Patient centred tasks can be further divided into those which require immediate physical engagement with the patient and those which are at remove but still relate to direct patient care. Those activities at a remove can be viewed as patient maintenance tasks and, for instance, cover making beds and porting. More immediate engagement with patients assumes a number of forms: basic and pastoral care, as well as clinical activities of a technical and specialist kind. A full list of activities carried out under these broad headings is set out in Table 2 attached as appendix.

HCAs a Friend

In general, HCAs were viewed in an extremely positive way by nurses. It was view a summarised by a matron who noted that:
Matron: I think nurses for the most part have a huge amount of admiration for HCAs and... find a good HCA utterly invaluable; and an integral part of the team, without exception really. I mean I think trained nurses recognise that they couldn't do their job if they didn't have the support of the HCAs.

More specifically, HCAs were seen by nurses to contribute to their working lives in a number of ways, often reflecting the aims of national policy makers. First, in interview nurses suggested that the HCA was playing a relief role, taking away some of the more routine of tasks. Confirming the scenario presented earlier, it was suggested that nurses under pressure to take on new tasks were leaving the more basic patient care to the HCA:

Nurse: They make it easier because they are there, you know that even if you're off doing phone calls or filling in forms or sorting out drugs, they are still there plodding through doing the care, coming and telling you if there's a problem, and just getting on with it. [Emphasis added]

Nurse: The reason I came in to nurse (was) because I liked nursing the patients, but the focus has shifted more to paperwork and auditing and all sorts of other sort of things that you just would never have had to do before, and the sort of basic nursing care is pretty much undertaken by the healthcare assistants who we basically, we manage and lead and, you know, monitor, but they're pretty much doing the basic sort of care.

The observational data provided some confirmation of this picture. Figure 1 below compares the distribution of HCA and nurse time across a shift between different nursing tasks. It confirms that HCAs were spending a higher portion of their time than nurses on patient centred activities: basic and pastoral care. Indeed, it is clear the well
under half the nurses’ time is spent on patient centred activities (41%). Figure 1 also suggests that HCAs are taking on the more routine or ancillary tasks: one of the most striking features is the relatively high proportion of the shift spent by HCAs on patient maintenance. However, this picture does need to be qualified. These data indicate that there is not a great deal of differences between HCAs and nurses when it comes to the provision of basic patient care, both groups spending around a quarter of their time of this activity. The major differences in the shape of HCA and nurse roles seems to lie in the fact that nurses spend a relatively high proportion of their time on ward/team centred activities.

Second, the HCA was seen by the nurse to act as a co-worker; in other words, the nurse and HCA shared tasks which could not be performed by one of them alone. There were many examples of co-working:
- Changing beds together
- Moving patients together
- Changing a dressing together.

Third, the HCA was perceived as complement, with the nurse using the HCA to undertake different but often related tasks. For instance the nurse and HCA could be dealing with a patient at the same time but carrying out different task. Alternatively the HCA and nurse could be working on different patients from the nurse’s caseload at the same time. Thus, during one of observation session, it was noted that while a nurse was changing a complex dressing, she was asking the HCA to undertake Blood Monitoring on another of her patients and receiving reports back from the HCA on the readings as she continued to change the dressing. In another, recounted instance, when patients were admitted on to the ward, the nurse assessed while the HCA ‘calmed’ relatives and dealt with the patient’s personal belongings:

*Nurse: They might do the obs. for me, but when a patient's admitted it’s such a period of assessing because it’s crucial, that’s our skill. When somebody’s admitted, where a HCA at the moment is such a great help is making sure that everything’s there, their belongings are safe, the patient’s calm, the family is seen to. They're those things which are so important, that's their shining light is, making sure that the patients’ relatives know the times when the ward’s open, they can make it just run so smoothly by dealing with that. And making sure if there's any valuables on the patient, because sometimes people bring lots of money in.

Fourth nurses often viewed HCAs as an extension of themselves, acting in effect as their ‘eyes and ears’. The value of HCAs in this respect derived from the greater physical involvement they had with patients particularly in providing them with basic
care and the scope HCAs also had to develop a closer personal relationship with the patient through time spent with them:

**Nurse:** If you know that [HCA] really well and you’ve worked with them a long time they come back to you and say oh, and you know that they’ve got a feel for certain things and they can come back to you and say, you know, “I’ve been to see Mrs so and so, I don’t think they look as well today as they did yesterday, you know, I just gave them a wash and they’re not acting like they were yesterday”. And, you know, certain HCAs can pick up on certain things and they’ve done the job for a long time, and they make your life a lot easier.

Finally, nurses viewed HCAs a potentially adding value to nursing care. This was seen to derive from the kinds of people likely to fill it. HCAs at the Trust had somewhat different personal backgrounds: they were much more likely to have attended a local school and perhaps therefore to be more embedded in the local community and more readily relate to or even empathise with patients. Certainly, many of the nurses felt that HCAs had a different relationship with patients:

**Nurse:** Because they’re with their patient a lot more than the trained nurse, they can develop a relationship more and they get to know them better. Because actually we’ve, I mean the HCAs are very busy but the trained nurses, you’re flying around doing doctors’ rounds, you know, all those sort of different ones which HCAs can’t necessarily do. So they will sort of get to know the patient well and develop a rapport with the relationships, so.

**HCA as Foe**
Given the generally positive nurse perceptions of the role, it is an exaggeration to suggest that HCAs might be viewed in any strict sense as a ‘foe’. The nurses did, however, highlight a number of tensions in their relationship with HCAs. The drift away from basic care was giving rise to some concerns, particularly senior nurses:

**Sister:** *I think that we should be as qualified staff be as involved in basic patient care as the HCAs. I think unfortunately reality can sometimes pull away from that, as I say with medical rounds, doctors’ rounds and trying to discharge patients, admit patients for theatre, take them to theatre, it can pull us away from that. But, as I say there, are those staff that don’t feel that that’s their role, that is the HCA role but I would discourage that and myself, try to be involved with basic care as much as possible.*

HCAs encroachment on core professional nurse tasks was only partially realised. At the outer limited of nursing the boundaries were firmly set. Nurses were authorised to dispense medication and this was a boundary which was universally acknowledged and maintained. Moreover nurses tended to take responsibilities for many of the aspects of admission and discharge, for example, liaising with primary healthcare and social services. However within these parameters there was considerable flexibility and variation in the distribution of task between nurses and HCAs. Certainly patient basic care and maintenance remained the core to the HCAs roles, with many HCAs moving little beyond these activities. However, at the margins HCAs were taking on team centred and even technical and specialist tasks, including those only recently passed on by junior doctors such as taking bloods and canulation. In the main, the possibility of HCA assuming an extended role caused little disquiet amongst nurses; those HCAs performing such tasks were typically trained and experienced (see
below). This is not to ignore a number of concerns raised by nurses about such extension and other issues.

First, there was a feeling that HCAs might push the boundaries of their role to take on more specialist and technical tasks regardless of whether these skills were needed on the ward and to the possible neglect of core aspects of their role:

*Nurse:* Recently we had a healthcare assistant who was not working with us and he got very keen to do cannulation and blood letting and would, “I'll go and do that, and I'll look on the computer for the results” and blah, blah, blah and actually it's like you need to go and do that commode and strip that empty bed first, and you're kind of thinking, it's all very well learning these things but actually you are here to go and empty the skips and keep the trolleys stocked up, as well as do the extra role if you can.

Second, there was a perceived danger that while HCAs might mechanically be able to undertake a task, they were less well placed to interpret a situation and exercise judgement. This was seen as particularly the case in relation to ECG and the taking of observations:

*Nurse:* They do tend to do observations. Most HCAs enjoy doing them; they like the clinical, they do. Again, I think the training needs to be more developed because it is very much what they're taught on the ward, so they have no anatomy, pathophysiology knowledge, to backup what they find. They always write them down and give them to the nurse to look at, but half the joy of the job is knowing what you're looking at, and I think they'd get so much more joy out of it if they had some knowledge why the stats are low and when the pulse is high. When you understand that, it all makes sense.
Third, and more generally, nurses expressed some concern about their ultimate accountability for the actions of HCAs. As one nurse noted, it was always their registration ‘that was on the line’. As others highlighted:

**Nurse:** Clinical really, we’re directly involved with the patients, that’s the main thing with the clinical decisions, anything that happens to the patient it’s going to be the nurses. I don’t think it’s going to be the HCAs, they don’t have the responsibility because they’re here to help us only; they’re not accountable for anything that happens to the patient. Because I’m not saying that they don’t have the knowledge but since we have been educated with all this, with nursing.

Indeed, the need for the nurses to take responsibility occasionally could spark a twinge of nurse resentment towards the HCA:

**Nurse:** It does actually annoy me when they go home on time and I’m still there, I mean they've been sat reading a magazine and I’m still working.

**Matron:** It’s accountability. At the end of the day, we [the nurses] have the accountability. They don’t have the accountability for what they’re doing.

**A Contingent Relationship**

While some clear patterns emerged on whether nurses viewed HCAs as friends or foes, it is equally that the nature of this relationship and how it is seen by nurses is contingent: it is contingent upon features associated with the HCAs and characteristics the nurses themselves.

The value nurses places on the HCA contribution is related to the perceived **experience** of the HCA. Many nurses and sisters stressed that they had a core of
HCAs who could be relied upon to perform key tasks. But the value of the HCA to the nurse was also dependent upon the perceived motivation of the HCA; an HCA who lacked enthusiasm and commitment was unlikely to provide the same level of support as one more positively orientated toward the role:

**Nurse:** We have one in particular (HCA) who doesn’t like to work, you know, and you think “oh gosh, I’m spending half my time chasing them around”. And she has been known to say “I’m hiding from”...But she knows what I say, and I say “I love you dearly but you’re a nightmare”.

The more qualified the HCA in a formal sense, the more likely he or she was to take on tasks for the nurse, while the value of the HCA to the nurse was also enhanced by self awareness on the part of the HCA. Thus, the value of HCAs could be diluted if the nurse was constantly worrying about them working beyond their capability. In most of the wards the limits on the HCA had become well established in routines and habits:

**Nurse:** One of our healthcare assistants is fond of saying, “you need to speak to a grown up” or “I’ll get my grown up” because she absolutely knows her limits and she’s very experienced but she knows that she’s the healthcare assistant...

As noted the value of HCAs to nurses was not only conditional on attitudinal and behavioural characteristics associated with the HCA, but also on the backgrounds and orientations of the nurses themselves. In particular, the training nurses had in dealing with HCAs and their knowledge and experience of working with HCA had an influence on whether and how they used them. Two patterns appeared in these respects: one linked to the age of the nurses and the other to their national roots. There were suggestions that younger or less experienced nurses would either under-
or over-use HCAs, in short they needed some time to develop a balanced relationship with HCAs.

**Nurse:** There are some that perhaps don't entrust them (HCAs) enough perhaps, particularly with new nurses that come on. I think our healthcares are good in the fact they do a lot on this ward, I mean more than a lot of wards, they can do admissions, and I think some nurses are quite surprised at first.

**Sister:** Sometimes some of the overseas nurses might expect more from the support workers and that might be because of what they're used to, you know, where they trained or where they worked before.

In addition, the nurses’ use of the HCA might be seen as related to their *personal disposition* which lead them to draw on the support of the HCA to a greater or lesser extent:

**Nurse:** This is going to sound really bad but you know the nurses that are particularly, are lazy, for want of another word, they don't want to sit there and have to do this, this and this to patients, they'd quite happily sit on a chair and let the HCA do it and then do all the writing afterwards. Which is not really of any use to anyone, but there's people like that.

**Discussion and Conclusions**

At the outset it was suggested that the increased importance attached by policy makers to the role of assistant represented a ‘double edged sword’ for the public service professional: it was a role explicitly designed to reduce routine burdens on the professional but at the possible expense of relinquishing control over core activities. It was a dilemma seen as taking different forms depending on the model of
professionalisation adopted. Losing routine burdens might well be viewed as strengthening a professional project founded upon closure around a set of theory-driven, expert tasks. By contrast, the discarding of these very routine burdens might be regarded as undermining the position of the professional based upon the provision of holistic care. This paper sought to explore how this dilemma played itself out in the relationship between nurses and health care assistants in a British hospital. Was the health care assistant a friend or a foe of the nurse?

The findings revealed that in general nurses viewed HCAs in positive terms. Nurses were using the role in a number of ways, including as a means of complementing and extending their involvement with the patients along with adding distinctive value to patient care. Crucially, HCAs were seen by nurses as relieving them of certain routine tasks, particularly related to basic patient care. However, in observing nurses and HCAs it was clear that this flight from basic care should not be overstated: there was not a great deal of difference between nurses and HCA in the time spent on this activity. The ‘dangers’ associated with HCA encroachment on core nurse tasks should also be treated in a qualified way. Within acknowledged boundaries, particularly related to medication, there was considerable scope for HCAs to take on technical and specialist tasks, but this was not typical and rarely seen as a threat to nurse status. This is not to suggest the absence of certain tensions between nurses and HCA. Nurses were conscious of their accountability for HCA actions, and concerned that in taking on extended roles HCA might drift away from their essential focus on basic patient care. More striking, however, was the contingent nature of nurse-HCA relations. Whether HCAs were viewed as friends or foes was seen as likely to be dependent on the conditions and circumstances of the nurses and indeed the HCAs themselves: their respective dispositions and levels of experience as well as skill.
REFERENCES


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### Appendix: Shape of the HCA role

<table>
<thead>
<tr>
<th>Patient Basic Care</th>
<th>Patient Maintenance</th>
<th>Pastoral Care</th>
<th>Ward/Team-Centred</th>
<th>Technical</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathe patients</td>
<td>Serve meals/drinks (fill jugs)</td>
<td>Talk to/reassure relatives</td>
<td>Cleaning away from the bedside</td>
<td>Monitor/record patient observations</td>
<td>Catheter care (e.g. cleaning, removal)</td>
</tr>
<tr>
<td>Feed patients</td>
<td>Make beds</td>
<td>Reassure patients</td>
<td>Clerical (e.g. filing)</td>
<td>Obtain/Send specimens</td>
<td>Take blood samples</td>
</tr>
<tr>
<td>Other personal care (e.g. shave, personal comfort)</td>
<td>Cleaning around patient’s bedside</td>
<td>Dealing with confused patients</td>
<td>Helping other members of staff (e.g. queries, requests)</td>
<td>Assist with drug administration</td>
<td>Invasive procedures (e.g. cannulation)</td>
</tr>
<tr>
<td>Cleaning bodily fluids</td>
<td>Helping with discharge/admissions (including care plans)</td>
<td>Updating patient/answer patient queries</td>
<td>Updating patient details to staff members</td>
<td>Taking blood sugars/blood monitoring</td>
<td>Dressings and wound care</td>
</tr>
<tr>
<td>Taking swabs</td>
<td>Responding to patient buzzers</td>
<td>Answering the phone</td>
<td>Changing/cleaning feed bottles</td>
<td>ECGs</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>Patient checklists (e.g. Theatre)</td>
<td>Keeping stores &amp; cupboards stocked</td>
<td>Handover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collecting tablets</td>
<td>Updating nursing notes</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Updating notes</td>
<td>Laundry skips</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry (e.g. washing patient clothes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portering</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>