

**EXTENDING THE ROLE OF NON-PROFESSIONALS: THE CASE OF HEALTHCARE
ASSISTANTS (HCA) IN SECONDARY HEALTHCARE IN THE UK NHS**

BY

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DECLARATION

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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'It is the professionalism of health professionals which prevents them from attempting procedures which are beyond their competence, and ensures that they will involve colleagues with appropriate competence where necessary. In addition to individual responsibility, it is also the responsibility of the employer to ensure that the creation of any new or extended role comes with appropriate support and performance management mechanisms'

CHRE 2010

ABSTRACT

This thesis sets out to understand the nature of non-professionals as they engage in extended roles and develops a sophisticated understanding of the drivers and causes of extended roles. It therefore, uses healthcare assistants (HCA) in healthcare in the NHS as an illustrative case, to address the theoretical concerns of the research. These questions ask, first what are extended roles, why do they persist among non-professionals and whether policy can explain why extended roles occur. The contributions offered are based on the analysis of the labour process of HCA work and inter-professional boundaries and how these limit extended roles. It also offers an assessment of how Agenda for Change (AfC) policy working in an environment in which resources are constrained and the factors that lead to these outcomes. It offers the theory of psychological contracts and introduces the notion of third party obligations as part of the reason why extended roles within non-professionals persist.

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DEDICATION

I dedicate this thesis, to my beloved nieces Shani and Surraya, to my lovely daughter Ishara, and in memory of my dearly departed brother, Kenneth Omoro and my late father Festuz **Zadock Omoro.**

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GLOSSARY OF TERMS AND ABBREVIATIONS

Abbreviation	Full Term	Meaning
Trust	Acute Trust	An NHS Hospital Trust, providing secondary healthcare services
AfC	Agenda for Change	Established in 2004, as part of the new and current grading and pay system for staff within the NHS, there are some exceptions of professions such as doctors, dentists. It harmonises pay scales and career progressions across the different groups.
BM	Blood Monitoring	A test to measure sugar levels in the blood
DH	Department of Health	Department in the UK government responsible for policy on health, social care and the National Health Service
FT	Foundation Trust	NHS Trust is part of the National Health Service in England and has gained a degree of independence from the Department of Health and local NHS strategic health authority
GP	General Practitioner	GPs usually work in primary care, and are the first port of call for most patients. They have extensive knowledge on medical conditions, hence offer assessment of the problem and decide on the appropriate course of action.
HCA	Healthcare Assistant	Act as support staff to nursing and nursing roles
HCSW	Healthcare Support Worker	Similar role to that of HCA, just a different title
KSF	Knowledge and Skills Framework	A framework that supports and charts the personal development and career progression within the NHS forms a pillar of the Agenda for Change.

NMC	Nursing and Midwifery Council	Professional body that regulates the nurse and midwifery professions
NHS	National Health Service	The healthcare system in England
NVQ	National Vocational Qualification	Work based qualifications that are based and achieved through training and assessments on the job.
Oedema	Oedema	Oedema, also known as dropsy, is the medical term for fluid retention in the body
PDR	Performance Development Review	Part of the KSF and used to chart and assess the performance of individuals
	Primary Healthcare	The first contact a patient has with a care provider and is usually with a GP, dentist or optician.
	Project 2000	A programme introduced in order to professionalise nursing; it formed the basis for academic education for all nurses and midwives.
RCN	Royal College of Nursing	A professional and membership organization representing the interests of nurses and nursing
	Secondary Healthcare	Is the care provided by medical specialist who do not have first contact with the patients, and is usually delivered in hospitals or clinics, after referrals by GPs.
SHA	Strategic Health Authority	SHA form part of the structure of the NHS in England. Each SHA is responsible for enacting directives and implementing fiscal policy as stated by the Department of Health.
CWP	Changing Workforce Programme	Policy introduced to enhance workforce participation
IWL	Improving Working Lives	Policy introduced to ensure the improvement of working conditions by introducing aspects such as job sharing, flexible working hours etc.

HRM	Human Resource Management	Is the process of managing people in an organization in a structured manner
HR	Human Resources	HR function in contemporary organizations is concerned with the notions of people enabling, people development and a focus on making the “employment relationship” fulfilling for both the management and employees.
Er	Employment Relations	ER is the work concerned with maintaining employer-employee relationships that contribute to satisfactory productivity, motivation, and morale.
ER	Extended Roles	Roles that are carried out by proxies while those tasks remain in the jurisdiction of the main profession.
SE	Skills Escalator	Component of KSF and aims to redesign jobs and enhance the roles of the workforce
PC	Psychological Contract	Represents the mutual beliefs, perceptions, and informal obligations between an employer and an employee.
CHRE	Council for Healthcare Regulatory Excellence	The role of the CHRE is to promote the interests of patients and the public within health professional regulation.
	Skill Mix	The mix of posts in an establishment; the mix of employees in a position; the combination of skills available at a specific time; or the combinations of activities that comprise each role.
OECD	Organization for Economic Cooperation and Development	An organization with 30 member countries that believe in the free market system. It provides a forum for discussing issues and reaching agreements some of which are legally binding.
NPM	New Public Management	NPM broadly denotes the government’s policies, since the 1980s that aimed to modernize and render the public sector more effective.

Cannulate		To introduce a cannula or thin tube into a vein or body cavity
Venflon		Venflons will normally be inserted in those patients admitted with a diagnosis of chest pains thought to be due to cardiac cause, those requiring intravenous fluids or intravenous antibiotics,
Venepuncture		In medicine, venipuncture, venopuncture or venepuncture is the process of obtaining intravenous access for the purpose of intravenous therapy or for blood sampling of venous blood.
Phlebotomy		Is the process of making an incision in a vein with a needle. The procedure itself is known as a venepuncture.
CSU		Catheter specimens of urine (CSU) may also be required for: Levels of particular metabolites or presence of particular drugs/drug metabolites, for example hormone metabolites and toxicology screens in the poisoned or overdosed patient; or for point of care urine analysis (urine dipsticks)

CHAPTER ONE

STUDY OVERVIEW

1. Introduction

The purpose of this introduction is to set the platform for the research and to state the central themes of the study. It highlights the issues tackled by the thesis, presenting the approach taken, including the main findings as well as the main contribution of the thesis. This chapter concludes with a thesis overview which provides a breakdown of each chapter.

The UK government, just as other governments internationally has been encouraging changes in workforce configuration and skill mix which has been driven by a range of pressures and challenges (Hyde et al., 2005). Some of the drivers include labour costs, skills shortages, need to enhance service delivery and effectiveness and changes in professional regulations (Adams et al., 2000; Hyde et al, 2005). Skill mix changes to the workforce especially between professionals and non-professionals has been seen as a way to increase efficiency and delivery of services in the public sector. In the UK, the government has been quite vocal about encouraging skill mix, but within health this has been focused on the professionals while excluding the non-professionals. Therefore this study fills this gap in research by focusing on the use of skill mix on non-professionals in health.

1.1. Research Problem

Skill mix has been described as an amorphous term as it means different things to different stakeholders (Buchan, 1999; Richardson et al, 1998; Richards et al., 2000). It is defined more generally as the combination of skills and activities needed for different jobs within an organization and more specifically as the particular mixture of occupations, posts or grades within an organization (Buchan and Dal Poz, 2002; Sibbald et al. 2004). Skill mix has also been

associated with the need for cost reduction, by cutting expenditures on staff rather than a planned approach to introducing multidisciplinary teams within the workforce (Buchan and Calman, 2005).

This study therefore, uses extended roles as an example of skill mix change, and focuses on how it affects non-professionals in health. Extended roles are defined as additional roles that are not part of the core training and can also be referred to as duties not specifically outlined by the traditional limits within a profession (Last et al., 1992). Extended role within healthcare is further described as members acting in a proxy capacity, by covering specific medical tasks, which remain under the jurisdiction of the medical profession (Harvey, 1995; Abbott and Meerabeau, 1998).

The aim of this research is to explore the nature of extending the roles of non-professionals. Therefore this study examines healthcare assistants (HCA) in the UK National Health Service (NHS) as a case study to investigate the reasons why they as non-professionals extend their roles in secondary care in the NHS. A better understanding is sought on the nature of extended roles, and the non-professionals' thoughts on their participation in extended roles as well as the role of policy in influencing extended roles. Investigating this particular group of non-professionals is important because their numbers has been increasing over the years. According to the Cavendish review, the number of frontline staff that are not registered nurses that perform direct, hands on care to individuals either in hospitals, care homes or homes stands at 1,3 million (Cavendish, 2013). Because of the various titles within this workforce, it has been difficult to make a precise count of their number, however from the total given about 332,000 of them provide support to doctors, nurses and scientific staff (Francis, 2012). Recent numbers from the Health and Social Care Information Centre (H&SCIC) suggest that in 2012 in England the

number of nurses dropped by 2,284, while that of HCA rose by 2,691, indicating that HCA were being substituted for nurses (Cavendish, 2013). Their increased involvement in the NHS has been linked to changes in skill mix in part due to increasingly constrained economic circumstance (McKenna, 1995; Allen, 1997; Nancarrow and Borthwick, 2005). The interest in skill mix changes in this study is therefore based on evidence which suggests that skill mix delivers improved healthcare results (Lankshear et al, 2005; Bosley and Dale, 2008).

Research specifically targeting the extended nature of the HCA role and their own perception of their employment within the UK healthcare system is scarce, as most of the research available is inclined towards information on nurses and nursing. Studies that have been carried out have focused mostly on other areas such as the tensions perceived between registered staff and healthcare assistants, or on the changes and developments to the roles of HCA and the possible threats that these have on the role of registered nurses (Hyde et al., 2005; Robertson, 2007). The studies on the HCA, include case studies that explore the nature and consequences of support workers in hospitals (Kessler, 2010). There are some about challenges in providing care such as the role and experiences of HCA in certain wards (Schneider, 2010). Some evaluate the dynamic professional boundaries and issues relating to changes in working practices that challenge the traditional order of professional power (Allen, 2001; Nancarrow and Borthwick, 2005). There is also research that dwells on the development and impact of assistants supporting the work of registered nurses as well as the consequences of boundary management (Spilsbury, 2011; Bach et al., 2012). Other studies are on the role of support workers in community and intermediate care, (Nancarrow, 2010). Yet some studies have focused on enhancing the role of HCA and formalising their roles within healthcare (Spilsbury and Meyer, 2004; RCN, 2007; Storey 2007), but these do not target the extended nature of support workers and especially not the reasons why these continue.

However, two studies that were of particular interest for this research and helped cement the need for this study were; first a study on the impact of changes in work organization in the NHS, based on discourses of care and relationships between nurses and HCA (Daykin and Clarke, 2000). The study looked at the responses from nurses and HCA to the introduction of skill mix, but it focused solely on the nurses' perception in relations to theories of occupational closure. The findings were that claims to distinct knowledge and care processes were undermined by changes in work organization, as a result the study highlighted the nurses' opposition to the skill mix project and the need for nurses to embrace the project as their ambivalence to the HCA left them vulnerable to a working environment consisting of Fordist practices. An interesting aspect was the complaint of lack of participatory work practices that are often designed to involve workers in making decisions on how to organize their work. It has been suggested that enabling workers to participate in the management of their work generates better performance at the workplace (Forde, et al, 2006).

The second study was on whether the shifts in the division of labour within the context of organizational change could lead to empowerment or degradation of workplace roles (Bach, Kessler and Heron, 2007). It focused on the fact that in the UK public service, there was an emergence of assistants and the quest was on whether this resulted in either empowerment or degradation for those in the roles as well as for the professionals that they worked for. It centred on assistant roles in education and in social care (Bach, Kessler and Heron, 2007). This is significant because some of what was highlighted in their study mirrors some of the findings from this current research, however there are some differences in this research, which reflects the fact that consequences may vary depending on the various sectors and contexts in which the assistants are applied.

There is no specific study that reflects on the non-professional's perceptions and outlooks towards their continued engagement in extended roles in health. Therefore, there is a need to fill this gap in knowledge and one way of doing that is by exploring the nature of the HCA role and specifically reviewing their individual perspectives on why they engage in extended roles. There is a need to understand the causes and drivers that lead to extending HCA roles. And to also understand the impact brought on by changes in organizational policies and regulation of extended roles, such as in the need for change in skill mix.

This study therefore, intends to contribute to the research on skill mix by focusing on healthcare and exploring the factors that facilitate and or impede the development of extended roles for non-professionals in healthcare. This study explores the interrelations between the different occupational groups in healthcare and their contribution to the outcomes, especially as it pertains to the roles of non-professionals within the healthcare environment as this has not been explored. It will bring a healthcare perspective on the role of non-professionals as well as further inform on the differences that come about from healthcare assistants extending their roles. Especially because in this study, the HCA were not satisfied with their job, neither did they feel that their working lives were enriched nor did they feel that they had career opportunities, these are major differences between this study and that carried out by Bach et al. (2007). This study therefore seeks to further research by asking the following specific questions:

- ✓ What are extended roles and why do they occur?
- ✓ Why do HCA participate in extended roles?
- ✓ Can policy changes explain the use of extended roles; Agenda for Change policy?

1.2. Research Approach

This thesis employs a comparative case study strategy, in which qualitative data collection methods were used to investigate the current research interests. Qualitative research enables

investigations of micro-level concerns, whereby the research is designed to provide details from the participant's point of view (Denzin and Lincoln, 2003). The case study approach in this research encompasses the need for a holistic in-depth investigation into the factors that affect the development of HCA extended roles. This is necessary because it will capture and illuminate on actions and behaviours of HCA of which there is currently insufficient research available (Strauss, 1987; Bryman and Bell, 2007). This study also employs a comparative case based analysis that uses an inductive logic, which examines the form in which extended roles occur and theorises the reasons that allow for HCA to engage in extended roles.

1.3. Research Findings

The main findings from the study reflect on the fact that extended roles indeed seem to be happening and in the cases where non-professionals are involved in extended roles, those said roles are taken as part of their formal roles. Most of the times when extended roles occur it is due to skills shortages and influences from management practices. As a result, there are instances of work intensification, and fordist strategies of deskilling by routinizing care work and increasing surveillance by management, which happens at different rates within different contexts this also illustrates the implicit nature of taking on extended roles, there seemed to be no other choice but to take on the roles. The research evidence also shows that there was a lack of human resource (HR) infrastructure to support extended roles even though formal policies within the organizations formulated based on government guidelines existed. Even though these negative contexts were apparent, most of the non-professionals felt that they had to carry on with extended roles out of the sense of duty to their patients. This was a feeling that resonated well with most of the interviewees, and enabled the use of psychological contract theory to both explore and explain the reason why extended roles were continually taken on by HCA.

1.4. Research Contributions

There are both theoretical and empirical contributions offered by this thesis. Empirically this thesis offers evidence about the nature and the drivers of extended roles. It also demonstrates that extended roles occur contrarily within different contexts. The thesis highlights the fact that currently the prescribed policies have had little salience in supporting extended roles. Theoretically this thesis offers a novel application of the theory of psychological contract in relation to tertiary commitments, which in this case refers to patients and uses it to explain why extended roles persist.

2. Thesis Structure

This thesis is organized into seven chapters, appendices and a bibliography. This chapter has dealt with the introduction into the research. It has highlighted the issues that the thesis tackles which is the need to understand the nature of extended roles as taken on by non-professionals in secondary healthcare. This is because the research that currently exists does not focus specifically on the individual perspectives of these non-professionals and their continued engagement in extended roles. Also of interest in this study is the fact that skill mix has been encouraged in other sectors of public service, but not so much in healthcare and even when skill mix has been taken up in healthcare it has focused on the roles of the professionals, there has not been much focus on non-professionals. Therefore there is a need to explore the context in which HCA as non-professionals participate in extended roles because evidence given from other sectors may not necessarily be the same within the healthcare context.

A comprehensive literature review is offered in chapter 2 titled theorising extended roles. It begins by defining skill mix and presents more content in terms of the labour process theory and closure approaches linking them to the specific concerns about extended roles such as the division of labour and boundary issues within the professions. It provides a definitions for extended roles and presents it as a specific type of skill mix change and includes debates on

extended roles, which culminate with a set of research questions that form the basis of this study. These are the need to develop a more sophisticated understanding of the causes and drivers of extended roles, and the need to understand the impact of organizational policies and regulation on extended roles including the individual responses from staff on how they experience extended roles.

New theory will be introduced that helps to address the research questions which is the notion of psychological contract and third party obligation. Literature on human resource management (HRM) which suggests that human resource planning (HRP) might provide an understanding into how organizational policies might support or inhibit taking up extended roles is also explored. Proper HRP suggests that the workforce willingly take on extended roles, given the policy prescriptions which are reviewed in chapter 3, this should be expected. It concludes by outlining the research questions and the approach taken in the study to define theories used to understand extending HCA roles in the NHS.

Chapter 3 presents the history and emergence of extended roles. A background on the NHS is offered, including highlights on NHS staffing issues and management and policy issues. It introduces the HCA workforce giving their history up until their current status in the NHS. It makes the case that extended roles emerged as a result of the need to do more with less. It also highlights the fact that various policies that have been prescribed suggest that the current HR infrastructure should support extended roles adequately. The chapter concludes by adding that there is a compelling case for empirical investigations into extended roles by stating the specific research questions of the thesis, as already noted earlier.

Chapter 4 presents the methodology, in which the research strategy and methodological rationale for the study as well as a discussion on the data collection methods is given. This study is a comparative based analysis that uses an inductive logic to examine how extended roles occur.

The study used a purposive sample in which the research respondents were selected from two NHS Trusts with three specialities each used for the data collection. One organization was a Foundation Trust while the other was not. The differences in the organizations as well as in the different types of units selected, enable the study to observe differences in work regimes and also compare the conditions that affect extended roles. This also enabled a different mix in the sample of HCA to be interviewed as variation in HCA roles between the two trusts were examined. This process was done in order to give more depth to the research as well as validate the findings. Ethical consent was obtained before the commencement of the study and the fieldwork technique for the study was by interviewing.

Chapter 5 presents the case studies. It gives a background to the organizations, the units/wards and contextual information about the two hospitals. A description of the nature of extended roles is provided for each case. The first research question – what are extended roles and why do they occur – is tackled in this chapter, in which certain sections explore in detail what extended roles involve, including the range of task based on each case as well as variations within the cases.

Chapter 6 focuses on the findings of the study with attention on the two other research questions: Why do HCA participate in extended roles? And can policy changes explain the use of extended roles; focus being on Agenda for Change policy? It reviews and explains why HCA take on extended roles. The chapter also explores the role of AfC policy and whether it has an influence of extended roles, how was it meant to work. It also focuses on the regulation of the HCA role especially as they take on extended roles and the reviews the influences of policy in terms of how it works versus how it is supposed to work. It further explores the theory of psychological contract and uses it to explain the occurrence of extended roles as well as the reason why staff respond to extended roles the way they do through the notion of third party obligation within psychological contracts.

Chapter 7 presents the discussion and conclusion of this thesis. It highlights the research questions and offers a summary of the findings including the contributions of the study. The research contributions include; first, empirical knowledge in which this study offers new data on the nature and extent of extended roles in the NHS, how extended roles vary depending on the context between organizations. It also contributes important information on the lack of effectiveness of HR policies and regulations in the NHS. Second, theoretical knowledge whereby the study develops a novel approach to understanding the causes and responses of extended roles by staff, and that is through the use of psychological contract theory and in particular the notion of third party commitment, as it advances our understanding of this phenomena. Lastly, the study also offers some implications for policy and practice in the NHS and other health organizations and the methodological considerations for the study. It also offers directions for future research.

In the following chapter 2, a literature review is presented with sections that review what might be expected as significant influences to the way in which extended roles are approached and the way in which they play out.

CHAPTER TWO

LITERATURE REVIEW: THEORISING EXTENDED ROLES

2. Introduction

This review chapter is particular in that it assesses the literature that is directly linked to the nature of non-professional roles and explores the reasons for their continued engagement in

extended roles. The sections that are introduced here link the different aspects of the study by first presenting a review on skill mix. Whereby, the focus is on why skill mix is used to perpetuate the continued engagement in extended roles.

Second it offers a review on extended roles, which is defined in healthcare as members acting in a proxy capacity, by covering specific medical tasks, which remain under the jurisdiction of the medical profession (Harvey, 1995; Abbott and Meerabeau, 1998). This can be subcontracting selective tasks to a subordinate adjacent profession, whilst the tasks remain under the ownership and control of the dominant professional groups (Riley and Peters, 2000). In other quarters the term role drift has been used to describe the notion of professionals delegating their core duties to assistants and those duties then form part of extended roles (McKenna et al, 2007). Extended role is therefore introduced in this study as a specific type of skill mix change.

Third is a discussion on theories that have been used to explain skill mix change which include labour process theory, system of professions and social closure approaches. These approaches discuss issues that arise out of changes in the division of labour such as exploring the consequences brought on by the blurring of role boundaries within the professions (Daykin and Clarke, 2000). They compare the workforce environment and how they engage in their work, hence the use of the labour process theory to define the compromises that organizations have to make in terms of resource allocation, which in turn has an impact on the roles that the workforce engage in. This also enables an assessment into the interrelations between different occupational groups in healthcare that contribute to this debate especially the influence of jurisdiction and closure approaches within the professions as these explore reasons why groups of staff engage in extended roles (Hyde et al., 2005; Kessler et al., 2007; Bach et al., 2012).

Fourth section offers a review of the research that has been conducted on extended roles, highlighting the deficiencies in the research. From these debates a clear gap emerges which is

based on the fact that research has been carried out on non-professional roles, but not much within the health sector. This is significant because there has been a quest by government to make major changes in the skill mix of professionals and non-professionals in the public sector. From this gap arises some more specific research questions which focus on extended roles as a specific form of skill mix, and the need to develop an approach that elaborates our understanding of the causes and drivers of extended role. The review also raises the need to know the impact of organizational HR policies and regulations on extended roles and the response from the staff on their experiences of their taking on extended roles.

Lastly is an introduction of a new theory that makes it easier to address the research questions. This includes a review of psychological contract theory and the introduction of the notion of the third party obligations. This section also introduces human resource management (HRM) theory on human resource planning (HRP), which broadens the scope to understand nature of work and reviews the evolution of HRM, especially as it relates to pressures in the public sector due to the increased influences of policy changes that affect the environment in which extended roles might occur.

2.1. Skill mix

In practice there is a great deal of variation in what is meant by ‘skill mix’ or ‘personnel mix’. The term ‘skill mix’ can refer to the mix of posts in an establishment; the mix of employees in a position; the combination of skills available at a specific time; or the combinations of activities that comprise each role. Skill mix can be examined within occupational groups, or across different groups, such as nurses and doctors, or between different sectors of the health system (Buchan et al. 2000; Hyde et al., 2005). Needham (1996) defines skill mix as the balance between;

‘trained and untrained, qualified and unqualified and supervisory and operative staff within a service area. Whereby, the optimum skill mix is consistent with the efficient

deployment of trained, qualified and supervisory personnel and the maximization of the contributions from all staff" (Needham, 1996; 127).

In healthcare this is further described as re-distributing care tasks and responsibilities across different types of staff (Adams et al, 2000). This means that within each skill mix all members pull in their weight in terms of their experiences and expertise for the benefit of the group and also for the end result.

Over the years skill mix has been associated with the need to reduce spending on staff and enforced economies of scale, rather than a planned approach to genuine multidisciplinary or mixed teams (Buchan and Calman, 2005). In various contexts, skill mix is defined as part of a larger discussion on cost-containment, stressing efficiency, competency and reform. Issues such as cost containment has led to the delegation of tasks to less qualified, lower paid workers often referred to as non-professionals (Bourgeault et al., 2008). As an example local authorities have used skill mix as a response to reduce the demand for agency staff, whereby together with a variety of other measures such as offering flexible working they use them as a solution to address staff recruitment and retention issues (Hoque et al., 2011). In other instances, skill mix is viewed as both a determinant and determined by organizational and system context, because the basis on which skill mix is viewed and taken up is dependent on the identified needs of a specific population, then matching those needs to the skills of available staff as in the case of health (Dierick-VanDaele et al. 2008).

Skill mix change can therefore be defined as encompassing descriptions such as substitution/delegation, workforce remodelling multi-skilling, workforce redesign, diversification and task or functional flexibility (Halliwell et al., 2000). These definitions simply refer to the way in which the skills components of jobs are altered within organizations as well as shifting work between different staff groups (Tuohy et al. 2006). In health skill mix has been highlighted as a policy issue over concerns about existing roles and the need to focus

on human resources because they are the backbone of all health actions. As the HR remains a key focus, these changes in skill mix may be driven by various motives including; the need for service innovation, staff shortages, the need to improve quality and service, the focus to reduce costs and improve the delivery of services and efficiency, career development and quality of work-life for the workforce (Buchan and Calman, 2004; Bourgeault et al., 2008).

In this study skill mix is viewed as the attainment of a balance between trained and untrained, qualified and unqualified, supervisory and operative staff within a staff group and service area. Of great importance is the need to balance between the members of staff within the different units and enable special focus within the departments in order to provide good quality, cost effective and efficient care. Therefore, the professionals and non-professionals need to have a good working relationship in order for the changes brought on by skill mix to succeed.

The next section explores the definition of extended roles and it use as an example of skill mix change.

2.2. Extended Roles Defined

This section further explores the definition of extended roles and uses it as a as a particular example of skill mix change. As was stated earlier, extended role is described as a proxy role, in which members take on specific tasks that are not normally their roles, while those roles remain under the jurisdiction of the main profession (Harvey, 1995; Abbott and Meerabeau, 1998). This can be sub-contracting selective tasks to a subordinate adjacent profession, whilst the tasks remain under the ownership and control of the dominant professional groups (Riley and Peters, 2000). Extended roles consist of different and varied roles from one institution to another; they are additional roles that are not part of core training and are better characterised as specialized roles (MacDonald et al, 2005).

There are two distinct notions that combine to form the definition that reflects the authors understanding of what is meant by extended roles. The first is the notion of role drift, as stated earlier it stresses the fact that extended roles are roles that have been under the preserve of a recognised profession, but over time those roles have been delegated to other occupations, through a process of occupational imperialism (Larkin, 1983). Occupational imperialism therefore, implies that professionals discard undesirable tasks from their profession and delegate them to occupations with lesser qualifications (Larkin, 1983; Nancarrow and Borthwick, 2005). The professionals essentially do away with tasks that they deem unsuitable while simultaneously noting that their time would be better served elsewhere, if those tasks were not part of their core roles. The second notion perceives extended roles as the extra additional roles that are added to ones' duties without considering whether they are qualified or not to take up those roles. As it is expected that extended roles become taken up by junior staff or non-professional workforce, it is therefore important to be informed of the reasons that lead the workforce to engage in extended roles.

This study views extended roles as a particular example of skill mix change, because non-professional staff are being used as substitutes and often as complementary staff for professional staff. This is done to the extent that extended roles have become routine roles for these non-professionals (Sibbald et al., 2005; Bluestone, 2006). The substitution and increased roles for the non-professionals may result in development and enhancement of services and not necessarily labour substitution. Therefore a focus on the reasons for non-professionals engaging in extended roles is sought in this study, with the need to explore the results of skill mix changes such as HCA engaging in extended roles (Richardson et al., 1998). The next section explores theories and concepts that help in understanding skill mix change.

2.3. Change in Skill Mix

In this section a discussion on theories that have been used to explain skill mix change are explored. These theories include labour process theory, system of professions and social closure approaches. An overview is given on these perspectives so as to help in understanding how these processes have led to changes in skill mix resulting in extended roles. The goal is to explore the nature of skill mix change and link these theories to the research concerns which are based on understanding how and why extended roles occur.

2.3.1. Labour Process Theory

This section explores the labour process theory and contextualizes its role in changes in skill mix. The transformation in the public sector and changes in the division of labour through HRM has led to changes in public sector employees and made for tighter management controls over their labour process (Bolton, 2004). Debates on management control based in terms of degradation gained prominence after Braverman's publication of *Labor and Monopoly Capital* (1974). He defined the labour process as the separation of the work of production into its constituent elements. In which objects, people, tools, knowledge and tasks become organized such that they can be transformed into different objects or services that have some form of value for others (Wardell, 1999). He argued that capitalism meant degradation of work through deskilling which made for a cheapening of the labour process through the scientific method (Braverman, 1974). Degradation therefore became more known as a management control strategy at the expense of other approaches that were based on empowerment (Bach et al, 2007).

Labour process theory provides a platform in which to analyse work and work organization (Adler, 2007). As in the case exploring the employment relations of the nursing professions, it is the view that nurses have been the target of management's goals to create efficient and quality services in the NHS (Nancarrow et al, 2005). There has been a continued drive towards cost-

effectiveness, quality of care and clinical governance that has led to the move by managers to increasingly assess the mix of staff skills. The way in which this initiative has been approached has been through establishing an NHS workforce with a reasonably low pay bill in order to provide value for money (Bewley, 2006). This has led to policy initiatives that re-design and enlarge jobs as an attempt to change skill mix within the workforce.

Changes in skill mix have enabled the re-profiling of the workforce, which has been achieved through replacing high-level expertise with less specialised workers at lower remuneration (Thornley, 2000). It is therefore expected that as healthcare organizations adopt HRM principles that facilitate engaging in skill mix and thereby encourage extended roles, there is bound to be more reactions from the workforce as to the way in which the practices are adopted and the way it affects them in their working environment. The introduction of such a principle with the objectives of delivering improved patient care by enhancing the role of staff provides the template that encourage extended roles within healthcare (Crossan and Ferguson, 2005). The result is that organizations are increasingly being forced to take up new ways of working by making compromises on how they deal with their workforce, especially in terms of re-organizing their work. In the end, labour process becomes more of a way in which managers are pressured into making decisions that makes work intensification inevitable, leading to more forms of management control as a response to dealing with changes in HRM (Applebaum, 2002; Hyde et al., 2005; Nancarrow and Borthwick, 2005). Another aspect is that skill mix changes are part of a wider process of systematic deskilling, such as in the debates on proletarianization and professional deskilling whereby deskilling occurs because it is driven by economic priorities.

2.3.2. System of Professions

This section reviews the systems of professions and it explores the issue of power relations and jurisdiction within the professions. This encourages discussion about control within the labour process and, in turn, factors that affect the roles of the workforce within organizations.

It is important to begin with a definition of professions. Abbott (1998:4) defines professions as

‘Organized bodies of experts who apply esoteric knowledge to particular cases, in which there are; elaborate systems of instruction and training, together with entry examination and other forms of prerequisites. They also possess an enforced code of ethics or behaviour’

In Abbott’s definition he further offers a theory linking professional life to the profession and its work, which he then refers to as jurisdiction. The focus is on how a profession is anchored by formal and informal social structures (Abbott, 1998). Whereby, the ability of professions to sustain their jurisdiction is dependent on the power and prestige attributed to its academic knowledge. Academic knowledge therefore, legitimizes professional work by making clear the foundations and cultural values within those professions. Modern professions are referred to as those professions that exhibit ‘values of rationality, logic and science’ (Abbott, 1998:54).

The focus in the study of systems of professions has been on the ability of professions to claim jurisdiction over certain tasks, in addition to that has been to gain privilege so as to be in direct competition with other professional groups (Abbott, 1998). The model of system of professions basically links professions with tasks, whereby the main premise is to show that professions exist within a system. This point has also been made by Friedson (1970) and later Larkin (1983) when they argued that the key point in the professionalization of occupational groups was the need to have their practices acknowledged and then for the occupational groups to be able to receive state sanctioned licenses. Therefore the professions’ connections with the State makes it possible for them to secure professionalism, which then leads to the occupations having market control and social mobility such that occupations can maintain a legal monopoly

supported by government. The support from government re-enforces the fact that professions exist within a system.

In exploring professions therefore, the main concern then becomes the evolution and interrelations of professions especially the ways in which occupational groups control knowledge and skill (Abbott, 1998). Parsons (1951) was one of the functional theorists who tried to clarify the importance of professionalism through the use of the 'sociology of knowledge' (Parsons, 1951). He recognised how the capitalist economy, the social order and modern professions were interrelated and acted mutually to stabilise the social order (Parsons, 1951; Evetts, 2006). There are two ways in which professions establish control. The first emphasises technique, such that for a group to control certain occupations then the issue of control lies in the technique of the specific occupation. The second is abstract knowledge, in this case, practical skills come from an abstract system of knowledge, in which controlling the occupation depends upon controlling the abstraction that creates the practical technique.

Abstraction therefore makes it possible to survive within the competitive system of professions. The question then becomes how do professions sustain their jurisdiction? The response lies in the notion that professions, through academic knowledge, can claim to hold some power, prestige and legitimacy, to claim and justify their universal importance within the professions. In order to claim jurisdiction, a profession asks society to recognise its structures through exclusive rights. The professions compete within interacting systems to expand and defend their respective jurisdictions and even have control over access to education, training and the labour market through knowledge formalization (Macdonald, 1999). Therefore what is happening in the health sector epitomizes what has been happening within the professions as analysed above. It simply means that the knowledge is controlled by specific professions, who then control the healthcare environment to the extent that they are able to limit as well as increase the roles that certain groups of occupations can do. This therefore means that jurisdiction plays an important

part in controlling the labour process by stipulating the roles and tasks that are to be taken on by which occupational group.

In healthcare, there are high levels of coordination between professions in which formal divisions of labour tend to be informed by the blurring and negotiation of roles (Friedson, 1994). Abbott (1988) uses the concept of workplace assimilation to refer to the flexibility in the working conditions, such that boundaries between professionals disappear as non-professional staff engage in extended roles. Workplace assimilation therefore is a form of knowledge transfer in which non-professionals learn 'craft versions' of a given profession's knowledge because non-professionals lack the theoretical training that justifies them gaining membership into the profession (Abbott, 1988:65). A key feature of workplace assimilation is that it is an informal process, this concept is important in this study as it highlights this idea as part of the reason why extended roles occur and continue to persist. In addition the flexibility in extending roles across traditional professional boundaries has been informal and so far, no efforts have been made to change it (Saks and Allsop, 2007).

Therefore as stated earlier, the formation of the professions into distinct occupations occurred under different professionalization projects. These protected and secured specific areas of knowledge to ensure that regulation would be in place. This, it meant that entry into these occupations and work practices would be acquired and maintained for these professions, in order for them as a group to preserve social, economic and political advantage (Macdonald, 1995). Workplace assimilation also ensures that changes in skill mix and especially boundaries between professionals and non-professionals occur through a continued informal process. The need to preserve a profession to itself and its members is what has been referred to as the process of social closure, which is further discussed in the next section.

2.3.3. Social Closure

This section explores social closure as a theory that accounts for how occupations react to changes in skill mix. Social closure is a process whereby ‘human groups or organizations seek advantages and then erect barriers around themselves’ to exclude others and protect those advantages by only admitting specific ‘eligibles’ (Watson, 2001:89; Macdonald, 1995:29). This exclusion is not only aimed at maintaining a monopoly, but involves usurping existing jurisdictions so as to attain upward social mobility by the groups engaged in social closure whereby they secure their own advantage over other groups (Macdonald, 1995; Witz, 1992). Social closure has therefore been the means by which dominant groups have been able to achieve and maintain their position, and is a very useful concept in understanding cases of professional projects.

A conceptual framework that has been able to illustrate the complex relationship between various closure strategies, is that by Witz (1992). Witz draws on Parkin (1979) who defined professionalism as an exclusionary closure strategy, in which an occupation limits entrants and controls entry so that existing members gain power and increase their social status. Witz’s model defines the relationships between four key strategies of professional closure: exclusionary, demarcationary, inclusionary and dual closure. Demarcationary strategies are defined as mechanisms of inter-occupational control within related occupations in the division of labour, these strategies are useful as they also target different health and social care professions. Demarcation is an extension of exclusion, but with the addition of strategies that demarcate boundaries between subordinate occupations (Witz, 1992). Demarcation often occurs while maintaining advantage over practitioners in other fields and is quite common within the medical field (Macdonald, 1995).

The idea of demarcation as explored by Witz is similar to Larkin’s (1983) notion of occupational imperialism. Occupational imperialism is whereby certain occupations mould the

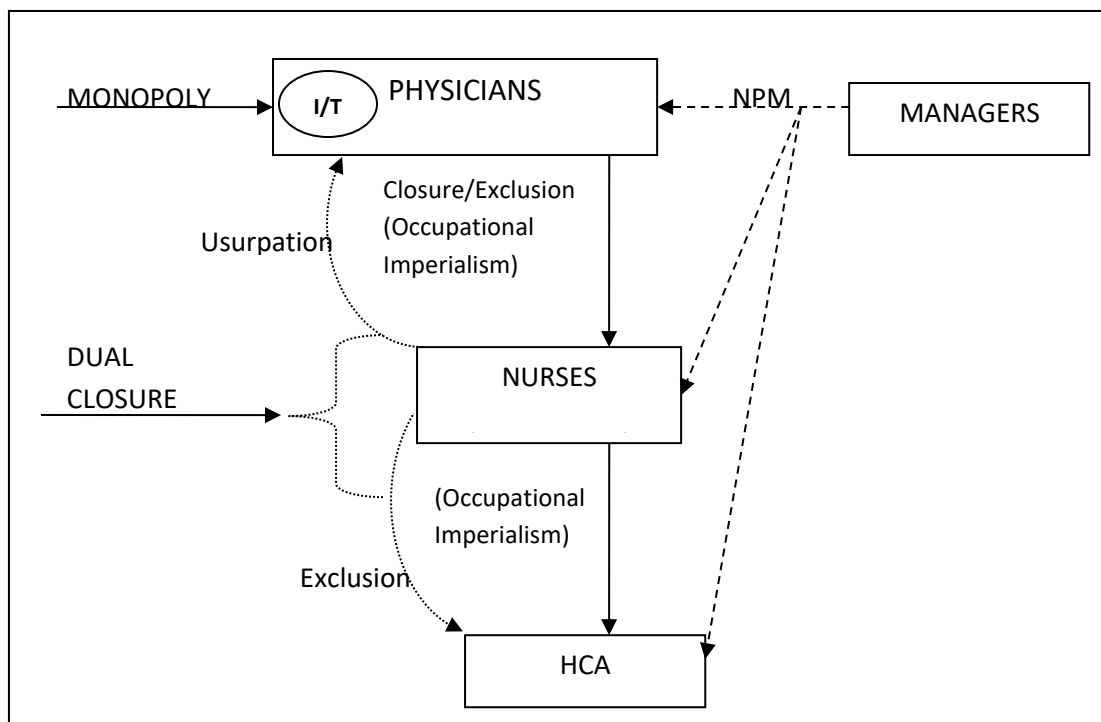
division of labour to their own advantage such that they can pick and choose what parts within their profession they can or cannot do (Larkin, 1983). This does not necessarily occur within all types of occupational conflict, as others can be reflected by Abbotts (1988) idea of struggle for jurisdictional control. Under this notion, as was stated earlier, boundaries within professions are always in competition with each other. Abbott (1988) argues that although a profession might be able to secure for itself monopoly over its work. It still needs to compete in the market, against others who can provide substitutes or complementary services. Consequently, the need arises to strive for jurisdiction over the occupation's knowledge and skills in order to defend it (Macdonald, 1995).

The concept of dual closure is more interesting for this study as it describes the double-edged nature of occupational closure strategy. Dual closure involves the simultaneous exercise of power in an upward and downward direction. Exclusionary strategies of occupational closure involve internal occupational control, where the main concern is regulating an occupational group's labour, and creating monopoly over their skills and knowledge. While demarcationary strategies seek to control the positioning and internal affairs of adjacent or related occupations within a particular profession. Exclusionary strategies have been used by the nursing profession and others alike towards groups of non-professionals and support workforce, making it difficult for them to gain opportunities and rewards.

HCA are a subordinate group to nurses by virtue of their status as non-qualified or non-professional staff. This fact has enabled the nursing profession through dual closure, to pursue their own efforts at professionalizing while at the same time frustrate the efforts of the non-professionals and support workers in trying to gain more recognition for their work and roles in healthcare. It is therefore quite significant that the exclusion aspect within dual closure is useful in explaining the status of support workers within the healthcare system.

The following figure 2.1 (page 40), illustrates the perceived hierarchy within the healthcare professions. The different aspects of social closure are defined, in which professions and other occupations pursue an agenda to develop and maintain monopoly in the market place for their skills, while they exclude others from their profession, by creating boundaries between themselves and the competing professions and occupations (Coburn, 2006).

Figure 2.1. Social Closure Theory – Power and Control of the professions Hierarchy in the Healthcare Professions



The physicians at the top have monopoly over the medical profession because of their power and control over medical knowledge. This notion has been defined by Jamouse and Peloille (1970) as high indeterminacy to technicality ratio (I/T). By this they suggest that professional work could be understood as a combination of activities that are based on some technical ability combined with some form of formal expert judgement, by individuals who possess specific personal qualities that are based within the profession (Jamouse and Peloille, 1970). They proposed that all professional work be characterised as having high levels of indeterminacy relative to technicality. Such that members of a profession can claim to exercise professional

judgement, where they place themselves, their actions and decisions beyond the scrutiny of their clients and the lay public. In the case of physicians, it means that by virtue of them having the medical knowledge they are the only ones with the liberty to exercise the rights and privileges that comes with the acquisition of that knowledge.

The illustration therefore suggests that through social closure, the physicians exclude the nurses from attaining professional status. On the other hand the physicians through occupational imperialism trade off some of their responsibilities to the nursing profession (Larkin, 1983). The nurses conversely, are involved in dual closure as they attempt to usurp the physicians on one end in trying to professionalise their occupation by taking on some of the roles that are defined as professional roles. And on the other hand they deny non-professionals access through exclusion, in that they do not wish for HCA to be granted status as an occupational group as they would be taking on roles that directly affect their nursing role. The non-professionals, in turn, end up taking up some of the roles that the nursing profession discard (occupational imperialism) as their own roles become extended. This can be attributed to skills mix changes in which nurses roles are enlarged to managerial, medical, and therapeutic remits, and increasingly devolving bedside nursing to the non-professionals -HCA (Adams et al, 2000). Consequently, the struggle for control goes on within these groups of professions. Within this mix there is also another aspect brought on by the role of new public management (NPM) and the inclusion of managers to this cycle of control. The managers bring another element of control as they have more power than the professionals because they control the budgets within the organizations.

Thus social closure refers to the ‘monopolization of opportunities’ or the ‘process of subordination’ where a group monopolizes advantages by closing off opportunities to other groups. Social closure theory accounts for how occupations react to skill mix change, in particular why established professions, like nursing, may try to prevent changes in the skill mix

and extended roles from being formally recognised. Following Abbott (1988), workplace assimilation takes place but professions try to ensure that this occurs within their limits in such a way that it does not challenge their control of the jurisdiction. The next section discusses research on extended roles, as it is the view that extended roles tends to happen due to closure strategies.

2.4. Research on Extended Roles

In this section the aim is to review some of the research that has been carried out on extended roles and to highlight the deficiencies. This section will then offer some research questions that will be pursued in the study in response to these research gaps.

As was noted earlier, extended roles seem to occur as an informal process whereby extended roles are increasingly delegated to non-professional staff (Hasson et al, 2007). There are three main reasons highlighted in the literature as part of the reason for participating in extended roles. The first is as a means of cost cutting measures, second is due to the increased shortage in numbers of skilled staff and third complex division of labour (Grimshaw, 1999; Nancarrow et. al., 2005; Spilbury and Meyer 2005; McGuire et al, 2007; Buchan and Evans, 2008, Bach et al, 2012). These reasons have been of focus because role extension seems to be driven by the idea of creating more efficient and effective forms of delivering services. It is seen as a less radical approach to redesign jobs than that of creating new roles, and it tends to perpetuate further extended roles as people take on additional tasks and responsibilities (Kessler et al, 2012).

The NHS modernisation agenda for instance has encouraged the use of flexible workforce, in order to not only enhance patient centred care, but also address the issues that arise due to systemic staff shortages that are encountered throughout the healthcare sector (DH, 2000; 2002). Role redesign on the other hand advocates the idea that extended roles ought to be

developed along the lines of ‘expanding the depth and breadth of roles, moving tasks up or down traditional uni-disciplinary ladders and crossing traditional boundaries’ (Hyde et al, 2005). Such programmes are introduced to encourage more workforce participation, facilitate skills mix and encourage extending the role of the workforce (Ham, 2004). These approaches show that part of the reason for engaging in extended roles is to modernize the workforce, but also to reorganize the way in which traditional working boundaries are structured, therefore making it easier for skill mix and extended roles to occur. Some of these programmes are by extension policies facilitated by government to encourage the occurrence of extended roles, in reality therefore it is expected that there is a well-organized approach to extended roles which is sanctioned by government.

Another reason has been highlighted as the pressures of the need for labour costs to meet with budget targets, which has caused changes in the organization of work such that it has encouraged extended roles as well as the increased recruitment of less qualified workforce (Grimshaw, 1999). Grimshaw’s review (1999) revealed that the engagement in extended roles was inevitable, as there were less numbers of qualified staff being hired. And the alternative was to hire unqualified/non-professional staff for less which led to the increase in number of unqualified staff and the take up of extended roles, these were done in order to balance the budget which was often a major concern. Harvey (1995) also attributes the pursuit of extended roles to part of the pressures piled upon the workforce to meet targets set such as the delivery of service that are set for maximum throughput, in her case it was that medical consultants were given specific targets for operations that they had to meet, and this caused pressures that led to extension of medical treatments using subordinate groups to facilitate meeting those targets.

The extension of roles and skills acquisition have been described as being attributed to two opposing paradigms that have resulted from the restructuring of work and the drive for new technology within organizations (Harvey, 1995; Bolton, 2004; Nancarrow and Borthwick,

2005). On the one hand it presents a drive to flexibility, multi-skilling and job enhancement which are all related to Post-Fordist forms of social regulation, and on the other hand increased de-skilling associated with intensification of work, in pursuit of Taylorist/Fordist forms of work organization (Harvey, 1995; Bolton, 2004). An exploration of changes within the professions in healthcare found that professional boundaries today are not as was thought before. This is because of the changes in the current workforce climate, which has been brought on by upward expansion of existing roles and introduction of new workers (Nancarrow and Borthwick, 2005). A reason for this happening more often is because there are unmet demands for health service professions. Research by Hyde et al. (2005) focused on the fact that government policies have shifted from restructuring and re-organising health services towards modernization, as attempts at tackling workforce reorganization and job design have become unsuccessful.

There are other studies that focus on re-organizing the workforce, an interesting distinction is that of the dynamic professional boundaries explored by Nancarrow and Borthwick (2005). They suggest that there are four directions of workforce movement within the professions these are diversification, specialization, horizontal and vertical substitution. Diversification and specialization are based upon expansion of professional roles within a discipline, while horizontal and vertical substitution are much more interesting for this analysis, as they involve movement of a discipline outside its traditional boundaries. As in the case of non-professionals engaging in tasks that are normal practice for other professionals, which is an example of an inter-disciplinary change. Taking on extended roles in the form of encouraging substitution has led to certain risks to the professionals, such as, the risk of encroachment in the existing professional boundaries as other groups take on their roles through the various means mentioned earlier.

Borrill et. al, (2005) strongly endorse the development of professionally non-affiliated staff as a resource within healthcare trusts. This group of unregulated workforce has brought the issue

to bear, as the focus is on how to utilise their human resource. The extension of their roles is seen by others as a strategy to change the roles and tasks performed by healthcare support staff for cheaper forms of labour through role enhancement, substitution, delegation and innovation (Nancarrow and Borthwick, 2005; Saks and Allsop, 2007; Thornley, 2007). The pressures and issues piled upon organizations with regards to ensuring that they have a sustainable workforce, with greater responsiveness to its patients/customers have enhanced radical changes in the roles of the workforce (Harvey, 1995; Grimshaw 1999; Hyde et al., 2005; Srivastava et. al., 2008).

It is important to note that some drivers of extended roles, have largely been in part sponsored by government through the initiation of policies that encourage the workforce to engage in skill mix change including extended roles. Also that the strain caused by budget cuts within organizations ensures that management have had a substantial influence on encouraging extended roles, because with insufficient budgets, it is impossible to hire adequate numbers of staff, with that said the few available staff have to engage in extended roles in order to meet their obligations.

Therefore, the reasons why extended roles occur can be stated as the following. Extended roles seem to continue through an informal process as roles become delegated to non-professionals. Other reasons are cost cutting measures, shortage in skilled staff, complex division of labour, implementation of policies which seek to modernize the workforce as well as change working practices making them more flexible. The need to better utilize human resources and address staff shortage issues (Buchan and Dal Poz, 2002; Buchan and Evans, 2008). These have led to extended roles being used as a strategy to change the roles performed by workers into cheaper forms of labour through role enhancement, substitution, delegation and innovation. These have also led to other factors that facilitate the use of extended roles are; the lack of resources to pay more qualified staff, which also translates to inability to train the available staff which means in adequate ways to advance their skills. This also means that the need to meet targets and the

pressures that arise from changes in the work organization make for the easier choice to engage in extended roles. The next section considers the issues highlighted in this section to explore the consequences of engaging in extended roles.

2.4.1. Consequences of extended roles

In this section the impacts of engaging in extended roles are discussed with the intention of highlighting the consequences of the same. Over the years, extended roles have taken on different forms. For instance in healthcare the increase in HCA/support worker recruitment has been linked in some quarters to having a direct impact on the role of nursing where substitution of some of their traditional nursing roles has taken place. In contrast, Paquay et al. (2007) view the changes occurring within nursing as a 'role drift' which has a double impact on the roles of both nurses and HCA. Role drift has been described as the cause of intensification in nursing such that nurses feel 'squeezed' at both ends of their working spectrum. On the one end, they drift towards medicalisation by extending their roles and taking on more professional roles that are in the domain of doctors and on the opposite end unqualified and unregulated workforce are seen as taking on extended roles which include some of the more traditional nursing roles (Paquay et al, 2007; Hasson et al, 2007).

The study done on the consequences of assistant roles in the public service is of particular interest (Bach et al, 2007). The study focused on the fact that in the UK public service, there was an emergence of assistants and the research sought to explore whether this influx led to empowerment or degradation for those in the roles as well as for the professionals that they work for. It centred on assistant roles in education and in social care. Their findings, suggest that there are different effects that occur as roles of non-professionals change, resulting in blended and contradictory outcomes for the workforce.

Intensification in this case is an example of what happens, an example is that it leads to nurses having less time to perform their main nursing duties such as taking observations, taking blood and discharging patients and so on, hence those duties get passed on to support workers. This change has also led to the increased involvement of support workers in patient care which has in most instances been associated with the shortage of qualified nurses (Nancarrow and Borthwich, 2005; McGuire et al, 2007; Saks and Allsop, 2007). These changes have therefore, led to an urgent need to address the ever-changing boundary between nursing and medicine. The Wanless Report (2002) also underscores the role extension and expansion of registered nurses (RN) as having a subsequent effect on the work of HCA, even to the extent of taking on some of the functions currently carried out by RNs (DH, 2002).

These issues while they demonstrate the nursing workforce's flexibility and the rapidly changing healthcare environment that non-professional staff are involved in, raises the issues of 'delegation, deployment and substitution' and whether the rise in HCA numbers leads to substitution of nurses or just a ploy to extend roles of HCA without having to recruit a more qualified workforce (Spilsbury and Meyer, 2002:66). This latter issue raises the need to evaluate the cost implications and whether the high cost of labour makes taking up extended roles as the only viable option. This seems to have been the case in healthcare, as some of the policy goals highlight that strategy. Policy debates have centred on the need for a healthcare workforce that can deliver quality, through efficient and cost-effective services but the way to achieve this is still not clear (Spilsbury and Meyer, 2005; McGuire et al, 2007; Buchan and Evan, 2008).

There has been a concerted effort to engage in extended roles through making changes to traditional workforce boundaries such as the increased drive to develop a flexible workforce where different professions are able to take up each other's traditional roles (McPherson et. al., 2006, Bach and Kessler, 2007). Some of the impact has been that more unskilled workers and non-professionals take on tasks that were previously the reserve of professional staff (Buchan

and Dal Poz, 2002). Extending roles have therefore, become recognised as a process in which groups of people with different skills work together in order to enhance their own skills and performance. As more professionals delegate tasks to other professional and non-professional groups, healthcare provision has increasingly changed into a conveyor belt of inter-professional teams with the potential to influence the roles of the members within these teams (Appel and Malcom, 2002; Nancarrow and Borthwick, 2005). These teams are not necessarily a bad thing, but the potential for exploitation is much higher.

It is said that to him whom much is given much is required (Luke, 28:12), hence once in team situations much is expected of members and therein lies the potential for extended role to occur. As members acknowledge the need for team effort to succeed because everyone's involvement plays apart in that success. On the flip side there might be a danger in the quality of services provided vis a vis the potential risks to the service users or patients and providers, and these should raise concerns to those that engage in extended roles, or supervise the same. Extended roles might not only be seen as created to make cost savings rather than improve services, but also results in instances that put the non-professionals under pressure to perform practices that are at levels beyond their expertise. This is often true when those taking up extended roles do not understand the standards of practice that guide the different roles within the particular professions. Consequently, those who take up those roles are not bound by those standards of practice; hence these situations might result in difficulties when trying to gauge fitness to practice issues especially where extended roles and practice occur (CHRE, 2010).

In support of the notion that teamwork provides improved results especially as team members engage in skill mix. On the part of the workforce, engaging in extended roles might be an opportunity to enhance their skills and careers (McPherson et al., 2006). The workforce may encounter job satisfaction to an extent that there would be no adverse issues arising from taking

on extended roles. As an example they would be content with their psychological contract and their perceived roles of what the job is.

Thus extended roles present an avenue to assess the way in which workers conduct their roles and in that respect review the balance in which service is provided in terms of the interest of the user vis a vis the experience and expertise of the workforce whether they work individually or in teams. This study will therefore, underscore the significant influences that are to be expected as extended roles occur. From what we know about extended roles, the questions that are raised from this review, suggest that there is a need to assess the way in which the non-professionals in healthcare perceive their extended roles in the organization, how they view their psychological contract especially as they engage in extended roles and lastly the influence that their psychological contract has on their organizational commitment and employee engagement. These issues are discussed next under psychological contracts.

2.5. Psychological Contract (PC)

In this section the psychological contract theory (PC) is introduced to help address some of the research questions. The PC offers a sophisticated way to understanding the drivers and consequences of extended roles, and the impact on staff as a result of their experience and response to changes in their roles. The goal is to discuss PC to discern its implication on the workforce as they engage in extended roles. It is important to explore whether a positive PC can be expected within a workforce that engages in extended roles and whether the workforce having a positive view of their PC may lead to positive outcomes as a result of that engagement. It is therefore, essential to first review the literature on PC as well as highlighting the author's use of it in the study and finally discuss how PC helps to better understand and address the research questions raised earlier.

2.5.1. Defining Psychological Contract

The workplace is changing such that the relationship between employees and employers are being redefined both fundamentally and permanently (Guest, 2004). Some of the changes in organizations may lead to transformations that alter employment agreements to fit those changing circumstances (Guzzo and Noonan, 1994; Knights and Kennedy, 2005). As changes occur at the workplace, new behaviour is required of the employees. However the actual changes occur at an individual level through their own individual interpretations and most likely within the individual employee's psychological contracts (Maguire, 2003).

In this section, the goal is to explore the definition of psychological contract and then use it to better address the research questions. The concept of psychological contract has been referred to in the literature as the implicit and explicit promises that parties make to one another, as each party to the relationship brings their own perception of what is promised within the relationship (Rousseau and Tijoriwala, 1998). Simply described the psychological contract relates to the exchange relationship between the employee and the employer (Conway and Briner, 2005).

Psychological contract is not a new concept, even though there has been a renewal of interest in the past two decades. Coyle-Shapiro and Kessler (2000) suggested that the changes in employment dynamics have contributed to the re-discovery of the psychological contract. This resurgence and influence has partly been attributed to the works of Rousseau (1989, 1995, and 2001). However its historical roots can be traced further back to the writings of co-operative systems under the title 'The Functions of The Executive' by Barnard (Barnard 1938; Roehling, 1997; Coyle-Shapiro and Kessler, 2002). Under the cooperative system, Barnard (1938) proposed the theory of equilibrium which adopted an exchange perspective in which the employees' continued participation at the workplace depended upon adequate rewards from the organization. In other words there are conditions at the workplace that necessitate the contributions of the employee. The premise was that organizations worked as cooperative

systems by integrating the contributions of individual participants, such that there had to be a collective purpose that became morally binding on the participants.

This idea led to the exchange perspective that was later echoed in the discussions of other contributors notably March and Simon (1958), Argyris (1960), Levinson et al. (1962), Blau (1964) and Schein (1965). The work of March and Simon (1958) was very important as it brought about the idea of reciprocal exchange which consequently forms a core part of the psychological contract. Under the inducements-contributions model, they proposed the notion that employees tend to be satisfied when the inducements offered to them by the organization are greater in value than their actual contributions to the organization (March & Simon, 1958). The reciprocal aspect is that the offers made by the organization should be worthy of the employees commitment and contribution, which is to say that the organization should offer so much more to its employees in order for them to make greater contributions to the workplace (Roehling, 1997; Coyle-Shapiro and Parzefall, 2008). This mirrors some of the arguments that later developed in the field of psychological contracts.

Research on the psychological contract was on going and run independently and concurrently with the studies on social exchange theory (Gouldner, 1960; Blau, 1964). Under social exchange theory, the central premise was the need to focus on the compromise that had to be made within social relationships. Homans (1958) who founded the theory was concerned with the behaviours of individuals as they interacted with one another; his was the concern over the reinforcement principles that made people select their next social choices based upon their past experiences.

According to Blau (1964) the exchange of social and material resources was a fundamental form of human interaction. At the core of the exchange relationship was the notion of shared understandings and reciprocal contributions for mutual benefit, referred to as norm of

reciprocity – where individuals are obligated to respond positively to favourable treatment by others. Social exchange therefore entailed unspecified obligations and unequal powers that influenced resources, such that when a favour was accorded to an individual it was expected that there would be some form of return in the future, a reliance on trust that in the future it would be reciprocated (Blau, 1964).

Norm of reciprocity therefore perpetuates the notion that ongoing fulfilment and gratitude are important aspects within the social exchange relationship. Gouldner (1960) also projected the same argument on the norm of reciprocity stating that the strength of an obligation to repay was contingent on the value benefit received, therefore the higher the value of the benefit the stronger the obligation to reciprocate. Norm of reciprocity suggests that employees seek to maintain a balance in the employee-employer relationship. Therefore, psychological contract and social exchange theory share some common elements, because there are sets of expectations that are brought into the relationship by the different parties. This is the notion that within the exchange relationships there exists some tangible and intangible elements expressed by the norm of reciprocity (Coyle-Shapiro and Parzefall, 2008). Social exchange theory prescribes a better understanding to the employee and employer relationship, in which employees reciprocate employer treatment. Social exchange theory therefore conjectures that employees are encouraged to seek fair balanced relationships between themselves and their employers (Suazo et al, 2005).

Research on the psychological contracts culminates in the work of Rousseau (1989) who is credited with re-energising research on this topic. As mentioned earlier, her work reconceptualised the notions attributed to psychological contract in such a way that it became easier to connect early works of psychological contract to current contemporary research into the area (Coyle-Shapiro and Kessler, 2002; Conway and Briner, 2005). Rousseau (1989) defined psychological contract as the employee's perception of the reciprocal obligation which

exists with their employer, as well as their own obligation to the employer. Central to the employee-employer relationship within the psychological contract is the unwritten agreement on the reciprocal exchange elements existing between an individual employee and the organization (Rousseau, 1995). Therefore the psychological contract consists of the individual's perception of the mutual obligations within the employment relationship and these tend to be bound by the norm of reciprocity.

Conway and Briner (2005) state that earlier research depicted the relationship as being focused on expectations within the relationship, but Rousseau highlighted the notion of obligations. Obligations would arise out of the perception that a future promise had been made based on expected actions and outcomes. In contrast to Schein (1965) who stressed the need to match expectations between the people within the employment relationship, Rousseau (1989) emphasised the idea that the psychological contract was inherent in the individual. She emphasised individual expectations rather than matching those expectations of both parties to the exchange relationship, hence the shift in focus from two parties to the exchange to that of an individual's perception of the obligations of both parties to the exchange relationship.

Locating the psychological contract to the individual level is the distinguishing feature of Rousseau's work (1989). This is what makes her definition a focal point in this study, the author identifies with it because it portrays the view that the individual has the power within the employment relationship. The power comes in the fact that they have influence over their contribution to the relationship which does not necessarily consider the promises made during the exchange between them and the employer. The next section explores the usefulness of the psychological contract to evaluate the employment relationship within the context of this research.

2.5.2. Why engage Psychological Contracts in this study

Research on the psychological contract is a fairly recent development, such as how it affects work attitudes and behaviours, but it is in the health sector and within the NHS that using this theory is appropriate. This is because the NHS has for long been viewed as a good employer with commitment to staff and the general perception is that the NHS is associated with high levels of satisfaction and loyalty from the workforce (Guest & Conway, 2004; Hyde et al., 2009). Kirkpatrick and Hoque (2005) devised the term ‘model employer’ to denote the fact that the state as a public sector employer was able to maintain employment relations that was distinct from the private sector. And as such, the state was viewed as exemplary in terms of the quality of employment relations, terms and conditions of employment and fair treatment to employees. Emphasis was placed on staff training, equal employment opportunities, collectivized industrial relations and employee joint participation in decision making; all this resulted in high job security and generous pensions (Black and Upchurch 1999; Boyne et al. 1999; Brown 2004). These conditions were considered ‘necessary to attract, retain and motivate the most skilled and professional staff’ (Farnham and Giles, 1996:118).

In view of the fact that using psychological contract is appropriate, Schein’s definition of the psychological contract therefore resonates well with this study. This is because it describes the fact that the individual and the organization are at cross purposes with each other, each assuming different expectations from each other. This is interesting because the idea of matching expectations is important when reviewing the positive impacts of psychological contract and is useful in the study when reflecting on the impacts psychological contracts have on extended roles for the healthcare workforce. It is of interest to explore whether a positive psychological contract may lead to positive outcomes as a result of engaging in extended roles. Especially because there might be tensions within the workforce that may make positive psychological contracts difficult. Thus a positive outcome such as job satisfaction, commitment

and performance is dependent upon matching the expectations and fulfilment of the needs of the parties to the employment relationship. The author agrees with Schein's analysis because it is important that within the psychological contract the perspectives espoused by both parties to the employment relationship are considered, even though the lack of cumulative works around the differing emphasis on psychological contract has led to the ambiguities that have still lingered in the field (Conway and Briner, 2009)..

In addition, Rousseau's definition is also adopted for this study, because it considers the psychological contract as an employee's subjective understanding of a promise based on reciprocal exchanges between them and the organization (Rousseau, 1989). This definition aptly captures the tenets of psychological contracts, in which there is the acknowledgment of the subjective nature of the employee's interpretations of the terms of the contract and the existence of the promissory nature which is closely associated with a contract. The psychological contract offers a framework that helps to relate the employer and employee relationship within the changing labour market dynamics (CIPD, 2008). The ideals of psychological contract have over the years changed from offer of job security, to being defined as the offer of commitment by employee and in return the employer agrees in essence to offer fair pay and treatment and develop opportunities for training and development.

Organizational changes whether by policy initiatives or other causes have always resulted in the breakdown of these traditional relationships between professionals and non-professionals (Guest, 1998). In terms of employees' psychological contracts, especially what might be expected to happen as they engage in extended roles it is important to reflect on the subjective nature of the psychological contract. This is because in this study it refers to the extent in which healthcare employees view the happenings in their environment and whether they view this as occurring in the same manner (Conway and Briner, 2005). The definitions given of psychological contract emphasise the fact that they are held at an individual level, such that an

employee never fully understands the organization's behaviours and equally the organization never fully understands the behaviour of the employee, making the interpretations on both sides incomplete and highly subjective. In addition there are often contradictory sources of information which influence the way in which psychological contracts develop which makes them remain subjective. It is important to note that within a psychological contract, there exists a perceived agreement, in which each party believes that there is an agreement. This is significant because it raises the issue on whether psychological contracts should be considered individually or whether some degree of an actual agreement is needed between the parties. It therefore portends that if psychological contract are predominantly subjective, then it is better to analyse it at an individual level, but if it involves agreement between parties then an analysis that reflects the relational level would be better (Rousseau, 1990; Conway and Briner, 2005).

It can be expected that individual non-professional attitudes towards their careers will influence their individual views on extended roles. Hence the need to focus on their individual attitudes towards their work as they engage in extended roles and from that discern their views of psychological contract at work. There are many factors that may influence the employees' attitude towards their psychological contract at work. From the first day of employment employees already have their own expectations of what the employment process is about, what is expected of them, their colleagues and the organization. They bring existing expectations to the place of work, together with outside factors that they may have heard of on the nature of the employment relationship, in addition other broader political and economic factors add up to shape their perceptions of their psychological contract (Conway and Briner, 2005; Maguire, 2003).

The nature of the role has an influence on an individual's psychological contract. The perception already exists as to the status of non-professionals, in which they are viewed as unqualified staff with less standing, whose role is that of taking directives from the more

qualified and professional staff (Nancarrow and Borthwick, 2005). The fact that often non-professional's work is often scrutinised and their input or opinion is not necessarily sought after while in the working environment. This precedence does not encourage a view in which non-professionals are optimistic of their roles, even as they engage in extended roles. Equally, the way in which non-professionals are treated in their organizations has an impact on their psychological contract. This notion is referred to as exchange ideology whereby the way in which employees are treated by the organization reflects upon their work effort.

Huseman et al. (1987) refers to this notion of exchange ideology as the individual's equity sensitivity preferences, whereby they offer three categories defining the dynamics of equity perceptions. The first are the 'equity sensitives' they are employees keen on getting fair and equitable returns for their efforts, they exhibit the classic equity theory preference whereby they seek equity and preference for input and outcome to be equal when compared to the other (Adams, 1963; 1965). The second are the 'titleds' which refers to those employees who are comfortable with being over rewarded given the effort they put on the job and prefer their outcomes to exceed their input. Third are the 'benevolents' who are employees that tolerate being under rewarded for their efforts, they prefer to offer more to a relationship than what they get from it. As non-professionals are viewed as employees of less standing, as they are neither highly qualified nor regulated as their other counterparts, it is therefore expected that they would naturally want to improve on their working arrangements. They would be grouped in the equity sensitives category because of their perceived need to be treated fairly at work and receive equitable returns for their efforts, while on the same token other non-professionals would fall under the benevolents' category as they may tolerate the position in which they find themselves for one reason or another - another suggestion is explored in the section under third party involvement.

The concept of the psychological contract captures the reciprocal promises and obligations that are implied within the employment relationship, it is therefore assumed that it is part of a mechanism in which levels of work satisfaction among employees might be explained. Especially as they extend their roles or work beyond contract consequently making more contributions at the workplace (Penna, 2007). The term psychological contract therefore offers a broad explanatory framework to understand the impact of changes in the attitudes and behaviours of workers (Latornell, 2007). It is based on the beliefs that employees and employers have of their working relationship. It is about fulfilling obligations that might not be written on the employment contract (Rousseau, 1989). With the decline in collective bargaining and increase in personal interest at workplaces, informal agreements have become more significant (Guest, 2004). In this study's context of non-professional workforce are expected to work beyond contract even as the recognition of their extended roles have been curtailed by the more established professions. The fact that there might be differing agreements within the employment relationship open up the notion that these might result in breach and violations of the psychological contract, this is explored further in the next section.

2.5.3. Psychological Contract: Breach/ Violation

In most studies on the psychological contract, the concentration has been on the idea of breach or violation and the consequences that arise from the failure of contracts, yet it remains an area of concern as it is still underdeveloped (Conway and Briner, 2005). Breach is often used interchangeably with the concept of violation and in most instances it seems a disadvantage to treat the two notions as separate ideas. However, a key distinction which is accepted in most fields describes 'breach as a cognitive comparison of what has been received and what was promised, while violation is the extreme affective or emotional reactions that may accompany breaches' (Morrison and Robinson, 1997; Conway and Briner, 2005:64). The employment relationship provides the opportunity for members to the contract to abide by the stipulations

of the said contract, with failure by any members to the party leading to consequences that might affect either party adversely. Exploring the idea of breach is important as it reviews issues associated with attitudes and behaviour of the workforce which informs part of this study.

Psychological contract violation has been described as the failure to comply with the terms of the contract. They tend to be the employee's perception that the organization has failed to fulfil one or more obligations, in other words it is the non-compliance to what they expected of their employer's promises at the start of employment (Knights and Kennedy, 2005; Osland et al., 2007). As a result of these violations it can be expected that there would be changes in the employee's behaviour, commitment and obligation (Robinson et al., 1994; Wolfe Morrison and Robinson, 1997; Knights and Kennedy, 2005). Moreover, this study uses the research evidence that violations of psychological contracts tend to occur and highlights this fact within the study's setting. As the added aim is to further explore the repercussions of the violations, as employees seek to create psychological contracts that they perceive to be more about self-actualization and purpose (Turnley and Feldman, 1999). Exploring psychological contracts helps address the research question as it offers a new theory, in psychological contracts and the concept of third party involvement, as the attributing factor to the why non-professionals engage in extended roles and this is further discussed in the next section.

2.5.5. Psychological Contract: The Third Party Involvement

The author puts forth the notion that in the public sector just as in other sectors, there is a high chance of violation of the psychological contract. But the empathy that exists in the nature of work that the non-professionals in this case HCAs are involved in renders this constant violation problematic. This is because the psychological contract involves more than just two parties. The third party involvement happens to be the role played by the patient and or customer receiving the services offered or rendered at the organization or institution. Through this distinction the author suggests that psychological contract not only involves two parties as

earlier studies of the psychological contract (Argyris, 1960; Levinson et al., 1962; Schein 1965) suggest nor the individual and their sense of obligation as current studies imply (Rousseau, 1989; Tekleab and Taylor, 2004), but that the involvement of a third party changes the way in which psychological contracts should be assessed.

The inclusion of the third party means that there are certain factors that need to be considered when defining the psychological contract. Firstly, the number of people involved in the contract. In this case it is three people, first the employer, second the employee and third the patient or customer. Secondly, this means that the individual in this case the employee, has an unwritten obligation to the employer as well as to the patients or customer, because the employee acts as the custodian in terms of ensuring they provide direct and necessary care or service to the patient or customer. Lastly, is examining whether there might be violations to the individual contract with the employer, whereby there are two options that may be expected. The employee may still feel obliged to the patients or customer and because of that ensure that their psychological contract with the patient/customer is not broken. But if they retaliate, then the opposite applies. This is because they may feel less obligated to neither the employer (the first party) nor the patient/customer (third party) as they might feel acutely affected by the failure of the first party to abide by the contract, which would lead them to state that their psychological contract is violated.

The author's suggestion of the third party involvement in the psychological contract in the context of the employment relationship has repercussions to the dynamics of the relationship. The employee it seems is ready to engage in extended roles and work beyond contract because of the involvement of the third party to the psychological contract. They have a duty and are also bound to the third party. All the actions they take within their roles, becomes much more considered due to the third party factor and this also informs their ideology and reasoning behind their role towards the third party. Therefore, the fact that their role involves the duty of

care to their patients/customer as the top priority and to also ensure that they take care of the patient/customer's needs, that aspect of their obligation takes primacy even if their employer would be in violation of their psychological contract. Consequently, this means that they might not retaliate and betray the employer because they have an obligation to the third party. They would still engage in extended roles, even with the violations as their obligation to the patient/customer is not just a duty, but the higher cause or ideology that they engage in.

The notion of working for a higher or greater cause, has been highlighted by Bunderson (2001) as well as Thompson and Bunderson (2003), they refer to it as ideological currency. They argue that psychological contracts may be premised on ideological rewards and when a worthy cause is represented this alone can encourage employee contribution and commitment (Thompson and Bunderson, 2003). As noted elsewhere, the real motivation for employees comes from believing their work has a purpose and their part in making that goal achievable (George, 2001). Nevertheless, Thompson and Bunderson (2003) suggest that this motivation stems from company policy which is similar to the approach most commonly referred to as corporate responsibility (Branco & Rodriguez, 2007). Thompson and Bunderson (2003) define worthy cause as the employer contributing to a greater cause and by extension the employees feel that they support that cause. This study therefore suggests that the higher cause or ideology is what drives the engagement in extended roles.

The notion behind ideological currency suggests that the greater cause is attributed to organizations seeking to establish and adopt principle driven missions that may induce greater employee contributions. But in this study the author goes further to suggest that in the search by the workforce for meaning in the work that they do including the search for a greater purpose, the urge and endeavour to do better comes from within the individual worker. Therefore, when they are discouraged by the actions of their employer, they persevere because they feel their psychological contract is only half broken. The patient/customer is the primary cause of their

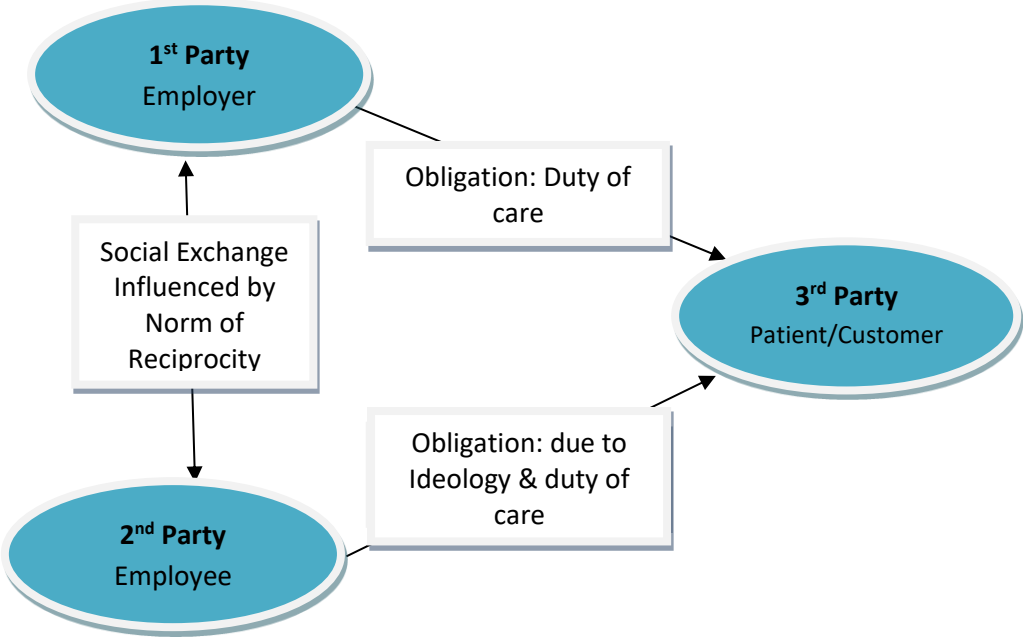
role, and their ideology is based on doing more for that cause or their patient/customer. This is highlighted by their endurance in the situations that they are caught up in which might include engaging in extended roles and other actions. The involvement of the third party reflects the transition to a new deal as expressed by Burr and Thomson (2002). This has been brought on by the increased cynicism within organizations, in which the workforce searches for a broader meaning in their work. They then tend to re-examine their main purpose at work as they seek to create other psychological contracts within the organizations because the older notions of the psychological contract no longer exists (Burr and Thompson, 2002; O'Donohue and Nelson, 2005). As a result the individual seeks to put their mark onto the organization and carve out a niche for themselves, then evaluate how well they fit into the organization, whether the organization fits their perceived notions of what it should be and do (Burr and Thomson, 2002).

The notion argued for in this study is the workforce finding out their pursuits within the work environment, what do the organization value, does that conform to some of their individual beliefs? The addition of pursuit for a valued cause or principle which is not limited to self-interest is the ideology argued for here. When an individual forms a commitment with the organization through the psychological contract, their ideology and instilled notions of the contract reflect their beliefs, Whether or not the organization provides for the environment in which their value can be utilised, the cause is greater and therefore they pursue it because they are bound to a third party within that contract. Under these circumstances, the proposed notion of a third party and discerning the persons involved in the psychological contract are highlighted as involving; the employer as first party, the employee as third party and lastly the patient/customer as the third party (See Fig. 2.2 page 64).

The argument then becomes that the third party to the relationship makes it possible for the individual to accept violations or breach of their psychological contract, due to the fact that their sense of obligation is not only to the organization, but also towards the third party. The

suggestion here is that the study of psychological contract can be enriched by considering the effects that the third party has on an individual’s assessment and sense of their psychological contract. The author argues that the sense of obligation is based on the fact that there is a third party involved. This ensures that the individual is engaged and represents a distinct inducement that brings out their commitment and contributions at work and partly the employee’s commitment to the obligations of the organization. The third party involvement means that the employee views their role as not just an ordinary role, but their ideology and the notion of a greater cause attached to their role which then influences their decision to engage in extended roles.

Fig. 2.2: The Psychological Contract and 3rd Party Involvement (Nature of relationship).



Source: Author adapted from (Blau, 1964; Schein, 1965; Rousseau, 1989; Thompson and Bunderson, 2003; Cullinane & Dundon, 2006).

The involvement of the third party to the psychological contract explores the notion that there are three parties to the psychological contract. Besides the social exchange idea that defines the relationship between the employer and the employee, the notion of ideology explains the

relationship between the employee and the patient/customer (Blau, 1964). This therefore, explains the reason why employees engage in extended roles, even when they feel that their psychological contract is broken by their employer.

This notion will be interesting to explore in the individual responses in the study. As the author goes further to suggest that the worthy cause comes from the individual's perspective of the need to do more, not as part of the organization doing more. It is based on them wanting to make their own contribution, and as stated earlier for them to come to self-actualization that the work that they do can count for something. The next section explores human resource management (HRM).

2.6. HRM

A brief review on HRM is discussed in this section, as it is used to better understand how organizational HR policies and practices might support or inhibit the continued uptake of extended roles.

HRM is referred to as a system, policy and practices that influence an organization's workforce, it is an all-embracing concept on personnel management (Patterson et al., 2010). In all organizations different resources are needed to ensure growth and development. Key among these resources; is an organization's human resources (HR). This is because HR determines an organization's potential. Consequently, an organization's potential to succeed depends on its human resources and how well they are treated, hence the need for an organization to identify and plan to satisfy its HR requirements (Bulla and Scott, 1994).

The relationship between the individual employee and the organization, is important in order to attain the proper utilization of HR. The individual and the organization through the psychological contract make contributions to the organization and receive certain rewards and expectations (Conway and Briner, 2005). It is at this crucial interface between the individual

and the organization that issues such as training and development, career development, job motivation, appraisals and HR planning in general become of importance. The discussions on this section provides some direction and explanation on the nature of extended roles, whereby as premised by the psychological contract theories, there might be greater commitment by the workforce if HRM strategies are properly planned.

HRM is important because it implies understanding the structures and climate in which employee's potential can be explored, released, developed and rewarded (Hunt, 1999). The perception that the organization values employee contribution can be felt through the investment and implementation of HRM practices. The workforce may in turn have a positive attitude towards the employer, resulting in affective commitment whereby they identify with the organization and are emotionally attached to it (Meyer and Allen, 1997; De Ruyter et al., 2008). This often happens when they feel that the organization is supportive and as such the environment reflects that. There are several HR best practices reviewed here that may foster the development and engagement of the workforce in extended roles, these include: recruitment, performance appraisals and training and development.

This study reflects on employee experiences of HRM to understand their involvement and continued engagement in extended roles. The analysis thus explores HRM in terms of three aspects; first, training and development which is vital in reviewing employee skills and abilities to perform. Second, compensation or pay and remuneration which in some quarters encourages employee motivation making it crucial in assessing the importance of psychological contracts (Rynes et al, 2004; Reena et al, 2009; Manzoor, 2011). Third, performance appraisals which focuses on career progression as well as reviewing employee opportunities to perform by engaging their knowledge, skills and abilities on the job. These three aspects of HRM are important in this study because they are directly linked to Agenda for Change (AfC) policy and can be used to assess the way in which extended roles unfold. AfC is reviewed later, however

it is a policy meant to deliver improved patient care through enhancing the role of staff. Key to this was that it would introduce fairer pay, and with that focus on improved recruitment, retention and motivation of staff making permanent employment appear more attractive (Crossan and Ferguson, 2005).

These three aspects provides for a clear role for HRM and the way in which organizations should function. First, training and development is important because it reviews what skills are required with the current workforce. This is geared towards improving and developing the skills and abilities of the workforce through training and development. Training and development within an organization therefore, focuses on its ability to provide the workforce with the necessary skills and knowledge to fulfil an organization's goals. The second is retention, whereby the retention of employees has the intention of providing opportunities for the workforce for career advancements. Thus, an evaluation of the workforces' skills, abilities and knowledge on the job is key because of the need to monitor the performance of the workforce through the use of performance appraisals. Once the performance of an individual is assessed there is room for management to assess the overall performance of the organization. Third, is the motivation of staff, which tends to affect employee commitment and performance when accompanied by other supporting management practices (Forde et al., 2006). These are often reviewed through pay and remuneration, especially once an individual's assessment is conducted. Motivation, recruitment and retention are three aspects of HRM that are well suited to tackle the demands and aspirations of non-professionals as they engage in extended roles and offer a solution to some of their employment relations issues.

Facilitating these HR policies on rewards and compensation, training and development and retention needs to be done through the monitoring of performance appraisals. Accordingly, a planned approach into human resource planning (HRP) needs to be assessed, whereby the right person for the job is considered. Planning is of no use if no action is taken afterwards. Therefore,

as HRP is not limited to people planning, but is a process with a larger scope of issues. To have an effective HRP depends on how well the current crop of employees are utilized and also a keener view into their future prospects within the organization. Thus, HRP becomes a notion that depends on considering the balance in organizational needs and the needs of the employees.

2.7. Discussion and Conclusion

In conclusion, this chapter has dealt with the literature review on theorizing extended roles. A definition of the term skill mix was offered as the balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area, in which there is the need to find an efficient deployment of trained, qualified staff forming part of optimum skill mix. From this definition it was revealed that extended roles are an example of skill mix change because untrained, unqualified, non-professional staff take on extended roles as they are substituted for and often become complementary staff to professional staff (Bluestone, 2006).

The chapter further explored the changes in skill mix by using theories of labour process, system of professions and social closure to explore the nature of skill mix. It offered social closure theory to explore the notion that changes in skill mix can be exploited through control over the process and division of labour. This was bound to happen due to occupational imperialism or strategies of dual closure which encourage change in skill mix within non- professionals resulting in extended roles.

A review of the literature on extended roles was also outlined and the reasons why extended roles occur were stated as due mostly to policy initiatives and financial constraints, and other factors such as, staff shortages, skills shortage and pressures in changes in the work organization. Finally the theories of psychological contract was used to provide some direction and explanation on the nature of skill mix change. Whereby, an alternative perspective of third

party involvement within psychological contracts makes it possible and acceptable for non-professionals to extend their roles.

This research therefore focuses its questions on two main issues, the first is the need to develop a more sophisticated understanding of the causes and drivers of extended roles for non-professionals, as well as the workforce's experience and response to extended roles and second, the need to understand the impact of organizational HR policies and regulation on extended roles. Therefore, this study offers the theories of PC especially its notion of third party obligation as a concept that helps in understanding and addressing these research questions. It uses healthcare as an illustrative case, in which the non-professionals examined are HCA in the NHS. The next chapter is an introduction into the role of the non-professional healthcare workers - HCA as they form the basis of this study.

CHAPTER 3:

HISTORY AND EMERGENCE OF EXTENDED ROLES

3. Introduction

This chapter is based on the main subject of interest in this research the HCA. It presents a historical context on HCA and extended roles in the NHS. It outlines how extended roles have emerged through a historical narrative. It makes the case that extended roles emerge as a result of the need to do more for less. It explores the fact that there have been policy prescriptions made which suggest that there ought to be sufficient HR infrastructure in place to lend adequate support to extended roles, such as guidelines for training and development, and remuneration as offered by policies such as Agenda for Change (AfC) which is mentioned later.

3.1. NHS: The Historical Context

In this section, a brief history of healthcare in Britain is provided. The Second World War became the catalyst that ushered in the creation of a reliable healthcare service, as the state assumed responsibility for the provision of healthcare for the purposes of the war effort. Paradoxically what seemed as though it could not be achieved in peace was achieved with remarkable speed after the onset of the war (Allsop, 1995:24). The 1942 Beveridge Report set the ball rolling for the creation of the NHS. It stated that basic healthcare service was to be made available to the whole population. Consequently, in 1946 the National Health Service Act became law and by 1948, the NHS came into existence and was the first health system in the western society to offer free medical care to the entire population (Klein, 1995). Over the years the provision of healthcare, has been seen as increasingly taken over by the state as exemplified by the creation of the NHS as a healthcare provider for all and funded by the state. The next section explores the organization structure of the NHS.

3.1.1. Organization structure

The formation of the NHS in 1948 involved consultations which included the health policy community and a range of pressure groups on one side and ministers and civil servants on the other (Ham, 2004). It has been argued that the structure of the NHS followed its historical formation, which resulted in its organization into three parts forming a ‘tripartite’ structure (Leathard, 1990: 27; Ham, 2004).

The first and closest link involved the general practitioners (GPs) and other services such as dentist, opticians and pharmacist, managed by executive councils. They were funded directly by the Ministry of Health, and in turn provided services to individual practitioners who were paid under contract through a capitation basis (Allsop, 1995; Ham 2004). The second link involved the Local Health Authorities (LHA) at Country and County Borough level. They were responsible for environmental and personal health services such as health visitors, immunization, ambulances, prevention and development of health centres (Leathard, 1990; Allsop, 1995; Ham, 2004). Third was the Hospital System, administered by new bodies, Regional Health Boards (RHB), University Medical Schools (UMS) and Teaching Hospitals (TH) and Hospital Management Committees (HMC) (Ham, 2004).

The ‘RHB were associated with UMS and TH to plan, provide and supervise regional services. The HMC were under the RHB and undertook the day-to-day administration of the RHB’ (Leathard, 1990:29). The Ministry of Health appointed the RHBs, which later on appointed the HMCs. The teaching hospitals were accorded special status organized under the Board of Governors and in direct contact with the Ministry of Health. The Ministry was answerable to Parliament and they were also in general control of the NHS and received advice from the Central Health Service Council (Leathard, 1990; Klein, 1995; Ham, 2004).

3.1.2. Reorganization

After 26 years of existence, the tripartite structure of the NHS was changed in 1974 as it had been accused of being an uncoordinated and fragmented system. In the past services were administered separately, but in changing and integrating the services the NHS would be able to provide for the development of comprehensive care through the new departments. It became evident that the divided services impeded the rational for allocation of resources, and as NHS services developed, calls for its unification grew much stronger (Leathard, 1990; Ham, 2004). The changes in 1974 unified health services by supervising all provisions under one authority.

Almost as the new structure was beginning to take form, attacks were being levelled against it. The complaints ranged from delays in decision-making, difficulty in establishing rapport between administrators and their departments and general misunderstanding caused by the increased tiers and administrators. Research on the operations of the new structure revealed other problems such as ‘the unexpectedly high cost of reorganization and the impact on staff morale’ (Ham, 2004:26). Parliament was not enthusiastic about the lack of effective accountability and the high cost of the reorganization (Leathard, 1990; Ham, 2004). These calls led to a further reorganization of the NHS from 1982 to 1984. The restructuring in 1982, had the goal of simplifying the NHS structure. It emphasised the delegation of power to units of management and to control the perceived ‘explosion’ of healthcare costs (Leathard, 1990:81).

The restructuring gave insight into the changing nature of the healthcare policy. In which the change was not about political ideology and consensus, but of how to finance the NHS especially during a time of financial crisis and realising that the NHS works differently not as a single national organization, but one that is run differently at the local level. As these issues were discovered, the Griffiths Inquiry was formed to look into the management practices of the NHS. They resolved that the central problem with the NHS was a generalized failure of clearly

defined management functions and recommended commitment by management above and below the level of health authorities (Walby et al, 1994; Klein, 1995, Ham, 2004).

3.1.3. NHS Reforms

The Griffiths report symbolised a clear shift in policy as it marked the beginning of the NHS 'managerial revolution', shifting its concern from its organizational structure to its organizational dynamics (Klein, 1995:130). The introduction of 'general management' simply meant that considerable decision-making independence was delegated to managers within a framework of prescribed budgets (Walshe and Smith, 2006:254). Policy initially focused on local management, but a different form of management emerged later on within the NHS (Ackroyd and Bolton, 1999). Management further enhanced the focus to improved performance, efficiency and consumerism, which ensured increased responsibility and accountability which also strengthened the management control of health care delivery by healthcare professionals (Leverment et.al, 1998). This also meant a complete change in the way in which work roles were restructured, including the increasing pursuit of work re-organization.

The reorganization in 1984, focused on reforming regions, districts and units. For the first time the NHS created a single line of command from the top to the bottom of its organization. In each tier of service, there was an increase in the power of professional managers. The wheels of irrevocable change had thus been spun and therefore, 'Whitehall was no longer willing to share power with clinical trade and no longer content to leave matters to the doctors' (Strong and Robinson, 1990:27). Apart from nurses protesting through poster campaigns, Doctors moaned but did nothing about it. The reorganization was here to stay; 'the assertion of central control, using full panoply of modern business methods to all who worked within the health service' had finally begun (Strong and Robinson, 1990:66).

The difference between the major changes was that in 1974 the emphasis was on a unification of administration while in 1982 the focus was on decentralisation and structural simplification of the NHS (Leathard, 1990:79; Allsop, 1995; Klein, 1995; Ham, 2004). There were other economic and political issues going on at the time the NHS was developed, some of which restricted expansions planned for public service and public expenditure an example is the ‘oil crisis of mid 1970s’ (Ham, 2004:31). These made the Labour government at the time to introduce tighter economic policies that brought it into conflict with its traditional support base the trade unions, which eventually led to a change in the corporatist style of British government politics that dominated the 60s and 70s. These changes were accelerated by the election of the Conservative government in 1979; they in turn pursued programmes that privatized state-owned enterprises, reductions in taxes and controls in public spending (Klein, 1995; Bach, 2004; Ham, 2004). The main focus of government policy in the early 80s was on how to make the NHS more business-like and efficient. The Thatcher government prioritised on achieving value for money in the use of public resources and as a result health policy focus reflected the emergence of New Public Management (NPM). The 1983 Griffiths Report brought the greatest policy reform, it had a longer term effect as it identified the absence of clearly defined management functions as the main weakness of the NHS and later laid foundations for the creation of internal markets (Ham, 2004).

On paper the labour government removed the internal markets, but in principle its main elements remained, such as the purchasing role of health authorities, provider trusts and GP commissioning. In 2002, the reforms of service replaced the RHA and District Health Authority (DHA) with 28 new Strategic Health Authority (SHA) and 310 Primary Care Trusts, by 2006 the number of SHA had reduced to 10 (Naidoo and Willis, 2008). The case for change has been brought on again by the urge to further modernise the NHS and make it into an organization able to meet the challenges it currently faces and prepare it for future ones. The issues and

challenges include; the increasing demands and costs to healthcare treatment, improvements on services, focus on quality of care for the benefit of patients and increased accountability which has been lacking in terms of holding the different Primary Care Trusts and local trusts accountable for their clinical decisions. These issues are unsurprising as they are the same issues that the NHS has been dealing with since its inception. As reforms seem to be a continuing revolution in the NHS, it becomes difficult to make assessments as there are no points of comparison. This is not the only problem, but constant reform of NHS employment practices, have led to a decline in government and managerial expectations (Bach, 1998). To further understand the reforms within the NHS the next section will discuss the employment relations and salient issues in the NHS that relate to its overall strategy.

3.2. Employment relations within healthcare

This section explores employment relations within the UK healthcare system. A better understanding is sought for some of the key issues that arise from the phenomena of extended roles. Employment relations is defined as a study of the regulation of the employment relationship between the employer and employee, 'both collectively and individually and the determination of substantive and procedural issues at industrial, organizational and workplace levels' (Rose, 2004:8). This section will explore employment relations system in healthcare, it will provide a general chronology of the history of HRM in the NHS, including information on grading structures, pay setting and staff in the NHS.

3.2.1. NHS Employment Relations

The NHS is an important area of employment as it is the largest employer in the UK and the third largest employer in the world (McBride and Hyde, 2006). There are over one million employees in the NHS (Grimshaw and Carroll, 2007). The most recent figures puts the breakdown as illustrated in table 3.1 (on page 75), there is a total of almost 1.2 million

workforce within the NHS hospital and community health service (H&SCIC, 2013). From the total, about 348,240 are support staff, who provide support to doctors, nurses and to scientific and technical staff.

The NHS has also been described as a model employer, because it standardized practice by decentralizing employment relations policy (DoH, 2002). Until the late 1980s employment relations in the British public sector was distinct from those in the private sector, as it was highly centralised. Consequently, the state through the NHS changed the focus back to continuity of employment, fairness in collective bargaining, investment in training and equal opportunity for the workforce (Kirkpatrick and Hoque, 2005).

Table 3.1: NHS Hospital & Community Health Service (HCHS) workforce statistics

Workforce	Headcount
Totals	1,193,147
Professionally Qualified Clinical Staff	636, 088
Non-Medical Staff	1,081,936
Qualified Nursing, Mid-wifery & health visiting staff	351,924
Qualified Scientific, Therapeutic & Technical staff	154,883
Qualified Ambulance staff	18,895
Support to Clinical Staff	348,240
Support to doctors and nursing staff	273, 594
Support to scientific, therapeutic & technical staff	61,203
Support to ambulance staff	14, 028
NHS infrastructure support	211,368

Source: Health and Social Care Information Centre, 2013.

There are other factors that have enhanced changes in employment relations within healthcare. The focus has been to restructure the management and reorganization of the health service by

changing employment practices and taking a different strategic approach to staff management (Hyde et al. 2005). Another has been an approach towards employee involvement and collective bargaining and relations with trade unions as defined earlier. Trade unions have become a form of encouragement to managers who often sought their support to implement their own agendas, rather than have them as the most important source of independent employee voice (Bach, 2004). Changes in the role of unions have had an impact on the HR function as more power has been left to the central government. HR now focuses on fulfilling the requirements of the audit culture such as 'taking annual staff survey, finding ways to drive down absenteeism and ensuring trusts follow various policies as required by government' (Bach, 2004:190).

A policy of particular interest is Agenda for Change (AfC) which has key employment relations reforms presented for the NHS workforce. AfC was introduced to the NHS workforce in 2004, it has been described as the most ambitious attempt to introduce a new pay system in the NHS. AfC applies to over 1 million staff across the UK except for doctors and dentists (Buchan and Evans, 2007). It introduced simplified national pay spines, for different groups of staff, this was a welcome relief as it replaced the Whitley councils which had multiple pay grades within each profession and replaced it with two new pay spines, one for staff that were covered by the remit of the Review Body for Nursing and Other Health Professionals and the other for NHS staff that are directly employed (DoH, 2004).

AfC advocated for equal pay for work of equal value, hence the implementation of the job evaluation schemes which was to ensure that the pay system would be underpinned by job evaluations. Job evaluations were also used to move staff into the new pay system, whereby job profiles were drawn up and evaluated, and staff that were within those job profiles were then assimilated based on the new job profiles. Another component of AfC, was the use of a competency-based framework later referred to as Knowledge and Skills Framework (KSF) (DoH, 2004). The KSF is a critical element of AfC, as it acts as a framework that reviews the

development of each staff, and is used to determine the individual pay and progression of an employee. There are KSF outlines for each job, and this details the levels and skills required for one to undertake their roles effectively. There are annual developmental reviews that ought to be taken of the employee's progress, there produce individual personal development plans (PDP). The PDP is operated through an online e-KSF tool, which is used to maintain and record KSF outlines and PDP. The process has been described as simple, easy to explain and understand, such that it should be feasible to implement however this has not been the case on the ground (Buchan and Evans, 2007).

3.3. NHS Support Roles and HCA

This section will explore the nature of the support role and in particular discuss the emergence of the HCA role within the NHS, it will highlight some of the challenges of this workforce in the NHS. The assistant or support worker roles within the public sector are seen as emerging occupations that characterize the 'changing nature of work' (Kessler et al, 2006: 668). The support roles have been positioned by policy makers as members who reduce 'burdens' of professionals so as to allow the professionals to focus on their core duties (Kessler et al, 2006: 668-70; Hancock et al, 2006). The support worker role, often builds rapport with service user and the bulk of their work is composed of offering practical assistance to the professionals. They also act as a bridge between service users and professionals as they facilitate better communication and understanding (Skills for Care, 2008).

Support workers are used to cover a wide variety of roles ranging from housekeeping staff, administrative staff and assistant roles to healthcare professionals (Rogers, 2002: RCN, 2007). The term support worker is not universally applied to those who perform these roles, there are variations in the title some maybe known as healthcare assistants, care assistants, support workers, nursing assistants and so on, some of these terms will be used interchangeable in this

study (RCN, 2007). Support workers in health have always performed the supporting role for nursing care, and generally have been formally referred to as nursing auxiliaries. This group of workers perform 'generic' rather than specific, unskilled roles in which they provide direct personal care which does not require the knowledge of specific or complex skills (Rogers, 2002:7). They are defined as a discrete group directly supervised by registered nurses, in which case they are officially categorised as 'supporting doctors and nurses' (Nancarrow and Borthwick, 2005; Kessler et al., 2012:16).

3.3.1. The Origins of the HCA

This section discusses the role of HCA, from their definition, issues relating to their formation and their continued existence within the NHS. The aim in this section is to state the role of HCA as well as explain how their roles have evolved and become extended due to skill mix changes. An IPPR report, defines HCA as a term referring to unqualified staff working in clinical teams within a 'skills-mix' model in which they perform devolved tasks under close supervision (Rogers, 2002). The new grade of HCA was introduced by the 1990 NHS and community care act. It also happened at a time when nursing was attempting to professionalise their occupation, through changes in their education system this was referred to as Project 2000 (Meerabeau, 1998; Thornley, 2008). The move by nursing to initiate Project 2000 was viewed as the undoing of the nursing profession in its attempts to attain its own professionalization project (Walby et al, 1994; Salter, 1998). Project 2000 nurse-led education reform initiative aimed at establishing nursing in a more professional light. Therefore, it transferred nurse training into higher education within university settings, to make nursing appear as a serious profession with an improved academic approach to training (Meerabeau, 1998). The training of nurses within hospitals was halted and in turn done in universities which meant that student nurses were no longer practicing within the hospital setting (Grimshaw, 1999). This led to an increase in the number of support workers whose main purpose was to replace qualified staff, as the

programme became an excuse for hiring smaller fractions of qualified nurses supported by larger numbers of lower paid unqualified support staff. The new grade of HCA quickly started to replace the long standing nationally paid grade of Nursing Auxiliaries/Assistants and nurse student assistants (Grimshaw, 1999). It also became a form of cost cutting to reduce the skills mix ratio between qualified and unqualified nursing staff (Grimshaw, 1999; Grimshaw and Carroll, 2007; Thornley, 2007, Kessler et al. 2012).

The numbers of HCA and nursing auxiliaries employed in the NHS has been rising, and this can be attributed in some ways to the plethora of titles that are currently in use, the last count had the different job titles at 60 (Crossan and Ferguson, 2005; Cavendish, 2013). The current figures show that there are about 1.5 million HCA and support workers in health and social care. Table 3.1 (see page 75) provides key statistics on this workforce. Table 3.2 (see page 80) shows that the different titles held within the HCA workforce, has indeed made it difficult to make an exact count of their numbers in the NHS. As depicted, data from the Health and Social Care Information Centre (H&SCIC) suggests a figure of 215,000 which comprises of nursing assistants, healthcare assistants and workers that provide clinical support to professional staff and it also includes bank staff. The narrowest definition gives the number of 106,500 nursing auxiliaries, healthcare assistants and assistant practitioners in 2012, this is compared to 329,294 nurses. It therefore suggests that nursing workforce is about 59% of the care workforce in the NHS, while the HCA and support staff consist of 24%. The job growth within the NHS is quite varied, there has been an average growth in the number of doctors and nurses while that of healthcare assistants, support workers and managers has increased remarkably (Grimshaw and Carroll, 2007; RCN, 2007). As depicted from the recent workforce data, in which between 2011 and 2012, the number of registered nurses in England had dropped by 2,283, while that of HCA rose by 2,691 this might suggest that HCA have been substituted for nurses (H&SCIS, 2012).

Table 3.2 : Key Statistics on HCA and Support workers

	Health (1.4M NHS Information Centre, 2013)	Social Care
Workforce	106, 500 (2012, narrowest definition from H&SCIC data giving it about 215, 000 , which consists of all clinical support workers. Robert Francis figures. Have the total as 332,000 comprising of 270,000 providing support for doctors and nurses and 62, 000 are among the scientific and technical staff.)	1.6 million (Centre for Workforce Intelligence 2011)
Where they work	Over half work in acute sector (acute, elderly, general)	Almost half work in domiciliary care (providing care in a person's home).
Average age	45	35 (New starters), with no evidence of an ageing workforce
Gender	84% Female	84% Female
Ethnicity (Black and Minority ethnic groups)	15%	29%
Average number of years in post	4.1 years (Average across England).	59% spent between 2 and 6 years in the post, with 31.9% more than 6 years
Turnover	14%	19.8%
Pay	56% Paid between £14, 294 and £ 17, 425 pa (AfC b-2)	£ 13, 973 pa (Average)

There have been considerable changes in the type of care activities offered to patients by registered nurses (RN) following the introduction of HCAs (Chang, 1995). These changes were not necessarily based on an increase in patient care, but rather a refocusing of RN work and ultimately a decline in their nursing activities as some of their work became delegated to the HCA (Chang et al, 1998). The reallocation of RN work to HCA is similar to what is happening

to other occupations such as in education and the police force with the introduction of support teachers and community support officers respectively (Bach et al, 2006). The HCA have been able to take on duties such as patient observations, taking blood and dressing wounds, roles that have traditionally been associated with nursing (Hancock et al, 2005; Grimshaw and Carroll, 2007). This has been welcomed in more ways as nurses are freed up for other responsibilities while HCA are introduced to working across traditional boundaries, however this has also presented some challenges to the HCA workforce.

HCA are a subordinate group to nurses by virtue of their status as un-qualified staff. This fact has led to some of the challenges that they face as a workforce. The challenges they face in trying to advance their roles within healthcare are quite fundamental and include:

- a) The inability to have a regulated workforce, which hinders HCA from attaining a recognised status as workers with a specific role within healthcare (Kessler, 2012). This also raises the issues that there are no safeguards for this workforce, as there are no structures to regulate and issue directives for them.
- b) This in turn results in other employment relations issues such as low wages and a lack of provision for training and skills advancement. The lack of opportunities for learning is a major concern, there ought to be accredited training that links directly to competencies expected of the workforce, and these should be measurable against national standards, such as KSF (Lizarondo et al, 2010).
- c) High levels of low morale because of poor career advancement structures, low pay and difference in task allocation. They have the constant feeling that they are undervalued because of their lack of qualification, even though they were made to take on more roles including extended roles (Nancarrow and Borthwich, 2005; Kessler, et al., 2010)

d) The fact that there are difficulties in recruiting and retaining qualified workforce, makes it a challenge for HCA as they are expected to take on more roles to fill in this gap, they have even been referred to as substitutes to nurses (Grimshaw, 1999; Bluestone, 2006). Taking on extended roles also presents its difficulties because it requires one to have the proper skills and training for the jobs, which seems to be lacking based on evidence on the lack of budgets and the necessity for healthcare organizations to better manage their finances (Bosley and Dale, 2008). HCA also have a challenge when considering training, and that is often based on their financial situation, as mentioned earlier they receive low income and taking up training for new roles full time would mean giving up their positions and this is untenable.

The challenges mentioned above are not only due to HCA taking on extended roles, but are part of what the HCA have to deal with daily within their role and status. Even with these challenges, the HCA have become very crucial for healthcare delivery, this is because the implementation of flexible working a goal based on the modernization agenda seeks 'smarter' ways of working within the NHS. The HCA have therefore become an increasing and integral part of the healthcare workforce (NHS, 2007). This has been more evident as the modernization and restructuring of health care services and delivery of regulated care to protect the public have become top on the agenda of the UK health policy (Saks and Allsop, 2007; DoH, 2012). The next section discusses policy on HCA and specifically focuses on AfC policy.

3.4. Policy on HCA

This section will discuss the policy context of the NHS and how it reflects on the role of HCAs in which more insight is offered. There has been a focus on policy initiatives stressing the need for modernizing working practices, rather than focusing on restructuring and reorganizing

healthcare services (McBride and Hyde, 2006). Of interest in this section is to reflect on policies that enhance the role of support workers within the NHS. More specifically this section introduces one such policy that affects the role and significance of HCA which was mentioned earlier - Agenda for Change (AfC).

The AfC policy initiates the increase in numbers of HCAs at the assistant practitioner level. It is a policy that is solely based on the means of compensation for the worker. Its main premise is to allow for pay modernization in the NHS by providing a pay system that reflects working practices and skills mix (DH, 2002). It has three basic components job evaluation, harmonised terms and conditions and the Knowledge and Skills Framework (KSF). It enables the NHS to deliver the necessary workforce changes that are in line with other policy initiatives in order to advance the modernization agenda (Sandal et.al, 2006).

The AfC has established three new national pay 'spines' to cover all staff in the NHS, it 'ensures equal pay for work of equal value and the development of flexible job roles' (Bach, 2002:335; Grimshaw et. al, 2007, Buchan and Evans, 2007). The onus therefore, is on the trusts to assess jobs locally and base them on the nationally agreed criteria. The AfC supports personal development and career progression through linking the KSF to annual developments reviews and personal development plans (Bewley, 2006). It is a system that has been designed to replace demarcations and allow staff to chart their own pathways within healthcare in taking on new responsibilities (NHS Employer, 2008).

AfC has a component referred to as KSF, which is a tool that provides the basis for pay progression within the different bands on the AfC and is an integral part of the NHS AfC pay system. It describes the knowledge and skills that NHS staff need to use within their work and provides a consistent, comprehensive and explicit framework on which to apply their work and base the review and development of staff members The KSF offers a set of core and specific

dimensions for all jobs within the NHS, and uses common descriptions of the knowledge and skills required for each post. As stated earlier, KSF works with an appraisal system as part of Personal Development Plan, and offers developmental support to all staff during recruitment and selection and their careers within the NHS (Sandal et.al, 2006).

The KSF supports Lifelong Learning, Skills Escalator and the wider NHS HR strategy. This is because, it has been structured in a way that it can be used alongside current and emerging national quality assured standards and competencies such as National Vocational Qualification (NVQ) system. The lifelong learning framework was devised to ensure that the NHS together with its partners are able to develop their staff with the skills needed to support changes and improvements within patient care (DH, 2000). The skills escalator has been adopted as an organizational way to provide and develop staff members, whereby members are continually encouraged to renew and extend their skills and knowledge in order to enhance and advance their careers (NHS Employer, 2008). HCA qualifications are based on the NVQ system of competency-based accreditation, which is designed to maximise flexibility of career movement within the industrial and service sector (QCA, 2008). NVQs reflect the skills and knowledge needed to perform job roles effectively within their work areas based on frameworks that represent those jobs. As policy prescribes the way of encouraging the use of HCA in healthcare, more should be reviewed on how to regulate this group of workforce. There has been a lot of debate about HCA roles, and whether or not they should be regulated as a group of workers, this is explored in the next section (DH, 2006).

3.4.1. Regulating HCA

The regulation of HCA has in recent years been an issue of intense debates (RCN, 2006; RCN, 2007; DOH, 2006). There have been calls for registration and regulation of this workforce for various reasons. The most important reasons being the increased significance of task delegation and the other based on the grounds of the patients' safety (RCN, 2006; RCN, 2007). The reasons

for regulation as outlined by the Royal College of Nursing (RCN) policy paper provide the following mutually exclusive categories as functions for regulating support workers, '*professionally-led regulation* which encompasses public protection, education, competence and standard setting, *performance management and quality assurance*' (RCN, 2007:6).

Policies from various initiatives focus on increasing the number of HCAs within the assistant practitioner category in order to curb the gaps in staffing within the healthcare workforce. The flip side has been that the increase in this workforce has represented a form of cheap labour substitution as they are paid much less for their work, including taking on some of the professionals roles (Grimshaw, 1999; Grimshaw and Carroll, 2007; Nancarrow and Borthwick, 2005). Similarly, it also represents strategies that enhance the role of HCA workforce by creating pathways for career development, whether those careers exist or not (Walby et al, 1994; Nancarrow and Borthwick, 2005; RCN, 2007).

As the debates are still ongoing, and policies have been initiated with the goal of enhancing the role of HCA, more ought to be done by first directly identifying the roles of HCA within healthcare. Secondly, review the training that should be geared towards achieving those set goals as defined in their role. And lastly, regulation of the workforce in order to encourage participation, performance and growth. Moreover, better scrutiny is needed to accord them the wage that reflects their contribution within the healthcare setting. In this context a reflection of AfC policy provides a perfect example, as it lays out the foundations that need further review in order to create a system in which all stakeholders benefit, more so a re-evaluation of AfC presents a case for how the HCA role might be defined, compensated and enhanced for career advancement in healthcare as prescribed by the policy and as mentioned earlier.

3.5. Discussion and Conclusion

In summary, in recent years the UK healthcare policy has been consumed with the role of support workers not just by their numbers but the fact that they are a constant feature in assisting professionals and patients within healthcare. Research has been done to assess the effects of extended roles within the healthcare context but most of it has involved the medical professionals and their subordinates the nurses. However more research needs to focus on the HCAs and their role within this context. This is because there is a large HCA workforce involved in healthcare provision in the UK and of the greatest concern should be the safety of the patients as more support workers get involved in the direct delivery of personal care (Cavedish, 2012).

As policy drives the agenda of including HCA within the NHS, better ways ought to be devised to encourage their involvement. Issues of employment relations and role extension should form part of the focus for the need to regulate this workforce. Their involvement within the multidisciplinary setting depends on their skills and ability to demonstrate their definitive role within the world of healthcare delivery in the NHS. Defining these roles are still a problem, hence the clamour to regulate HCA which is still a concern. More should be done to recognise their position, therefore a reflection on AfC policy provides a perfect blue-print, as it lays out the foundations that need further review in order to create a system in which all stakeholders benefit, if only it is followed to the letter. The issue still remains on how to remove hurdles that make their work harder and focus on improving standards and their working conditions. The next chapter is on the research methodology.

CHAPTER 4:

METHODOLOGY

4.1. Introduction

This chapter presents the underpinning philosophical assumptions of the study, the research strategy and the empirical techniques used to collect and analyse the research data. It includes a description of the sampling, the research setting and data collection. The data analysis is described as well as the ethical considerations made for the study.

At the forefront of this study were the objectives and research questions that together formed a guide into the research. The gap found in research and is explored in this study is the need to understand extended roles among non-professionals in the health sector. This is beneficial at a time when the government seek changes to skill mix for professionals and non-professionals in the public sectors. It seeks a better understanding on the nature of extended roles, and considers opinions on why non-professionals participate in extended roles as well as the role of policy in influencing extended roles (Bosley and Dale, 2008).

The study had to be done within the time, space and resources available, hence the focus on the more specific questions outlined below (Blaxter, et al., 1999):

- What are extended roles and why do they occur?
- Why do HCA participate in extended roles?
- Can policy changes explain the use of extended roles; Agenda for Change policy?

The following outline provides a guide into this chapter. It discusses the research paradigm, the research design, the data sources including the description, the data collection process and lastly a discussion on the data analysis, which will lead to chapter 5 on the individual cases. This

study's philosophical perspective come from an interpretive tradition, which is explored in the next sections.

4.2. Research Paradigm

A paradigm is a basic set of beliefs that guide an action (Guba, 1990:17). Paradigms are human constructs that define the world view of the researcher (Denzin and Lincoln, 2008). In all social situations, philosophy plays a part in setting values and beliefs that are often carried into the research process. It has been suggested that the alternative to no philosophy is bad philosophy (Collier, 1994). It is therefore, important for the researcher to identify with a philosophical standpoint that allows for more coherent research. A researcher's philosophical view will always affect their epistemological position throughout the research process, this is important for this study as different aspects of the worldview might form an intrinsic part of the research process (Gummerson, 2000).

4.2.1. Theoretical Perspective

A researcher's theoretical perspective is based on their world view and basic beliefs, hence the need to state one's ontological and epistemological assumptions before beginning a research project (Guba and Lincoln, 1994). The ontological question is framed as the need to examine the nature and form of reality - what is the belief about reality- this often helps define how a researcher determines and approaches a research problem. While epistemology reviews how we acquire knowledge and our justified belief, it is the relationship between the researcher and the reality and how the reality can be known (Carson, et al, 2001). Therefore a researcher often starts off on the research with a set of ideas (theory, ontology) that then leads to a set of research question (epistemology) then uses different ways to examine (methodology) the phenomenon in question (Denzin and Lincoln, 2000).

This section highlight the researcher's choice of an interpretivist approach and critical realist ontology. The interpretivist perspective recognizes that the knowledge built reflects particular goals, culture, experiences among other factors to make sense of the world because of the notion that knowledge is built through the social construction of the world (Weber, 2004). On the other hand the realist position in case study research seeks valid explanations to knowledge (Easton, 2000). Explanations within philosophy have become a contentious issue, because there are varying ideas as to what is involved in an explanation. It is important therefore to remember that 'each meaning of an explanation can only be understood in the context of the philosophical position that is being employed' (Easton, 2000:207).

The realist view argues that the world is composed of real objects and their relations, these have structures and causal powers that combine in different ways to create events that occur in the actual world and are open to research in the empirical domain (Easton, 2002). This realist notion expresses research as the aim of 'understanding and explaining the reality underlying any event or set of events, by unpacking and describing the causal powers of the objects that brought them about' (Easton, 2002:214). This philosophy in combination with an interpretive approach were very desirable during the research process from the beginning to end.

The critical realist ontology is used to enhance the analysis and makes the research more robust, by posing questions that counter the interpretivist's popular position of taking members' explanations at their stated value. Critical realism rejects the positivist approach that there is a known reality, that exists independent of the research process and that causal relationships between variables exist and can be 'identified, proven and explained' (Hesse-Biber and Leavy, 2006:13). Conversely, the critical realist approach also sides with the positivist in that in this world there are events that are observable and independent of human consciousness as well as the fact that the acquisition of knowledge can be socially constructed (Denzin and Lincoln, 2007). Hence, the fact that people within society are free of their thought processes and

interpretations of their world view makes for an interesting area of study as through critical realism this reality assumes levels in which scientific methods are not entirely appropriate to gauge the outcomes. This is because there is a need for these methods to move beyond regularity of analysis and form other processes that account for the actual patterns of reality as observed.

The notion of causality within critical realism therefore comes into focus as we strive to analyse and uncover the causal powers that makes things happen the way they do. However this might not be an easy task to perform based on the earlier stated notion of social reality being viewed differently by different people as it is an open system with differing inter-related causal influences (Bhaskar, 1998). Hence, it is important to note that even though knowledge is socially constructed, through critical realism this study ensures that the organizations and people under study are viewed as possessing causal powers that need to be assessed through their separate experiences but within their contexts.

Consequently, an interpretive approach through case study analysis was appropriate for the objectives of the study, as it was used to explore the research problems and questions under investigation. The nature of the research problem was important in influencing the choice of research methodology. Therefore the need to find a method that would explore as well as find explanations to the research problem – why do non-professionals extend their roles in health- hence the choice of case study. This was the only method that would enable the researcher to understand the problem, the nature and complexity of the processes taking place and generate valuable insights from the changes within the context of the study (Yin, 2003). Thus, this study uses an interpretive approach with elements of critical realist ontological assumptions running through the research. The next section presents a discussion on the choice of case study research strategy.

4.3. Research Strategy

As mentioned earlier, the choice of case study research strategy is based on the need to gain an in-depth understanding of the concerned phenomena within a real life setting (Yin, 1994). The use of qualitative methods to study different aspects of human phenomena has come from the inability of quantitative methods to do the same. Consequently, Krasner (2000) argues that the study of human phenomena cannot and should not be reduced to ‘mathematical formulas’ (Krasner, 2000:72). Moreover, as pointed out by research in health this is open to all manner of inquiry; therefore, the use of the qualitative model is a superior choice over other conventional methods for this study (Speziale and Carpenter, 2007).

In social science research, it is important for the study to be recognizable and accepted as a form of science, this is done when researchers abide by the theoretical rules that apply to conducting the research. The research should follow a systematic procedure that uses approved methods and documentation that can allow others to assess the findings from the study (Creswell, 2006). Therefore, the method of choice in this study is philosophically based and dependent on the ‘how’ and ‘why’ questions. Asking how and why questions within different social situations enables us to understand the mechanism that generates those questions (Easton, 2000). In this study the aim was to figure out why extended roles occur between non-professionals in healthcare, the why and how questions are appropriately linked to qualitative research inquiry, hence the adoption of case study methodology.

In this study, time was spent considering what were the factors that led to the occurrence of extended roles within healthcare, what were the organizational HR structures that enabled these working arrangements, how were these changes in skill mix affecting the workforce and what was needed to make the situation change. It was a process in which these questions became asked in different ways and settings to ensure a better understanding of the research phenomena

under investigation, such that the contextual conditions of what was being investigated became critical to the researcher and yet the researcher had no control over how situations evolve (Yin, 1994).

Qualitative research, as a set of interpretive activities does not have a preference on selecting a single methodological practice over another (Denzin and Lincoln, 2003). However, it has gained credibility and status in the social sciences as a significant element in various fields within social inquiry (Denzin and Lincoln, 2000; Flick, 2002). The argument to support the method in this research comes from the understanding that qualitative research methods can be used in less studied areas, therefore the questions asked in this study made it appropriate to use this method. Qualitative research methods play a key role in any investigation, because the investigator is led to form a rigorous approach to the research process, from the review of literature to the conclusion of the research. Qualitative research also explores the subjective and micro-level concerns within research, in fact, it takes the communication between the researcher and subjects as an explicit part of knowledge creation, unlike quantitative research that excludes it, this fact was very important for this study (Denzin and Lincoln, 2000; Travers, 2001; Flick, 2002). As the study needed to dig deeper in the process to find out and understand why extended roles occur and the reasons for its continuance as well as the effects these had on the stakeholders.

The ultimate goal is to provide an original contribution to further theoretical developments within the field of healthcare and in particular the role development of non-professionals and improvements in their employment relations. This research uses the case study approach, as it 'captures the circumstances and conditions of everyday or common place situations' (Yin, 2003:41). Therefore, this study cannot be understood if removed from its social setting, as it uses an interpretive perspective to create understanding of the different situation within its context (Ghauri and Gronhaug, 2002).

This study gains qualitative significance in combining the methods previously used by former researchers, yet exploring a different approach with the cases selected. It sets out to use a comparative case study approach, which is discussed in the next section.

4.3.1. Comparative Case Study Approach

In this section a discussion on the choice of comparative case study is reviewed as well as the logic behind purposive sampling and its adoption in this study. Case study research has been referred to as using one or more cases from real life for research purposes, whereby the knowledge about an area is not available or sparse and when the object of the study is a complex phenomenon (Gummerson, 2003). A case study is also defined as ‘an empirical inquiry that investigates a contemporary phenomenon within its real life context, when boundaries between the phenomenon and context are not clearly evident and in which multiple sources of evidence are used’ (Yin, 1994:19). The vast majority of case studies largely involve qualitative data, because the data gathered in this way is able to examine complex, rich and contemporary phenomena (Easton, 2002).

There are many advantages to using case studies, some have been mentioned before: some cases can be embedded within larger cases, while others enable the study of ambiguous and complex detailing of research. Case studies provide a holistic and systemic approach to gathering and recording data which was needed in this investigation (Bryman and Bell, 2007). Consequently, case studies can be used in great success in planning and designing studies within real-life situations, as was the case in this study. In addition, there are many cases recorded in literature that have used the case study approach in various other disciplines (Gillham, 2000; Atkins and Sampson, 2002; Yin, 2004).

Critics of the case study approach cite the intense exposure in conducting the research as exposing the findings to biases, while some dismiss the method as only useful in exploratory

research (Travers, 2001). Case study methodology has also been criticised for its dependence on single cases, rendering it incapable of providing generalizable conclusions (Yin, 1994). In contrast, both Hamel (1993) and Yin (1994) argue that the relative size samples used within case studies whether they range from 2 or 100 they would still not be able to compare and transform multiple cases into macroscopic studies. In the same discussions other criticism have stated that case study research not only lacks statistical generalizability, but is not representative. This is because the data collected is both rich and complex, which may lead to varying interpretations that might be susceptible to researcher bias (Miles and Huberman, 1994; Easton, 2002). Despite some of these criticism, case studies are useful in developing and refining generalizable concepts which can lead to generalization of proportions such as in the use of multiple case studies (Pettigrew, 1985). Using comparative case study allowed for validity of the cases, as it ensured this study was able to use logical reasoning when describing, presenting and drawing conclusions from the case study (Walsham, 1993). The aim of case studies is to make it possible to generalise particular set of results to some broader theoretical propositions which is referred to as analytical generalization (Yin, 1994).

A goal within case study research should be to establish parameters that can be applied within the research such that whatever cases are being considered they can provide acceptable results based on the set objectives. In this case the objective was based on the need to examine how extended roles occur within non-professionals in health and to theorise the reasons why HCA engage in extended roles. Therefore to develop this understanding within the context of the research setting, an inductive logic was necessary to highlight the actions that have not yet been highlighted in research (Glasser and Strauss, 1967).

Consequently, within this research a comparative case study approach was taken in order to utilise several methods such as interviews, observation, and document analysis for data triangulation purposes and to increase validity in the research through cross-data validity

checks. Data triangulation uses various sources of information such as the stakeholders or participants in the research, whereby the in-depth interviews from them assist in gaining insights into their varied perspectives about the phenomenon under study. Other sources include public records, documents and observations. The triangulation of data, strengthens the research as it increases credibility and validity. This strategy is in keeping with Sumner's (2006) suggestion of using a range of methods to improve on various meanings and interpretations of social phenomenon and social processes based on their context and the instance in which they occur.

Comparative case studies provide for an interesting way to conduct analysis. These case studies often require two or more cases that are comparable along some dimensions. They are then examined and compared along their unit of analysis. As comparative case studies uses fewer studies, it enables discoveries of a range of factors and influences that come out of comparing the data. It helps to convey more specifics about a particular case and then these might be used to study wider or larger cases. This is because often smaller comparative case studies ensures depth of analysis, which makes for higher levels of internal validity, however their external validity is low as they are unable to generate broad generalization of the phenomena under study (Tobin and Begley, 2004; Creswell, 2006).

4.3.2. Purposive Sample

In this section the choice of purposive sample is discussed. The most important aspect when selecting a sample for research should be based on the research question that the researcher is seeking answers to, and then considerations for how to get the sample. That is when the researcher chooses the parameters of the study, such as what size of the population to study, how many people should be involved etc. It is very important to be specific about the desired informant when using purposive sampling, as purposive sampling tends to find informants with

a specific knowledge or skill. As in this case finding HCA that engaged in extended roles, and co-workers that are aware of extended roles that this workforce undertake.

Purposive sampling also ensures that the researcher is able to collect the data, as the informants are already pre-selected, even though this might be open to some bias, as informants may be chosen out of convenience. However, data that is collected from a purposive sample may still be valid, especially when the sample is representative as it then provides some form of validity for the jurisdiction it represents. It can also provide both reliable and robust data (Givens, 2008). Purposive sampling when used appropriately has been defined as more efficient than random sampling especially in field studies, because random samples might not be as knowledgeable as expert informants (Bernard, 2002). Purposive sampling is often used when resources are low, it can be more realistic than random sampling when you compare the time, effort and cost needed to fund informants (Topp et al. 2004).

As the study was based on a comparative case study, the types of institutions selected was also important, being that one was Foundation Trust and the other was not, this allowed for a comparison of differences based on the phenomenon that was under investigation. It was important to view the consequences of HCA extending their roles within these two organizations and whether there was a marginal or big difference.

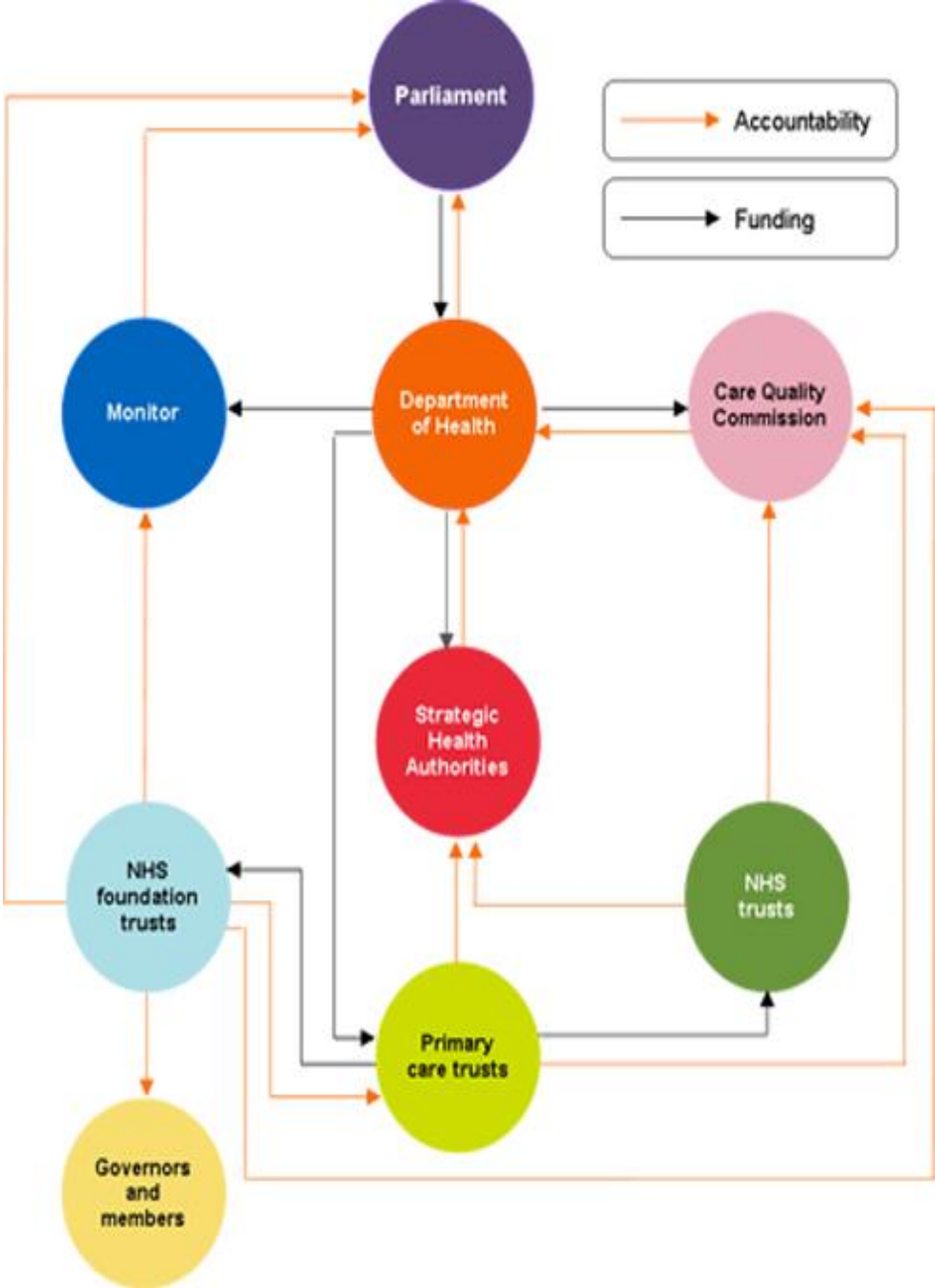
Foundation Trusts are NHS hospitals which are run independently from the Department of Health and have freedom to decide how they organize their services and function within their community (DoH, 2005). They have independence and autonomy in decision making within their organizations, but still have to abide by policy directives. As a Foundation Trust, the organization is a leader in improving the quality in health services as they are part of the NHS, but have autonomy in the decision making process within their organization through the use of their independent board. The board has the task of adhering to the requests and suggestion given

by its membership council and thus are able to respond to the direct needs of its members who comprise of patients, staff and the local community.

Apart from taking an interest in the memberships' concerns, Foundation Trusts are given the freedom to invest in changes that are needed within the community, and this is part of the need for these Trusts to strive for excellent performance and the best care for their patients. Figure 4.1 (page 98) and Table 4.1 (page 99), provides some information on how foundation trusts work, to whom they are accountable and how other aspects of the NHS form part of the operation and most importantly how funding flows within the NHS. NHS foundation trusts are free from central government control and are accountable to their local communities, through governors and members, to Parliament and to the Monitor. They are therefore free to make choices that directly affect their population, in consultation with the organization itself and the public as part members of the structure. They have total control over their finances, and this might be part of the reason why many Trust wish to gain Foundation status, and most importantly they can respond to the needs of their population while utilising their resources as needed. This would therefore portend to the fact that obtaining Foundation Trusts status, has more than just autonomy running for it, but the structure and processes they implement individually may aid in making changes to the way non-foundation trusts are run.

Purposive sampling was also used, as it allowed the researcher to choose the participants to include in the study, which was based on their ability to provide the data that was needed, as they were aware of the phenomenon under study (Creswell, 2002).

Fig. 4.1: How Foundation Trusts Work: Who are they accountable to?



The Monitor (2010) [www. .monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

Table 4.1: Characteristics of Foundation and Non-Foundation Trust Organizations in the NHS.

Non-Foundation Trust Organization	Foundation Trust Organization
Department of Health and local Health Authority are responsible approving decisions made by the Trust on big financial investments in order to improve its buildings and services	A Foundation Trust is free to make decisions for it, based on local needs and evidence that it would bring benefits to the local population. The decisions can be made much more quickly than before.
Controls to the use of surpluses finances exist – any extra income that the Trust has at the end of the year might not go to local services	No controls - Able to use all of its finances for local health services
Focus on meeting Government targets	Still meet Government targets so that everyone has the same treatment on the NHS, but able to focus on local health needs as well
Involvement from patients in individual services	Still have valuable involvement from patients in individual services, but also have involvement of membership in the whole Trust, helping to shape its future plans; the Foundation Trust will listen much more to local views and expectations through membership
Need to wait for financial allocations from local PCTs or the Department of Health to invest in improvements	Can borrow money when required for small and medium-sized improvements and make changes quickly. A Foundation Trust can only borrow money if it can afford to repay it; a Foundation Trust is expected to make good business and financial decisions.
Provides clinical services based on past requirements	Can respond more quickly to changing needs, such as a bigger population or greater number of cases of a particular condition (i.e. diabetes, heart disease etc) and use its resources in the most beneficial way to its local patients, as well as using guidance from the Government

Plans only made for the next 1-2 years	Need to have a clear plan for the next five years with your input, making sure we understand the challenges ahead and have a clear idea on how we will deal with those challenges, including what money, staff and facilities we will need in the future.

Adapted from NHS Website on February 28th 2010.

This table shows a summary of the characteristics and differences between a Foundation Trust and a Non-Foundation Trust NHS.

The researcher made initial inquiry with the subject experts in the organization, to set a platform worldview of the subject, this process made it possible to authenticate the questions that were asked and ensured that they were relevant to the people that were going to be engaged in the study. Other professionals were targeted such as managers and nurses in their different capacities which also made for the strengthening of the data and adding to its validity.

The organizations selected were from different regions in the East and West Yorkshire regions in England and this was to monitor whether there were differences based on location of institution, the type of institutions. In this study, similar units within each organization were selected in order to gauge whether there were any effects due to differences in regimes or structures within the units in the organizations.

Similar wards were chosen, also to review whether the similarity was a contributing factor into what roles were attributed to the HCA. A careful consideration of their units within the hospitals

and whether there was a predominant presence of HCAs in them was made during the sampling. This was for the reason that the study focused on the perception non-professionals taking on extended roles, therefore it was important to sample HCA that took on extended roles as well as other colleagues who were aware of this happening within the units. The organizations selected were also familiar with AfC policy and were in fact implementing it as a means of enhancing the role of their employees.

The overriding criterion in justifying the use of comparative case study method in this case study was its appropriateness for addressing the research questions. A particular advantage was its ability to emphasise depth of explanation and to address the general phenomenon from different perspective giving rounded insights from the respondents. The use of comparative case study in this approach makes it possible for structured comparisons between different healthcare trusts, which were selected through the use of a purposive sample. The next section reviews the research design, which provides the sequence in which the data was gathered and connected.

4.4. Research Design

Research design has been defined as the logical sequence that connects empirical data to the initial question in research and its conclusion (Yin, 2004). While Burns and Grove (2003: 195) define research design as a ‘blueprint for conducting research with maximum control over factors that may interfere with the validity of the findings’. This segment outlines the range of methodological issues and approaches considered in conducting this research. This study focuses on the opinions of professionals and non-professionals in healthcare, exploring the reason why HCA take part in extended roles within health. The following sections highlight the research process and how it was conducted, from the case selection, data sources, data collection and data analysis.

4.4.1. Case Selection

The selection of cases in a case study is never based on a sampling logic like in quantitative studies. The aim of case study research is often to describe the particular case in detail and is often referred to as particularistic and contextual. The sample size does not necessarily influence the quality or importance of the study, even as there are no guidelines to determine sample size within qualitative research. In qualitative research sampling tends to go on, until saturation point, this is when no new information is generated (Holloway, 1997; Holloway and Wheeler, 2002).

The study explored the development of extended roles for HCA within the wards in the organizations by monitoring and highlighting the way the processes worked and recorded the changes experienced. Evidence from multiple cases, is often considered more compelling and enables the robustness of the research hence its added advantage and use in this study (Tashakkori and Teddlie, 1998; Gillham, 2000; Travers, 2001). The rationale for choosing this approach was because the study was focused on seeking knowledge on why HCA extend their roles in healthcare and especially how they feel about taking part in extended roles. This was only going to be possible by focusing on the participant's experiences. There was also the need to vary different work regimes and conditions in order to determine which other factors influence extended roles. It was important to also see what influence policy had on extended roles, especially as two different types of organizations were being assessed in order to review how the policy in question was translated locally.

Using case studies requires the researcher to work effectively with the situation that they find themselves in, rather than target specific numbers of case studies or randomly selected ones (Strauss and Corbin, 1998). In this study, the use of two different cases from a purposive sample with differences in the way in which each organization was run, presents a 'revelatory' case that is ideally placed to facilitate a better understanding on the issues that affect the development

of extended roles for HCA in secondary care (Yin, 1994; Bryman and Bell, 2007). The next section further explores the data sources, providing descriptions on the collection process.

4.4.2. Data Sources: The Description

The main data sources was through semi-structured interviews with respondents, but there was initially a pilot study conducted with one of the directors, and his assistant in which some of the research questions were tested and refined, this formed part of validation of the data. There was documentary evidence in the form of reports, flow charts, procedural manuals, annual reports and duty charts. Data was also gathered through observation as well as participation in a meeting.

Research access was not easy to obtain. There were various stages to the process of gaining research access and all these had to be met before the commencement of the study. The most important stage was for the research project to gain ethical approval from the NHS Research Ethics Committee. This process was quite a long and tedious element of the study, because gaining access within the organization does not guarantee admittance to carry out the research. To gain ethical approval from the NHS research ethics board comprises various stages. First was the completion of an online application form, detailing every aspect of the research from details about the researcher, to the reasons for the research and specific sections on the research itself. In addition to filling the online application form, some attachments were required, these included: a covering letter on headed paper, the research protocol or project proposal, summary CV of the Chief Investigator/researcher and supervisor, a copy of the research participant information sheet, a copy of the research participant consent form, statement of indemnity statements which were provided by the university, the interview schedule or topic guides for the participants, a copy of any advertisement for members to participate and lastly the online application form together with a site specific form detailing information from the prospective organizations that would be involved in the research.

Once the application was submitted a reference number was issued to the researcher, and a date to meet with the NHS Research Ethics Committee was set to review the application. The researcher would be in attendance to answer any questions the members of the committee would need clarification on. The first hearing of the application led to an unfavourable response for the following reasons. The committee felt that from one particular section of the research questions, it would be possible to identify the respondents. Another issue the committee had with the application was their concern over 'what would happen would a governance issue occur in the process of the study'. They needed clarification due to the fact that the researcher was not an NHS employee which meant the researcher had no NHS background on how to tackle such issues.

On submitting the second application with the issues raised by the committee satisfactorily answered, the NHS Ethics Research Committee after 6 months (October 2008 till March 2009) through the process granted a favourable ethical opinion for the research and this set the research in motion. The researcher then approached the respective organizations, which had to gain approval from their respective research and development departments. Organization A, was quick to respond with a favourable response and access was granted in mid-April. This then gave the researcher ample time to set up dates with various departments, and send out the appropriate research protocols and participant information sheets so as to allow for the interested participants to respond. 4 departments had been selected by the researcher and these were the ones approached for participants. Dates were later set up for the interviews which commenced in mid-May. Organization B, took a little longer to respond, as the research and development department informed the respondent that even with the NHS Ethical Research Committee's approval, the Organization itself had to have its own ethical research committee review the application and give its own approval. This took a further 2 months before access was finally granted towards the end of the month of June, 2009.

4.4.3. Data Collection

Data collection was done in different yet distinct stages. The first stage involved documentary analysis, in which internal reports as well as reports written about healthcare research were studied. The internal reports provided detailed information regarding the backgrounds of both cases and also provided the setting for each of the different organizational backgrounds produced from the study. Other external reports provided by different independent sources also provided invaluable information which helped to build a more comprehensive picture about the organizations and their local circumstances. As part of the second stage of data collection, a pilot study was conducted with the director of Nursing and his assistant at organization A. This interview was important as it provided the researcher with some more specific lines of research inquiry. This study also helped to clarify certain aspects of the research design and this was partly influenced by the need to gain access into the organization. The third stage of the process involved face-to-face semi-structured interviews with HCA and other participants and some observations (Givens, 2008).

4.4.3.1. Doing Interviews

In a typical of qualitative inquiry, a relative number of samples are taken with an in-depth focus. The sample size was informed by the need to figure out what was being collected within the data and understand the information that was emerging from the data analysis. In total 35 semi-structured interviews were conducted, averaging 60 minutes each, the shortest interview lasted 45 minutes while the longest interview lasted 2 hours. The interviews were carried out between March 2009 and August 2009, given this time line it is important to note that the study provides a snapshot of practice at a particular point in time. The aim of carrying out the interviews was to gain the different perspectives of the respondents' views and interpretations without trying to limit their responses. As the research needed to have the most interpretive response within

the research situation, it would be an understatement to mention that there would be some observer bias as the possibility might be expected.

The data was recorded mainly through digital recording when the respondents consented to it and also through note taking. All the interviews were carried out on a one by one face to face basis between the interviewer and the respondent. The main advantage of using the digital recording device was to be able to capture all the information that was availed throughout the interview process. It also made it easy to capture information that was difficult to put down during note taking and made it easy to retrieve the information during the transcribing of the interviews, because playing the recordings was a second chance to go through the interviews and capture the respondents views, not only verbatim but to capture their meanings and perceptions in order to understand the context in which the information was given (Poland, 1995).

The study used semi-structured interviews as the superior mode of data collection, because this allowed for detailed data about the nature of the extended roles within the healthcare context. Semi-structured interviews were best determined to add a probing element to the research as the interviewees were able to either build upon or explain their responses. Probing is very important as it ensures the reliability of the data, because the interviewer is able to clarify any relevant issues that arise during the interview process (Yin, 2009).

This also encourages the respondent to express their thoughts freely as it tends to make the relationship between the interviewer and respondent more relaxed as they gain and maintain rapport with each other which tends to increase interactive opportunities (Strauss and Corbin, 1998). They also allow for a framework of themes to explore during the interviews, as the interviewer is able to change topics freely to enable the respondent to determine the flow of the interview (Grbich, 1999).

The semi-structured interviews were also selected for the fact that the interviewees were of different professions, with different roles and experiences and therefore a structured interview would not have been suitable. The interviews enabled thick data to be gathered, which was used to provide detailed information about the social world being examined as well as the actors in it. Interviews are often focused and adaptable as they allow flexibility and responsiveness due to their ability to provide for two-way conversation, they also allow interviewees to raise issues that may become relevant as they share their own view which was deemed important by the researcher (Bryman and Bell, 2007)

Table 4.2 (page 108) is an illustration of some of the statistics on the informants. As mentioned earlier there were two different organizations A and B which formed the two case studies. From each organization similar corresponding units were selected for the participants that were interviewed. Those who were interviewed included; Deputy Directors of Nursing, Deputy HR Directors, managers, supervisors, different groups of nurses, Matrons, Midwives and HCA. These groups of people were able to provide information that would aid in the aims and focus of the study as they were aware of the extended nature of the HCA role.

Table 4.2: General Statistics on Study Informants

Details on Informants	Organization A	Organization B
Gender	Total Informants 21	Total Informants 14
Male	3	2
Female	18	12
Average years in role/unit	8.71 years	5.75 years
Average Experience	12 years	13.5 years
Qualification		
NVQ or lower	14	7
BA or higher - RN	6	7
Average Age Range	45 – 55	30-45

A further comparisons of the respondents from the two organizations is offered in table 4.3 (page 109) with the aim of pointing out some themes or areas of interest from the chosen respondents.

Tables 4.3 Statistics on respondent’s qualifications and experience in role and AfC pay band level from organization A and B.

Organization A				Organization B			
Role	AfC Grade	Experience in role	Highest qualifications attained	Role	AfC Grade	Experience in role	Highest qualifications attained
HCA	Band 2	15 years	In-house Training	MG/RN	Band 6	3 years	BSc
HCA	Band 2	15 years	In-house Training	CSW	Band 3	5 years	NVQ3 In-house Training
HCA	Band 2	9 years	NVQ3	CSW	Band 2	4.5 years	In-house Training
HCA (M)	Band 2	3 years	In-house Training	CSW (M)	Band 2	4 years	In-house Training
HCA	Band 2	4 years	In-house Training	RN/Sister	Band 7	3 years	Registered General
MG/Senior S.	Band 7	18 years	School of Nursing	S. Staff Nurse	Band 6	4 years	RN/BSc
MG/RN (M)	Band 7	10 years	Registered General	MG/Sister	Band 7	18 yrs	Registered General
HCA	Band 2	25 years	In-house Training	CSW (M)	Band 2	4 years	In-house Training
HCA	Band 2	9 years	In-house Training	RN/T&D	Band 5	4 years	Registered General
RN (M)	Band 5	4 years	BSc	Matron	Band 7	3 years	BSc
HCA	Band 2	6 years	In-house Training	Auxiliary N.	Band 2	6 years	NVQ3, GCSEs
HCA	Band 2	6 years	In-house Training	HCA	Band 2	5 years	In-house Training
Clerical/HCA	Band 2	5 years	In-house Training	As. HR. Dir.	Band 8	8 years	N/A
MG/RN	Band 6	26 years	Registered General	As. RN. Dir.	Band 8	9 years	N/A
HCA	Band 3	10 years	NVQ3				
HCA	Band 3	3 years	In-house Training				
HCA	Band 2	3 years	In-house Training				
HCA	Band 2	7 years	In-house Training				
GM	Band 8	5 years	BA/ Healthcare Management				
As. HR Dir.	Band 8	8 years	N/A			Key	
MG/HR	Band 7	9 year	N/A			(M) - Male	

The particular areas chosen for comparing the details of the respondents were their gender, work qualifications, experience on the job and their pay grade based on AfC. These were helpful in gauging the respondent's answers to the questions posed to them, it also reveals that the samples selected were aware of the specifics of the study's aim in terms of being able to articulate their role, explain what extended role were, how it affects them and their attitude towards their working conditions based on taking on extended roles. It goes back to the fact that the sample was purposive in order to have the respondent's views based on their awareness and knowledge of the research context.

(i) Respondent's Gender Composition

The interviews carried out in organization A, just as in organization B, had a larger portion of female interviewees, than male. In the total count, there were 18 women and three men interviewed from organization A. Of the males that participated in the interview, two were nurses, but one of the two nurses was also a manager they were from the Acute Medical Elderly ward and the third was a HCA in the HDU/Surgical ward. In organization B, there were 12 women and two men interviewed. Of the total there were only two males from this organization that participated in the interview, both were referred to as clinical support worker (CSW) which is the same role as a HCA. They were both from the Acute Assessment Unit, which dealt with the assessment of patients, either before the patients are discharged or moved to a ward.

As the focus is on the HCA, it was important to review the gender proportions of HCA, which confirmed as other studies have shown that healthcare work is highly gendered (Acker 1992; Korczynski, 2005). Current organizational processes produce and reproduce gender ideologies that are implicated in the gender segregation of work, which enables gender to be embedded in the way in which organizations strategize on how to achieve flexibility (Acker, 1995). Therefore as illustrated in table 4.3 (page 108), in both organizations the majority of the workforce was females, and of the 17 HCA interviewed only 3 were male.

(ii) Respondent's Qualifications and Experience for the role.

Tables 4.3 (page 108) also compares employee qualifications and the experience they have for the roles that they are in. There was an interest in reviewing the qualifications of the respondents to their roles as well as gauging their experience in their roles. This was important especially when reviewing the benefits of AfC policy in terms of exploring the training and development that is available to the employees as well as in charting their individual career paths. It was interesting to note that most of the HCA were trained within the organization, and that very few had National Vocational Qualification (NVQ) training. NVQ training is meant to provide support workers with qualifications that are part of the NVQ system of competency-based accreditation, which is designed to maximise flexibility of career movement within the industrial and service sector (QCA, 2008).

NVQs reflect the skills and knowledge needed to perform job roles effectively within their work areas based on frameworks that represent those jobs. Extended roles within healthcare have become an issue because the government and other agencies are trying to formalize and recognise all the roles and jobs that are being performed by support workers (Witz, 1994; Larkin, 1995; Nancarrow and Borthwick 2005). This has led to the increase of the prospect of a 'numerically flexible, cheap peripheral' workforce such as HCAs, which have somehow been created through NVQs (Witz, 1994:40).

In the study though most interviewees had not qualified yet for their NVQ, most of their training was done in-house and it also encompassed the work they did which also formed part of the training program that would be evaluated in order to receive NVQ certification. The only reason that most stated they had not yet had the qualification, was because there was a delay in finding examiners. This was the same in organization B, which meant that there was indeed a shortage of nurses to perform the examinations, in order for the respondents to become certified with their NVQ qualifications. The lack of qualification however did not deter the HCA from

doing their roles, the only downside as mentioned by the respondents was that they were not paid at a higher band because of the lack of NVQ qualification, this is also reflected in the findings chapter.

The tables also show that most of the HCA in the organization received in-house training and relied on that for them to acquire both new skills as well as learn on the roles while on the job. In some cases the training was provided by other HCA who were well versed in the roles themselves, rather than qualified staff. This was often the case and the reason was that there were few nurses who were able to provide the adequate training to the HCA. NVQ training was not very common in the organization either, just as was mentioned in organization A, the main reason given was the lack of enough assessors. It is required of HCA that they show their competence to perform specific tasks and this is assessed by qualified NVQ assessors, the limited availability of such assessors and a lack of support for HCAs' training arising from pressures on budgets in some areas, tends to hinder or suspend the development of the HCA role and this was evidenced in the study as there were complaints that many had not been assessed for their NVQ certification (Bosley and Dale, 2008).

Most of the nurses and management informants had the highest qualifications. The table below gives some information on the management informants. This information helped in illustrating the experience that they had in their roles, which also meant that they were aware of the expectations of the organization in terms of policy implementation as well as the running and management of the organization.

Table 4.4: General Statistics on Management Informants

Details on Informants	Organization A	Organization B
Gender Female	4	4
Male	1	0
Average years in role/unit	13 years	9.5 years
Average Experience	15 years	16.5 years
Qualification – BA or higher	5	4
Average Age Range	45 - 55	30-45

It was also interesting to note that there was only one male manager from organization A, and he was also a registered nurse.

(iii) Respondent’s Title and AfC Pay Grade

It was also important for the study to review the AfC pay grades in which the respondents belonged to. This helped in identifying specific differences in roles especially between the HCA as checking whether or not their participation in extended roles, was reflected in their pay grade or whether it remained within the same range as was found to be the case.

It was important for the study to review the AfC pay grades in which the respondents belonged to. This helped in identifying specific differences in roles especially between the HCA and nurses. Whether or not the HCA participated in extended roles, their grade remained within the same range. In organization A, most of the HCA interviewed were in band 2, on the AfC pay band. According to the salary levels table 4.5 (page 113). Their salary ranges between a lower limit of £ 13, 653 to an upper limit of £ 16, 753. As for the 2 HCA who were in band 3, their salary range was between a lower limit of £ 15, 610 and an upper limit of £ 18, 577.

Table 4.5. Agenda for Change Pay Bands 1-9 Salary Levels (effective April, 2010)

	Lower limit	Upper limit	Typical Job roles
Band 1	£13,653	£14,364	Health records Assistant
Band 2	£13,653	£16,753	Healthcare Assistant Clerical Officer
Band 3	£15,610	£18,577	Senior Healthcare Assistant Dental Nurse (Entry Level) Porter Team Leader
Band 4	£18,152	£21,798	Assistant Practitioner Admin Team Leader General Office Manager
Band 5	£21,176	£27,534	Staff Nurse, Therapists Personal Assistant Dental Nurse
Band 6	£25,472	£34,189	Midwife District Nurse Specialist Therapists
Band 7	£30,460	£40,157	Specialist Therapist Nurse Team Manager Information Analyst Estates Manager
Band 8a	£38,851	£46,621	Modern Matron
Band 8b	£45,254	£55,945	Nurse Consultant
Band 8c	£54,454	£67,134	Head of Estates
Band 8d*	£65,270	£80,810	Head of HR Chief Finance Manager
Band 9*	£77,079	£97,478	Healthcare scientist Consultant director Director of Estates and Facilities Public health consultant

Note: * Very senior managers have pay scales outside Agenda for Change.

Source: Data and Charts, Warwick – National Guidance Research Forum, 2010.

It is also important to mention that ethnicity was not factored into the research even though from the data most of the workforce was predominantly white (see Appendix G Tables 4 & 5). This is fascinating in light of the fact that organization A states that as part of their HR strategy, the organization hope to ensure equality and diversity, this shows that both organizations have yet a long way to go in achieving some of their goals. It would be interesting for future research

to explore whether ethnicity and diversity at the workforce has an impact on the way in which the workforce cope with extended roles.

4.4.3.2. Observations:

A final stage, involved observations and in one instance participation in a Trust wide meeting involving different stakeholders, including directors, doctors, nurses and HCA. The observations required some extended periods spent with 2 HCAs from each organization from the women and children's units observing their daily routines and note taking at the end of the observations. The research approach during the study was mostly to observe how team members interacted with each other and the way they responded to patients while addressing their needs.

The first instance of observation was when the researcher was invited to participate in a nursing and midwifery study day, which started with a conference meeting attended by Directors, Doctors, Nurses, HCA and guests. During these two instances, the data gathered was used to analyse the communications and interaction between the key players within the study. Attending this meeting gave the researcher an insight into the running of the organization; it gave the opportunity to meet people from the organization, which eventually provided an avenue to receive more information from different stakeholders in the organization. Advantages to using this method included having a first-hand experience of the participants interactions which helped to provide and record unusual aspects noticed during the observations, and an opportunity to better understand what goes on within the units, especially when the researcher becomes a common figure within the study (Givens, 2008). The other instances when observations were made were during handovers for the afternoon shifts in the women and children's units.

As researchers we form part of the social world or setting in which we are investigating and it can be difficult to detach ourselves from it, or even ‘for that matter avoid relying on our common sense, knowledge and life experiences when we try to interpret it’ (Delbridge and Kirkpatrick, 1994:43). It is not possible to be completely free of bias, but researchers must guard against it, the suggestion is to use ‘analytic tools’ which increase the user’s sensitivity to help the researcher recognise relevant properties and dimensions they might need for their research categories as this helps to recognise any bias (Strauss and Corbin, 1998). This can be done in a process of verifying information provided by the respondents, either by restating their responses or giving them their transcripts to ascertain that their views were captured accordingly. This was quite helpful to the researcher, as re-reading the transcripts and listening to the recorded interview, also acted as a form of data triangulation (Poland, 1995; Sumner, 2006). The interview data with other forms of information gathered from different sources help to increase the validity of the study. The data analysis is discussed next, as it explores the process the researcher took in analysing the data gathered in the research process.

4.4.4. Data Analysis

In data analysis, the aim is to organize, provide structure and elicit meaning from the data gathered. Analysing data from case studies is quite difficult, and much of it depends on an investigator’s thinking, sufficient evidence, and ‘careful consideration of alternative interpretations’ (Yin, 1994:103). It was best to ‘treat the evidence fairly, produce compelling analytical conclusions, and rule out alternative interpretations’ (Yin, 1994:103). A holistic approach to data analysis was vital in this study because the goal was to include all the evidence, views and all aspects of the case combined with the researcher’s own prior knowledge of the case study.

The Nvivo software programme was used to analyse the data from this research. All the interview data was imported into the programme, and this helped in organizing the data into manageable ideas. The software was useful when making queries and in building concepts from the data and handling the data, during the analysis. The use of various data sources made the analysis phase become more focused ensuring that correct interpretations of the data was made, also the use of multiple sources added to the reliability of this understanding making it easier to give the data meaning. In the earlier stages the data collection and data analysis were carried out together as the processes at times did overlap. As the process of transcribing later interviews became quite lengthy, the analysis was done at the very end after the completion of the transcripts, all the transcripts became a source of documentary evidence.

During the transcription of the interview, the researcher read through each transcripts and made notes including phrases and theories of the summary of texts that were being transcribed. This form of open coding enabled the researcher to verify some of the themes that came up later once all the data was input on the Nvivo programme. This also helped to eliminate overlap by cross-checking and verifying the relevance of the context in which the codes appeared. Open coding enabled the researcher to identify, name, categorize and describe the phenomenon found in the research data (Givens, 2008). Through the use of grounded theory, the emphasis during coding is on causal relationships hence the use of axial coding later on to relate the different codes to each other which was done through an inductive logic, whereby the coding process was able to generate ideas and concepts from the raw data gathered from the study.

Other forms of documentary evidence was also collected including reports from the study day in which the author attended as an observer, flow charts, unit reports, minutes of some meetings, procedural manuals which were used to show the daily running of the different units within the organizations and the input of HCA, notice board, organizational charts, responsibility and duty charts, and annual reports for both Trust which were obtained from the

organization's websites as permitted through the Freedom of Information Act (FOI). These sources not only provided for data triangulation as mentioned earlier in which different sources were used to answer the same question, but were also useful in providing contextual data of the two different cases together with presenting different facts and figures of how the different organizations were run (Denzin and Lincoln, 2008). The documentary material and archival records were also used to corroborate and augment data from other sources. Most of this data was assessed using content analysis where the documents were examined according to its context and purpose bearing in mind the institutional, social, and cultural aspects that was led by the research inquiry (Sumner, 2006).

The documentary material was a great source and offered a wealth of information and reports on the different organizations' histories and backgrounds which were provided to the researcher. Also of interest were the policy documents that were able to ascertain the role of government through the issuance of the policy documents with their given agendas. The interview transcripts were reviewed with a keen interest in analysing the contexts brought out by the different cases because the evidence collected was able to both create and illustrate the actions that were observed and documented within the study. The argument that texts should be analysed at three levels reviewing their construction, perspective and impact became of use as both interview transcripts and documentary evidence were considered in order to understand the experiences and perspectives of those concerned within the study (Fairclough, 1992).

This research highlights the consequences through a predominantly inductive approach to theory and research development, even though the researcher was aware of some of the situation within the research context. The main feature was the use of categories that came from the respondents, and out of those categories interrelationships were made and further categories formed, which then made it easier to assimilate all the different categories into more defined themes or similar concepts and ideas (Givens, 2008). Labelling the themes was quite important

as it enhanced theoretical sensitivity, which enabled the researcher to develop insights into the data, by giving meaning to the data and separating the pertinent information from it. This process made it easier for coding of the data into conceptual units. A constant comparison during the data analysis was carried out as the data was collected and interpreted, this allowed for strengthening of the theory generation process, which is part of grounded theory approach (Glaser and Strauss, 1967).

This made it possible to observe rigour within the analysis, as the findings developed it was possible to test the findings among new information, as was reflected in the response to only 14 interviews being carried out in organization B, as the saturation point had been reached. As these patterns were detected as mentioned above, it was easier to then verify and qualify the findings gathered and then revise and adjust accordingly.

Then at this stage the study becomes more analytical and not just descriptive, as the details of the categories become more explicit. Coding process ensures that analytical framework is followed and minimises bias (Strauss and Corbin, 1990). As the theory is build up, literature reviews plays a part in confirming or either conflicting with the concepts that emerge from the data, this provides validity and generalizability of the data. Therefore, the data collected and analysed had a purpose in that, in most instances it was to provide not only a historical context of the cases, but be a point of reference which was then relayed to other sources in order to reflect on the differences or similarities that formed part of the actual reality observed in the study.

4.4.5. Findings

The final write up of the research is an integral part of the analysis and interpretation. It was important to reflect on each individual experience, therefore through the transcribing and re-reading it helped not to lose sight of every experience encountered in the data collection stage.

Direct quotes were incorporated in the main write up as it helped re-enforce certain arguments that were being made from the data, and also provided evidence of particular notions that were being discussed. A reflexive perspective is advised when writing up so as to ensure the integrity of the analysis process (Alvesson and Skoldberg, 2000). The researcher also aimed at portraying elements from the data as well as letting the information speak for itself.

4.5. Ethical Considerations

This section relates to the moral standards that the researcher considered throughout the research process. There were ethical implications to be considered while conducting this research. These were highlighted earlier under the heading data collection. Certain ethical principles involving NHS Trusts, when carrying out any form of research, in which prior consent needs to be given before commencement of any study. Letters requesting the same were sent to the NHS Ethical Research Committee and after attending the hearing a favourable response was given on the second attempt, this was after the first hearing suggested making a few changes to the research protocol.

For the participants to gain confidence and to be assured of their privacy and anonymity for purposes of the study, numbers were used in place of names, to guarantee confidentiality for all informants. The researcher devised this method to also ensure a coding system that not only protected the respondent's identities but ensured better data retention and making it easy to access while searching for patterns and explanations during the analysing phase of the study. Before the start of each interview it was made clear to the participants of their right to give the information based on their perception of their work, no pressure was put on the respondents to provide information that they were not at liberty to give.

Maintaining objectivity throughout the research process was a vital ethical consideration for the researcher. This was ensured through each stage of the research process, from data

collection, to data analysis and final reporting. Feedback from all the participants played a pivotal role and all the responses were fed back to the participants' in order to get the accurate translation, these efforts were also considered in order to prevent bias.

Ethical standards issued by the university's ethical standards and guidelines for researchers were also adhered to. Care was taken to ensure that neither the university nor researcher was liable to any third party contractual breaches and also ensuring that the university's code of practice on data protection was also followed.

4.6. Discussion and Conclusion

In conclusion the aim of qualitative research not only acknowledges the socially constructed nature of the world, but it uses the interpretations given by those within the setting and in the case study, the concepts that may be used to discern their world and in some ways this is useful because the goal is to understand how the notion of extended roles develop and for what purpose. The use of theory as an iterative process between the collection of data and analysing of the data has been applied in this research study for triangulation purposes. Whereby the use of various and different sources helped to validate the study (Denzin and Lincoln, 2008).

Purposive sampling was used to select the organizations and informants for the case study. This was because purposive sampling enables the researcher to make inquiries from informed participants, aware of some skills or knowledge about the phenomenon under study. A comparative case study was also selected as it allowed for a comparative analysis of the cases. The use of qualitative semi-structured interviews was mainly to understand how the individuals in the study construct the reality of their situation, based on their complex beliefs and values that they develop as they explain events in their world (Jones, 1985).

In the following chapter five, information on the case studies from the research is presented. It starts with an introduction into the cases in the study, with sub-sections on what are extended

roles, the HRM strategies of the organizations and variations within the cases. Chapter 5 presents a focus on the first research question which asks what are extended roles and why do they occur? While in chapter 6, further empirical data on the cases is provided including some new evidence on the nature and drivers of extended roles. Chapter 6, essentially addresses the other two research questions: why do HCA participate in extended roles? And can policy changes explain the use of extended roles; Agenda for Change policy? It highlights the fact that extended roles occur at different rates in different contexts and lastly it points out the fact that policy implementations has had little salience in supporting extended roles, even though the aims of the policy was to be more engaged with the workforce and thereby enhance their participation within their roles (DoH, 2004). The two chapters use the structure of the main research questions to provide concrete evidence and descriptions of the results from the study.

CHAPTER 5:

THE CASE STUDIES

5. Introduction

This chapter introduces the case studies used for the analysis that is presented later in chapter 6 which presents the findings including specific references from the respondents in the case studies. It also highlight the research questions that are at the heart of this study. The aim of the study was to provide answers to defining extended roles and exploring why they occur among non-professionals in healthcare, and in doing so be able to define the roles carried out by both qualified and unqualified or non-professional staff. Other questions were based on the need to explore why HCA participate in extended roles. Lastly, was on whether changes in policy could be used to explain the use of extended roles or whether something else explains the continuance of extended roles of HCA.

This chapter will not only introduce the cases, but it will also tackle the first research question, on what are extended roles and why do they occur? As has been stated earlier the research comprised of a comparison of two case studies within the NHS. The two NHS Trust hospitals were selected on the basis that they were actively implementing the AfC policy as a mechanism to enhance the role and employment relations of their workforce, including and more specifically the roles of HCA. Another aspect was that the workforce in the organizations worked in different units in different capacities and that they were engaging in extended roles. The study was carried out only in the North of England in the Yorkshire regions, as time and costs were limiting factors for sampling further regions. For the importance of the research context, the study incorporated the differences within the organizations to show a cross section of public healthcare organizations. Table 5.1 (page 123) and 5.2 (page 124) shows some characteristics of the case study.

Table 5.1: Characteristics of Case Study Organization A and B.

Characteristics	Organization A	Organization B
Type of Hospital	Teaching Hospital	Teaching Hospital
Directorates*	4 Clinical and 2 Non-clinical	7 Clinical and 2 Non-clinical
Employees	5,500	6,471
Annual Turn Over	188M	470M
Recent Developments	New Urology Unit £ 3.4 M	£ 1/4B in improving patient environment
	Investment in £ 1/2M CT Scanner	New Oncology Centre & Haematology Centre
	Full Program of refurbishment of Bathrooms	State of the Art Centre for Cardiology and Cardiothoracic Surgery
	New Family Birth Centre	New Medical Research and Day Surgery Facilities
	£ 8 M pharmacy manufacturing unit for produce of medicines for people across the country	£ 35 M Women & Children's Hospital and referred to as one of the best in the country.
	£ 1.1 M X-ray investment	£ 6 M Eye Hospital
	£ 10 M Health Centre	
	Main A&E departments approximately 132,000 patients per year (figure combined for both sites)	Main A&E departments approximately 120,000 patients per year
Site 1	614 Beds	722 Beds
Site 2	420 Beds	523 Beds
No. of Patients Referred & Admitted (2008/9)	313,000 patients	314,000 patients

Table 5.2: Directorates at Organization A and B

Clinical Directorates	
Organization A (4)	Organization B (6)
Surgery & Aesthetics Division	Surgery 1 (General Surgery)
Medical Division	Surgery 2 (Acute General Surgery)
Children, Women & Families Division	Women and Children Services
Diagnostic & Therapeutic Division	Cancer and Clinical Support
	Cardiac and Neuroscience
	Critical Care and Theatres
Non-Clinical Directorates	
Organization A (2)	Organization B (2)
Corporate Division	Corporate Functions
Estates & Facilities Division	Facilities

It was of interest to note that Organization B, was much bigger as it has a larger number of beds indicating that it can cater for slightly more patients than in organization A. This also means that it is able to deal with more complicated case mix as it had more specialisms. It also caters to a larger population in terms of patients referred to its doors from other areas surrounding it. Estimates put the number of patients that visited Organization B during the research period 2008/9 was 314,000, these were 148,000 patients for first outpatient appointment, 83,000 through surgery operations and Over 83,000 patients admitted as emergencies. The organization also has a much larger turn-over as well as a higher number of employees as compared to Organization A. This is significant especially when you consider the staffing ratios of staff to patient, and whether the recommended numbers are there to provide adequate care. This is later reviewed under the variations in the wards, which suggest

that the numbers are insufficient. Organization B, seems to have also made larger investments to its facilities, not only in repairs of certain units, but in making major improvements to the Hospital's infrastructure by building completely new units, which shows their commitment to embracing technology and making innovations in medicine. This might also be part of the strategy for acquiring foundation trust status, whereby they can show by evidence in the investments that they are ready to take care of the needs of their local population, and that they are ready to adapt to the changing needs within their region for their patients. The investments was evidenced by the opening of a new high-tech oncology unit and the new medical research and day surgeries facility.

The in-depth exploration within this study focuses on the context provided within each organization. It is important to explore the context of the research as the aim of the study is to review the utilization of extended roles on non-professional/HCA role within secondary healthcare. This study examines the factors that affect the development of extended roles for HCA within different departments in the cases selected and reports on these changes on the role of HCA. The cases were selected to enable a comparative case analysis where the differences in location, institutional strategies and agenda were likely to bring out the real picture on extending the role of HCA within the organizations. It was imperative to assess the impact of these changes to HCA role while reviewing the government policy agenda and whether these ideas were reflected in practice (DoH, 2004).

The next section defines the description of extended roles as derived from the study. The section following defines each organization and provides their HRM strategies. It also provides information on variations within the different wards selected, including specific examples of the roles that were referred to as extended roles within the units, checking for similarities and

or differences. More details on each case study is highlighted to underscore the focus and structure of the study as well as provide an overview of the research

5.1. Organizational Context

In this section details of each organization within the case study is provided. The organizational context including the differences in informant information, the differences within the two organizations and the HRM strategies of the two organization. Later on the first research question will be tackled. Thus, this section will put the study into context by providing tables with more descriptions of the units in the organizations. It will explore and provide evidence on extended roles from the cases, including responses to whether there were any variations between the wards and the staff.

5.1.1. Organization A

In both organizations skill mix was viewed as the senior nurses within the Trusts using their knowledge and experience in making professional judgement, with regards to the ratio of qualified nurses and support workers. This was to be done by examining the available staff, the number of patients on the wards, and then establishing the necessary number of nurses and support workers required in order to deliver the high quality care demanded. Organization A is located in the western region in the north of England. It gained its Foundation Trusts status in 2006. It has two sites serving an area with a population of about 435, 000 people and it is a teaching hospital (NHS Website, April, 2010).

5.1.1.1. Units Selected in Organization A

The units that were involved in this organization included Children and Women's Services Unit (CWS) – Neonatal Ward, High Dependency Unit (HDU) and Surgical Ward and lastly the Acute Medical / Elderly Unit. It is important to note that in this organization, there was an

innovative new approach to team working in one of the units interviewed referred to as PD – Practice development. It will be further explored in chapter six when exploring local initiatives on HCA roles for a better understanding as to the way in which this organization has taken up the idea of skill mix and incorporated it to the way in which the team engages in patient care and service delivery, as well as better engagement with team members in achieving the goals set out within the unit and the organization as a whole. These interviews, together with documentary evidence that was provided to the researcher, offered a better understanding of how the unit worked, how the organization was managed as well as the role that the members had in ensuring good healthcare service delivery and an understanding of the different roles played by the members in the unit teams. The skill mix in two similar units was sampled in each organization, this was done in-order to review the ratio of patient to staff. This was done so as to compare the ratio with the current staffing recommended ratio guidelines (RRG) in the United Kingdom (RCN, 2012). These recommended ratios guidelines are illustrated in the following table 5.3.

Table 5.3: Current Staffing Guidance in the UK – nurse to patient:

<u>5.3.(a) Adult Intensive Care</u>		
General recommendations regarding staffing numbers:		
<ul style="list-style-type: none"> • Every patient in critical care unit to have access to a RN with post registration qualification in the specialty • Ventilated patients should have one nurse per patient 1:1 • Nurse to patient ratio of a unit should not fall below one nurse to two patients 1:2 • There should be a supplementary clinical co-ordinator for units of six beds or more. 		
<u>5.3. (b) Children’s ward and departments: General Paediatric wards</u>		
Child Age	No. of Nursing Staff	No. of Children
Under 2 years	1	3
Above 2 years Day Shifts	1	4
Above 2 years Night Shift	1	5

Source: RCN 2012.

In organization A, the units were the adult acute assessment unit and the neonatal wards in the children and women service units a summary of these tables is provided in the section on variation in the wards.

Table 5.4 Nurse to Patient Ratio in Organization A

Units Org. A.	RN	HCA	Beds/ Patients	Org. A Ratio	RRG
Medical/Acute Assessment Unit (per shift)	29 (9)	68 (22)	52	1:6	1:2
C.W.S. Neonatal Ward (per shift)	24 (8)	54 (18)	26	1:3	1:2

It was interesting to compare the staff ratios in both organizations as this would aid in pointing to the reason why extended roles occur. And according to the current recommended staffing guidelines, both organizations seemed to fall short. Tables 5.4 (page 128) and 5.5 (page 132) shows the staff ratios as provided from two units from the two organizations, this was compared to the current recommended ratios for staffing guidance for the UK healthcare which provide the adequate nurse to patient ratio as in table 5.3 (page 127).

From the table 5.4 and table 5.5 the numbers shows that the recommended ratios are far from being achieved. This is because the numbers of nurses to beds is inadequate which tends to imply that the HCA have to often intercede in terms of giving assistance, so as to make up the numbers because of the shortfall in the numbers needed to take care of patients. From the recommended rations tables, it is suggested that in the acute assessment unit there should be 1 nurse for 2 patients. While in the neonatal units it depends on the type of unit, if it is in the high intensive unit it should be 1 nurse for 1 child, if it is in the high dependency unit it is recommended to have 1 nurse for 2 children, and if it is in the special care unit it is recommended to have 1 nurse for 4 children. The two organizations each have 2 units therefore the number of beds, patients and staff are totals of the larger sites on the two organization's

and this includes three shift patterns in which the numbers are divided or split into three for the workforce per shift.

Such that in the Medical /Acute Assessment unit in organization A at site I, there were 52 beds, and then with three shifts morning, afternoon and evening shifts, together having a total of 29 qualified staff and 68 non-professional staff. The shift division was spread thus; in the morning shift there were 10 qualified staff to 23 HCA, in the afternoon there were 8 qualified staff to 21 HCA and in the night shift there were 11 qualified staff to 21 HCA. The recommended ratio as stated before should be 1 nurse for 2 patients, but the actual ratio in the wards was 1:6 in the acute assessment ward. This means that the shortage in nurses was clearly made up with the higher number of HCA in the unit. This was the same case in organisation B.

Also comparing the children and women's services units the numbers show the same, the number of beds or patients are not served with the recommended number of qualified staff. In this instance the C.W.S. ward in organization B, just as in A, fits this description. The recommended number of nurse to patient ratio is 1 nurse to 3 patients, this would mean that of the 35 beds/patients available in this unit there should be at least 9 mid-wives per shift, instead there are only 6 mid-wives and then an average of 15 HCA per shift who make up for the shortage in nurses, while it is recommended to have a ratio of 1:3, and in this organization it was at 1:6.

5.1.2. Organization B

This organization has been in the process of applying for Foundation Trust status, and during the course of this research it was mentioned several times as part of the motivation for the organization to employ innovative and new ways of working within the units. As of the time the data gathering and analysis was completed the Organization had not yet received the

recognition of foundation trust status, and as of 2013, the Trust shelved to bid for Foundation Trust status (Hull Daily Mail, 2013). It is a teaching hospital. It serves a base population of around 650,000 which includes providing specialist services to areas immediately outside of its county borders aimed at an extended catchment area of about 1.2 million people. There have been massive investments into its research facilities including a new “State of the Art” Oncology and Haematology centre, “State of the Art” Centre for Cardiology and Cardiothoracic Surgery and New Medical Research and Day Surgery facilities. It also operates on two sites just as in organization A, but it has more beds as it serves an area with a larger population coverage. The units selected for the study were similar to those in organization A and this was mainly done as mentioned earlier for the purpose of comparison. The units included were the Children and Women’s Services Unit (CWS) – Neonatal Ward, High Dependency Unit (HDU) and Surgical Ward and lastly the Acute Medical / Elderly Unit.

The interviews carried out in this organization were 14 in total and were just as varied as in the first organization, including managing directors, ward managers, registered nurses, midwives and HCAs. However, the difference in number was because the saturation point was reached in terms of the information that was being provided in the data. This also meant that despite the different work patterns, patient dependencies and work pressures, the respondent’s outcomes from both organizations resonated with the data. Even though the numbers were fewer, the content was quite rich as a pattern could be made of comparison between the two organizations.

A first meeting was set up to meet the HR manager and Assistant Nursing Director in which the issues arising from the study was discussed. A few clarifications were made and even a tour of the A & E unit was given to the researcher and assurance was given that when employees were available for the interviews they would be given time to attend unless they were needed in which case, the researcher would wait a while or set out a different date to complete the

interviews. This is important because it happened several times in the Acute Assessment Units that during the interview with the HCA, the respondent was called out twice in order to perform a task, as depicted in the quote below.

'I'm sorry, I am needed to move and feed a patient, I will be right back once the job is done' **HCA AAU Organization B.**

The respondent, had to leave and the interview was picked up later after about 20 minutes. Most of the questions to the senior management were based on the Organization's policies and were compared to those introduced by government. The focus was on reviewing the uptake of polices and those that seemed to work in order to enhance the way in which care was provided within the organization. It was important to establish the main focus of the organization in terms of how it approached the role of HCA, and whether there was a future for this role in the organization. Some of the discussions were also based on any changes that were deemed as a result of the AfC policy and specifically the involvement of staff in skill mix and other initiatives that encourage the workers to gain more skills and extend their roles, which were just as in the interviews with senior management from Organization A.

In the actual interviews with the workforce it was of great importance to not only understand their perception of their role, but why the Organization did to enhance their role and participation in the provision of quality based care. The way in which the respondents internalised their roles, their skills and their teamworking was important in establishing their perceived notions of why they engaged in extra roles, in other words find out the reasons that they would give for participating in extended roles. This was gauged through inquiries on how the workforce perceived gaining more skills or extending their roles within the units, and the prospects they foresaw for themselves in terms of their own growth and career development. As in Organization A, the way in which each interviewee responded provided great insight into

their own perspective as well as how they merged that into what they assumed were the priorities of their unit and organization and what was expected of them in their role.

5.1.2.1. Units Selected in Organization B

The units involved in this organization included Children and Women’s Services Unit – Neonatal Ward, Accidents and Emergency Unit/ Acute Assessment Unit and High Dependency Unit (HDU)/ Medical Elderly Ward. Table 5.5 below shows the staffing ratios in two sampled units, just as was done in organization A. The number of staff once put in ratios per shift, shows a shortage in terms of matching up to the recommended ratio for care provision within healthcare facilities in the UK (RCN, 2013). This helps to stress the fact that indeed few staff are under pressure to perform their roles well and it also supports the notion that HCA take on extended roles because it is required that they supplement the shortage in qualified staff, and therefore they are used as a substitute (Grimshaw, 1999; H&SCIS, 2012).

Table 5.5. Nurse to Patient Ratio in Organization B

Units Org. B.	RN/MW	HCA	Beds/ Patients	Org. B. Ratio	RRG
Acute Assessment Unit (Per Shift)	39 (13)	60 (20)	82	1:6	1:2
C.W.S. Neonatal Ward (Per Shift)	18 (6)	44 (14)	35	1:6	1:3

Just as in organization A, the fact that organization B is bigger is evident from the larger number of beds being serviced in the Acute Assessment Unit. In the Acute Assessment Unit in organization B at site I, there were 82 beds, then because of the three shifts leaving the total number of qualified staff was divided into three forming an average of 13 qualified staff and 20 non-professional staff per shift. The recommended ratio as stated before should be 1 nurse for 2 patients, but the actual ratio in the wards was 1:6 in the acute assessment ward. This meant

that the shortage in nurses was also reconfigured with the higher number of HCA in the unit, this was the same case as in organization A.

In this organization, importance was given to the organization acquiring accreditation as a Foundation Trust. Hence there was increased focus on abiding by standards, making repairs to actual physical aspects of the Hospital such as repairs to damaged wards. Although there was focus on standards there seemed to be some acceptable lapses such as management accepting that employee appraisals were close to non-existent as they were unable to carry them out. As the following excerpt describes:

*Doing the appraisals is very difficult and time consuming when using the e-KSF that is why I am not able to do it. I don't have the time to mess around with a non-cooperative computer system. **RN/Manager Organization B***

The impression given, which was similar to the one from organization A, was that the program set up for doing appraisals is cumbersome and unfriendly for users. There was also a promise that there would be a resumption of carrying out appraisals, but as at the completion of the interviews none of the interviewees had reported having had an appraisal done or confirmed that there was going to be something in the pipeline. This confirmed the management's attitude as well as lack of support for HCA roles and advancement, as KSF is supposed to monitor and encourage growth of the workforce, this is not being implemented as should be (DoH, 2004; Buchan and Evans, 2007).

The non-compliance with carrying out appraisals is important because in a way it helps cement the argument that policy is established down on paper but not really in practice, hence benefits may not necessarily be visible. This also reflects the continued argument that there was work overload in a sense making it difficult for the appraisals to be done. The HCA and nurses had no time to get off work to have proper appraisals conducted and management were equally

unable to find the time to carry them out. These interviews which are further discussed in the next chapter together with documentary evidence provided, offered a better understanding as to how the units operated. It also gave an insight into how the organization was managed as well as the role of the members in ensuring good healthcare service delivery and an understanding of the different roles played by the each member in the team units.

The organizational context has highlighted the differences and similarities in the organizations selected for this study. It also provided information on the staffing ratios, which is significant as it illustrates that there is a shortage in the number of nurses to patients as recommended by guidelines on staffing ratio level (H&SCIS, 2012). This also illuminates the fact that in all units the numbers of HCA was higher, which meant that the HCA acted as substitutes for nurses and filled the gap that was left by the fact that there weren't enough qualified staff to take care of the patients (Cavendish, 2013). This also explains the way in which HCA roles become extended because there aren't enough qualified staff to take on the roles that are required of them. The next sections reviews the HRM strategy of both organizations.

5.2. HRM Strategy

5.2.1. Organization A

This section highlights some of the HRM initiatives at Organization A. Most of the data for this section was provided from interviews with senior management and HR director at the organization as well as secondary data that was given for further insights into the HR practices of the organization. It is important to put into context the specific areas of priority as envisioned in the organization and contrast those with the goals set out by government as well as make comparisons with Organization B.

It has been noted that for business success, in both good and bad economic times, the workforce and the talent therein is crucial. This is because when there are problems within the economy

then people issues such as workforce management, restructuring, retention and employee engagement become important issues for management. As the economy recovers then issues such as building workforce strategies become more important in order to reinforce workforce trends, demographic shifts and concerns over new risks (Lissack et. al. 2009). It is also important that the HR function within organizations makes it possible for all within the organization to understand the expectations and strategic requirements of the organization. In organization A, their HR strategy resembles the template offered by government under the NHS HR Plan, which was based on expanding staff numbers as well as redefining jobs through ensuring that the NHS becomes a model employer (NHS, 2002).

In order to support the strategic goals and objectives, the organization aspired to deliver on: its pledges to its staff, including excellent employment practices and a focus on developing the workforce, to improve staff health and wellbeing including sustaining positive initiatives for the workforce. Commit to supporting and facilitating the effective use of staff resources and employment practices, such as encourage innovative working and the use of radical service change so that the organization can achieve continuous improvement. Another goal was to ensure that the organization reflected equality and diversity in respect to every aspect of employment practice as well as provided training for management and staff on how the organization should work. The organization realised that the most important aspect in delivering its goals and objectives was dependent upon the careful management and planning of the workforce.

The realisation was that the organization ought to effectively use existing staff resources as well as develop innovative, cost-efficient roles and services that deliver the best possible value for money that did not compromise the quality of services provided to the community. In order to develop and produce the robust workforce needed, the organization has a regular workforce

score card that ensures that key workforce performance and cost statistics are monitored and managed effectively. This also includes benchmarked statistics that ensure that the workforce was at the best level of efficiency. Hence the development of the new approach to team working referred to earlier as practice development (PD).

The implementation of this process made it possible to have teams with staff and skill mix sets that ensured that excellence was provided to patients. Also, that there was direct communication within teams and with team members to ensure development within the roles as well as coherent best practice approach in terms of care delivery. Most team members involved in the PD Units reflected a different type of work ethic, greater concern for the patient and a keener approach to care provision which was reinforced with the right approach to delivering care, by each unit and with each team member.

The organization also has an employee life cycle and HR strategy. Employee life cycle is an HR model that identifies the different stages in an employee's career, in order to offer guidance and management of their potential. It involves talent and performance management, succession planning, tracking training record and so on (Von Grebmer, 2012). The employee life cycle and HR strategy for this organization are grouped into six areas the first is attract and recruit a workforce that maintains clear roles and responsibilities through role documentation and use of the KSF outlines. Second, induct and train new starters in the organization to become effective team members by offering appropriate training, and review annually as legislated through various programmes such as ; recruitment and selection, personal development review, KSF and updates to employment law. Third, manage, motivate, appraise and engage with the workforce, done by management as leaders as well as through reward and recognition that would be gauged annually through personal development reviews. Fourth, develop the

workforce through talent and leadership planning. Fifth, retain and reward the workforce so that the organization can have skilled and flexible staff, through the use of Agenda for Change which ensures that roles in the organization are graded and reviewed in an accredited and timely manner. The aim is to ensure that the skills escalator and career framework aids the staff in achieving their full potential within the organization, especially through the personal development review (PDR) as well as providing the necessary development opportunities. Sixth is to redeploy, retire and dismiss the workforce appropriately. This ensures the management of the organization is done well when employees exit, including the monitoring of employee turnover, controlling vacancy and replacement, using alternative skills and competency mix and so on. Finally, integrate equality and diversity in the organization in terms of improving the employee life cycle.

5.2.2. Organization B

In this section the focus is on highlighting the HR strategy of organization B. The focus will be similar to the HRM section from organization A, with the emphasis now being on stating some of the HRM initiatives at Organization B. The data for this section was provided from interviews with senior management and HR director at the organization, and it also includes secondary data which offered insights into the HR practices of the organization. The aim is to put into context the specific areas of priority from the organization and compare with the goals set out by government and make comparisons with Organization A.

The vision of Organization B is based on the strategic aim of great staff, great care, and great future. To achieve the stated aim the trust aimed to deliver excellent quality outcomes for its constituents as well as ensure that they participate in partnerships that add value and use public money wisely.

Among some of the goals they aim at achieving were ensuring that they satisfy regulators and commissioners as well as the community at large. They have identified seven strategic objectives that will define the future of the organization, from its short to long terms goals. The objectives included: first, provide safe high quality and effective care. Second, was to become a strong high performing Foundation Trust. Third was to create and sustain purposeful partnerships. Fourth was to ensure efficient economic use of resources and be able to prioritise and target effectively. Fifth was to be able to deliver on the organization's priorities and objectives. Sixth was to focus on offering capable, effective, valued and committed workforce that are sustainably skilled and equipped to deliver high quality care and finally to provide strong, respected and impactful leadership to the organization and community.

The HR strategy of the organization aims at aligning its activities and goals to the needs of the organization and the community it serves. As an organization it offers focus on the patient by providing clinical effectiveness and value for money in terms of the services offered. It will ensure that staff develop plans that best meet the needs of the patients as well as adopt a patient focused approach to healthcare provision. Through the Organisational Developmental Strategy, staff will be able to embrace changes that address the current and future development of needs of the community based on the skills of the workforce.

The organization pledges to value its staff, by developing strong commitment and loyalty to the organization through training and staff motivation. It offers to improve the working lives of the workforce across all dimensions and this is a priority, as the aim will be to expand the workforce through the recruitment of additional staff as well as build on the experiences of the existing well trained staff. The organization vows to provide quality, and as part of its strategy it aims at strengthening its internal structures so as to support the delivery of the quality and

patient experience promised. Another important aspect of the organization's strategy is that of finance, and management of the wage bill part of the solution has been to use planning services redesigns as well as utilise skill mix, these will be done in ways that do not hinge upon the quality and production of services offered.

The author was fortunate to attend a meeting that involved senior management and the healthcare professionals from across different specialities in the organization, this meeting provided primary data that was further used to assess and query senior management on the role the organization played in ensuring the success of its policies and those directed by government. It also helped in providing some insight for the study in terms of how the different occupations worked with each other and portrayed the value of their different input.

The goal of the meeting was to discuss and plan out the course to be taken by the organization, including discussions over the organization's budget and repercussions from there being a shortfall that would see changes to almost all aspects of the organization. It was noted that these changes were not to affect the way in which services were to be provided as delivering the best healthcare services to the community was their goal. The discussions after this announcement all suggested that there was a degree of worry among the professionals especially that there would be a downside to the fact that there would be cuts to the budget which would lead to shortfalls in departments within the organization. It was highlighted that there were already HR issues such as shortages in staff numbers that plagued the different units at times making it difficult to achieve certain set standards on some units, there was also the issue of gaining Foundation Trust status and the focus being on fulfilling the requirements and this issue was receiving more attention while excluding other aspects needed for the organization to function effectively. Others mentioned the lack of alignment between government policies and the fact

that most of the policies were difficult to implement at a local level, here AfC received particular mention in terms of remuneration for work done and the need for aligning pay with demonstrable and practicable skills.

It highlights the fact that both organizations have similar objectives in terms of both organizations acknowledging the importance of the workforce in the day to day running of the organization and taking care of the patients which is the main objectives of the organizations. It is interesting that both organizations state that they strive to have the best workforce, and endeavour to ensure that they have training that is reflected on the needs of the patients as well as ensure the career development of the workforce. They also aim at obtaining highly skilled workforce, maintain and retain them. This is significant, especially when you consider the fact that extended roles are taking place and as explained by some respondents due to shortage of skilled workforce.

This therefore paints a picture in which what is written on paper as part of the organization's HR strategy does not resonate with what they actually practice. It also helps to explain that just as the HR strategies are policies on paper, those that are given by government as well such as AfC, are just as difficult to follow through because certain pressure locally make the process untenable. Issues such as training for staff, was mentioned several times but due to budget shortages, it was difficult to get the necessary training for the workforce, which also shows that the organizations were both not adept with their strategy on effective use of resources.

5.3. Nature and variation of extended roles.

In this section the first research question is explored and that is what are extended roles and why do they occur? This will include stating some of the variation between the units examined as well as some of the responses from the staff on taking on and participating in extended roles. The aim is to explore in detail what extended roles involve. It is therefore prudent to describe

HCA roles and then discern which roles are extended once a comparison is made between HCA roles and registered nurses (RN) or qualified staff roles. Once this is done it will then be possible to explore extended roles, what they are and discuss why they occur in the next section.

5.3.1. Defining the roles of HCA

In order to explore extended roles it is important to review the roles of HCA. The reason for doing this as stated earlier is to first, identify HCA roles and second, how do the roles of HCA differ from those of Registered Nurses (RN). Finding out about the HCA, what their role was as well as their contribution to the daily running of a healthcare facility was central in then discovering roles that were termed as extended. The question on defining HCA and what their roles were, elicited various responses from the different groups that participated in the interviews - the HCA, RN, managers and HR directors.

The reflection on the HCA role for many was the concern for the patient first, then attention to the specifics of their role second. In a sense, they were compassionate and would often encourage patients and ease their anxieties especially when the patients felt that the qualified staffs were not forthcoming with information about their conditions. It often remained the task of the HCA to reassure the patients that all would be well. As was mentioned in the previous chapter, which stated that the HCA role made it possible for other professionals to do their work. This was because the HCA made time to talk with the patients, during these talks it seemed as the opportune time for the HCA to do more of their caring role by empathising with the patients (Nancarrow and Borthwick, 2005).

Two out of every three HCA interviewed felt this way, as exemplified in the excerpt below, where the respondent mentioned that they felt that:

‘the patients feel much more free with us, at times they talk with us and are able to give us more information about themselves which can often help with caring for them, they feel more free to talk to us than with the qualified staff’ (HCA- Org. A).

These types of responses imply that the HCA felt that their role often was to be sympathetic to the situation of the patient. The HCA often stated that most patients perceived that the qualified staff were often there to treat their illness, but the HCA role was a much more different role, it was to be there for the patients – *‘listen, encourage and care’*(HCA –Org B). The HCA were meant to have a softer and kinder side to them which would resonate well with the patients, and that was what they would strive for. This helped to ensure that the patients were comfortable and able to go on with their treatment. The patients were therefore aware of the HCA role, they felt that they could relate with them in their situation, that they were accessible and approachable in case it was difficult to communicate with the qualified staff, and the patients often took up that chance with the HCA, as this was noted from several responses from the HCA in both organizations.

The nurses had a different perspectives of the HCA role, some would come up with complementary statements such as *‘we would not be able to do our work without the help of the HCAs’* - (RN Org. B.), while others gave an opposite opinion and response to the effect that HCA were meant to be seen but not heard. The suggestion was that the HCA role was to take on whatever it was that needed to be done and not necessarily have an opinion about it. As is reflected from the following quote from a registered nurse in organization A, *‘we expect them to help us as we ask of them, they watch out for the patient and make sure their needs are met’*. This statement implies that the HCA role is to take orders from the qualified staff, which is not entirely wrong, as it reinforces and implies the subordinate nature of the relationship between these two groups of workers (Riley and Peters, 2000). It spells out that qualified staff have the ability to instruct the HCA of the roles that they should take on. It simply makes it known that the HCA receive instructions from qualified staff on what they need to do as part of their role.

These two responses tell of the difference in the way that some qualified staff perceive the HCA role to be. Some take the HCA role as subordinate to their own, while other view it as a partnership (Riley and Peters, 2000; Nancarrow and Borthwick, 2005). The qualified staff who often viewed the HCA role as a partnership, were often within units in which HCA were let to extend their roles such as in the Women and Children's unit in both organizations as well as in the Acute Medical /Elderly Unit and Surgical wards in organization A. This partnership was as a result and reflection of the managers within the on the role of the HCA workers.

In organization A for instance this was brought on by the introduction of the innovative approach to teamworking stated earlier as PD in the women and children's unit, while in a similar unit in organization B the partnership was born out of the vested interest in the unit by the team members to ensure that the children and their mothers received the care that they needed. The partnership was required in order for both groups of workers to ensure the best care was delivered to the patients, and this required mutual respect, *'as the goal is to work together with the HCA for the good of the patients'* as was reflected in this statement by a RN from the women and children's unit in organization B, it summarises the feeling of half of the qualified staff about their view of the HCA role, the other half were of the opposite opinion.

In contrast to some of the qualified nurses' views, higher management offered a different perspective on the role of HCA. The response from management on the role of the HCA followed a similar trajectory as the response given by both HCA and qualified staff, in that within the units in which extended roles took place, management viewed the HCA role as more than just basic care. It was more of a helping hand to the qualified staff, especially when stress levels run high within the units. Stress levels often came about according to a manager from Acute Medical /Elderly Unit, *'from lack of enough staff and resources to ensure that the work is handled with more care and effort required for the goodness of the patient's health and wellbeing'*. The manager further explained that the lack of resources to ensure that enough

workers assist with the provision of care, led to other stresses which often led to inefficiency in the work place, especially when it meant that there were more staff shirking from work, or just quitting because of the difficulties in meeting with the expectations at work (Ham, 2004; McGloin and Knowles, 2005). Therefore, a majority of the management view the role of the HCA as more than just a supporting role to the qualified staff, but because of difficulties within units the role of the HCA has become more important as they are depended upon to take up tasks that were only the reserve of qualified staff (Spilbury and Meyer, 2005; Hasson et al, 2007).

Some of the managers observed that the HCA have in many ways been able to make the importance of their role known, as with the following quote from a unit manager from organization B who noted that *'some of the work would not be possible without the help that the HCA give to the nurses'*. According to this view it not only states the importance of the HCA role but it also suggests that part of the HCA role involves taking on some of the roles that nurses do which is that they help nurses to perform their roles, which also re-enforces the fact that management were aware of the specific roles that HCA took on including taking on nurses' roles therefore engaging in extended roles.

From the responses given by the different groups interviewed on the role of the HCA, the author found the HCA roles as being grouped into three main categories. The first being patient care in which the HCA care for the immediate needs of the patient in terms of doing roles that keeps the patient comfortable such as changing beddings, feeding and so on. The second was assisting qualified staff; this meant that the HCA take on whatever roles that are given to them by the qualified staff. Lastly, the HCA role involving taking on extended roles. Following are further descriptions and details on the roles of HCA as grouped in the above mentioned categories.

5.3.1.1. HCA role as Patient Care

The first and most important role of the HCA is to take care of the patient's basic needs. This was often the first issue stated in reply to the question what was the role of the HCA in the unit. It was very important for the HCA to be able to take care of very basic care needs of patients as their priority role (Kessler et al., 2012). Some of the roles included basic hygiene checks, ensuring that the patients are given their meals and assisted in any way possible with regards to what they require for instance toileting. The HCA would often make comments to the effect that patient care was their one and only role, other aspects to their roles came second. This often meant that they did all that was needed in order to ensure that the patient received all the care they needed in order to get better. The following extract showcases an extract with the respondent's views on the HCA role based on the function of patient care.

The main thing is caring for the patients, you know, the hygiene needs, the feeding, washing, dressing, but then there are a few more roles which have become entwined in the health care role, like the patients' observations. Once you've done your NVQ training you've done some dressing practice you can do dressings, blood-sugar takings, the general running of the ward, as in tidiness, bed-making, and also escorting. There's a lot of escorting to clinics and scans. The main this is to just do the role you are asked to do. – HCA Organization

From most of the data gathered on this question, most respondents talked of the HCA role as taking care of the basic needs of the patients as depicted in the examples above. Some did not even view the fact that they were at times asked to do roles that are later defined as extended roles. To them their main objective was to always take care of the patient, and carry out their role as they were meant to do. There was not much commitment to the role, as the following excerpt also shows:

'When I come to work, I do my job, they should not expect me to take the work of nurses too, I am not a qualified nurse. We should only do our job and they do theirs.' **HCA Organization B**

That the HCA is unwilling to take on work that is seemingly outside of their role, even defines them as nurse's work which would imply that they are extended roles. It depicts that there is

the HCA is concerned about their role expansion and feels there is a need to stick to their own role and not engage in extended roles. This meant that they had all the basic skills to do their core roles and that was to take care of the patient's care needs and to do them well, but not willing to engage in other roles outside of what is specific to their task.

5.3.1.2. HCA role as Assisting Qualified Staff

In this section, the role of the HCA defined as that of assisting qualified staff is examined. Some other respondents defined the role of the HCA as that of assisting the qualified staff with their needs and requirements on the job. One in two HCA interviewed responded in this way and they also gave the impression that they acknowledged the fact that their role was subordinate to the qualified staff, and were aware of the difference between their role and that of qualified staff. They also knew that due to certain constraints in the units, mostly the shortage of qualified staff, they felt that their role went further than beyond providing basic care for their patients (Buchan and Evans, 2008; Bach et al, 2012). They knew that it meant that whenever their role was called upon to be extended, they took it on because they felt it was part of their responsibility. Their role meant more than just regular tasks because it involved a deeper sense of engagement in the role, it meant they were participating in a cause that went beyond what was expected and that it stood for something they cared for deeply and in this sense it meant the absolute care for the patient. As is depicted in the following quote;

I do like my role, it's different we learn lots of different skills and I just absolutely love the work. We get pushed into it a lot because of shortages of staff and sickness and things like that. You just have to get in and do what is needed, especially because the nurses know what they are doing and also because they are senior to us and more qualified for the role.

HCA Organization B

The difference between their role in assisting qualified staff and just performing patient care tasks, was the fact that those who assisted qualified staff willingly acknowledged the subordinate nature of their roles and accepted the role of directly assisting qualified staff

(Kessler et al., 2012). There are instances where doing patient care and assisting qualified staff roles get overlapped. The HCA in this category accept to take on roles given to them by qualified staff. However, many HCA also mentioned that they only accepted taking on the extended roles for the benefit of the patients, and that they do not wish to take on new roles in order for example to further their careers. It was interesting that many were not intent on pursuing other avenues to advance their careers. Most of the reasons that they gave for declining the opportunities to further their careers were due to their age, other commitments. Another was the fact that learning to become a qualified staff in this case to become a RN, took and needed money and a lot of time involving a lot of work which the respondents felt they were unable to commit to such training at this late stage in their working lives. Interestingly they also mentioned that the responsibility that qualified staff bore was daunting for some of them. An example of HCA declining nursing training is given in the following two quotes, in the first example is whereby the respondent is willing to stay on in their role because of lack of finances to further their career and in the second example, the respondent did not feel that they wanted the responsibility that comes with being a qualified nurse.

As a clinical support worker in this unit I've been given the option to do nurse training, but I am sure I cannot afford to pay for it and there are no secondment available, so due to financial reasons I am not interested in furthering my career. CSW Organization A

I am quite content with my role as HCA, I'm not sure I would cope with the responsibility that comes with becoming a Nurse. HCA Organization B

The main reason for some HCA reasoning this way was because they knew that qualified staff relied on a code of conduct and therefore were responsible for the patient's wellbeing including being accountable in cases of malpractice (RCN, 2007). In their mind this seemed a burden too great for them to bear. As it is HCA are not regulated and for that reason this group of workers are reluctant to get into a situation in which they have to take responsibility for the care they

provide. They do to some extent, but they are not the responsible party if anything were to go wrong. In spite of these concerns most responded positively to the fact that they took very good care of their patients, even without having to answer to a code of conduct and ethics. The following example highlights a response showcasing the pride that HCAs take in their role assisting qualified staff.

Our role in the unit involves making sure that the nurses have what is needed for the patient's care, If they need something and we don't have it in this ward we go and look in other wards. – HCA Organization A

This excerpt therefore means that HCA have a part to play in caring for their patients especially when nurses are under pressure to ensure that the patients are in good care, which means that they may have to extend their roles if needed and they are willing to do that.

5.3.1.3. The difference in roles between HCA and Qualified staff

The study compared two groups of workers, between qualified workers that were referred to mostly as RN or nurses and unqualified workers referred to as HCA. Because of the difference in qualification it was therefore important to review the differences between the roles of the HCA and the qualified staff. In reviewing the responses to the difference in roles between RN and HCA, the data was quite telling. In organization A, the HCA felt that the nurses let them do most of their roles except administer medication.

'They do the things we don't do - medicines, they deal with the doctors, we don't deal with them, I mean we occasionally pass something on to the doctors, but that's really a staff nurse's duty. If there was something I was concerned about I would tell the staff nurse and then it would be her job to get in touch with the doctor or anything like that.'
HCA (Nursing Auxiliary) Organization A.

The attitude that is portrayed above shows the somewhat casual way in which qualified staff took their role to be, as they often delegated their roles to HCA. The HCA suggested in the study that they were often left to take on other types of extended roles except giving medication. In a way they viewed it as being given more work except that the work that was handed to them

was untraceable. Handing out medication, was left to the qualified staff they were the only ones responsible for such roles, because of the paper work involved (Kessler, 2012). And the fact that one had to sign to state that they had handed the medication makes this specific type of role traceable to the person that actually performed the roles. Hence such types of roles were not given to unqualified staff and in the same context remained the strict reserve of the qualified staff, all the HCA interviewed stated that because of traceability, they felt that it was the main reason they felt that their roles did not extend to the role of handing out medication to the patients.

One out of two HCA felt that there was not much of a difference between the HCA and RN roles because most the HCA could mirror most of the work the RN did in the units. The HCA often took on those roles in occasions that they were called upon to do them. Some HCA mentioned the fact that they were trusted more to take on those roles because they often did them regularly and this made it seem as though there was no difference between their roles and that of the qualified staff.

*The only changes is that I'm trusted more - whether it's because they are too busy to check up on what we are doing especially when we do some of their roles, and I think on this unit here the staff nurses trust the HCA quite well, actually, because once again they are always so busy and they have to rely on the staff below them to do it, so in that respect I think the staff nurses are more trustworthy of us to let us handle extended roles. **HCA Organization B***

This message also came across for organization A, with the added element of the need for accountability in the roles that members were responsible for. The difference, as relayed in the following quote, is that qualified and unqualified staff have a responsibility to do their tasks and are accountable for the delivery of service, but with varying degree of accountability based on the skills that one has. The qualified staff therefore by virtue of their advanced skills sets have much more responsibility for their roles. They have to ensure and maintain the standards and safety of the patients at all times and that is a significant difference between qualified and

unqualified staff. Their involvement in teams ensures that there is an adequate skill mix, such that the patients receive the care that they need.

We trust that the HCA can handle the extra roles that we train them to do. However, everyone has got to be accountable, but the qualified nurses have got to be more accountable in everything that they do. We have to deal with the more technical things, and generally if there's any complaints the qualified staff are the ones that have to deal with it. Ensuring that the skills mix is adequate, such that if someone rings in sick, you can't just leave it, you have to sort it.

RN Organization A

The same question when asked to the qualified staff often resulted in an absolute “yes”: there is a major difference between the roles of the two groups. This was often followed by a description of the specific skills that qualified staff had to do such as:

'Well, there's a lot of difference, because they can't give IVs, they don't give medications at all because obviously they're not qualified nurses, only qualified nurses can do them. They can't do dressings, they don't give injections, they don't give IVs, and they can't order bloods. They can write in the notes, up to the point that it's only about the part of their role but they're not actually obliged to write, that's part of nursing. They can't refer a patient either. Their role is like an auxiliary's role; although obviously they're higher than an auxiliary; they do our obs, they do washing the patients, dressing, help them with hygiene needs, toileting needs, obs; like I said, they can do venepunctures and cannulate.' **Senior Staff Nurse Organization B**

As reflected in the previous quote, the qualified staff notes roles that they did as qualified staff and that HCA cannot do because they do not have the proper training and qualifications to perform those roles. And yet in the same context the qualified staff goes on to describe some roles that HCA taken on which are actually qualified roles and form part of their extended roles these are venepuncture and cannulation. The qualified staff insist on there being a difference between the roles of these two groups, yet in most cases when HCA take on extended roles there is not much difference in the RN roles and the roles that HCA take on. The difference is that qualified staff have the proper training and skills for those role, unlike the HCA as their training is less formal and acquired mostly through observation and in-house training.

In the two organizations in which the study was conducted, the HCA role was centred on personal care, observation, direct care and some extended roles. There were different examples provided from the different units of what these roles consisted of and this was because of the difference in unit specialism, but in general the roles and responsibilities of the HCA were often times similar. The responses given by the respondents indeed acknowledge the engagement in extended roles, as some HCA described that they took on roles that were specific to RN roles, and this was also confirmed by some RN and managers restating that those HCA who receive some training are allowed to engage in those specific roles, this has been discussed under the heading defining extended roles.

However, in most of the interviews it is clear that the HCA role was mainly composed of caring for the patients such as taking care of their hygiene needs, feeding, washing, dressing, but then a few more roles became intertwined into the health care assistant roles such as conducting the patients' observations, which includes taking and recording of the vital signs of patients which is also mentioned under extended role. Nevertheless, most HCA defined their roles as that of caring for the patients' needs and assisting qualified staff in making the care possible.

While the RN thought that the main definition of the role of HCA should be viewed not only as caring for patients, but also by them having conversations with the patients which allows for better assessment of the patients' needs and progress within the hospital setting. Some suggest that the informal role HCA play in observing patients makes for the patients to open up more than they would to other staff and this was also evident in the study, as the HCA mentioned that they were often quite free with the patients (Nancarrow and Borthwick, 2005).

The members from senior management also weighed in on the role of the HCA and were in agreement with the qualified staff that the role of HCA should not be underestimated as they make a lot of the care possible. And this is exemplified in the following quote;

HCA help us work more efficiently for the patient and obviously ultimately our role is to get things done quicker and better for the patient. Their involvement is invaluable - we really couldn't manage without them.

RN/Sister & Ward Manager Organization B

The HCA role has thus been defined in various ways by the different respondents, but the main tenets to the role as well as differences and similarities shared by the RN roles are as has been reviewed here. It is a role that concerns itself with the care of the patient first and foremost; doing all that is possible to enable dignified care to the patients' needs. Then it is followed by taking on roles that are asked of the HCA by the qualified staff, that is assisting them with whatever is required and this may also include taking on extended roles, which is explored in the next.

5.5. HCA role as taking on Extended Roles

Therefore now that the HCA roles have been defined it is possible to identify extended roles and then explore why the HCA take them on. Exploring and defining extended roles was done in the two different organizations across similar specialities to gauge whether there was a significant difference in the way in which extended roles were defined and carried out. This meant not only defining and making distinctions in the roles but also presenting examples of the roles that are defined as extended. This section therefore further explores what extended roles are through the responses provided from the research data. It reviews some of the responses that described the extended roles of HCA and reviews the reasons that led their occurrence. This is important because though answers to these questions may differ they are all related. It was also possible through the responses provided by the interviewees to ascertain the descriptions of some of the roles that form part of extended role.

Extended roles within healthcare is described as members acting in a proxy capacity, by covering specific medical tasks, which remain under the jurisdiction of the medical profession

(Harvey, 1995; Abbott and Meerabeau, 1998). This study highlight the fact that extended roles consist of different and varied roles from one institution to another. It has been suggested that the fluidity of occupational boundaries between nurses and HCA has enabled HCA to extend their roles, taking on some of the more technical tasks that previously belonged to registered nurses and this is illustrated in the tables that show some of the extended roles taken on by HCA such as venepuncture, removing catheter, venflons and phlebotomies (Thornley, 2003; Spilbury and Meyer, 2004; Bach et al.2008).

5.5.1. Defining HCA extended roles in the wards

In this section extended roles will be described from each unit and compared per organization. In this study the question was asked of what the respondents considered as extended roles, the answers were quite insightful as they also offered examples of what extended roles were as well as the reasons that led them to take part in them. Some examples include the following excerpts from the interviews;

'Extended roles are roles which you wish to take on but are not necessarily yours' HCA Organization A

'That auxiliaries taking on more roles that qualified staff have stopped doing, it is currently what we do on here' HCA Organization B

'Doing something beyond what you've done before, being asked to do something that you have not been used to doing before' HCA Organization A

'Obviously you have your job description and then that's taking all the extra jobs which are outside of your job description - so more jobs' HCA organization B

'It basically means more work' HCA Organization A.

'That means doing things that are perhaps not in my job description to do. I suppose we're doing it all the time, extended roles.' HCA organization B

'An extended role would be something that you want to do that gives you more skills to fulfil the role that you're in' RN organization B

From the responses that have been provided it shows that the HCA actually had their own understanding of what was meant by extended roles. The last respondent as a RN provided a

rather different perspective to extended roles that is the notion that anyone participating in extended roles is often willing to take on the said extended roles. The view is that those taking on extended roles want to go the extra mile to gain the skills required to perform those roles well. This is in complete contrast to some of the responses provided in this study. Yes there are some members of the workforce that are willing to take on extra roles and acquire the skills that are required to perform those said roles, but this mainly applies to the qualified staff and from the study only 3 out of the total number of HCA felt this way. This is so because there is an added incentive for the qualified staff to take on extra roles, they have a clearer path to gaining more pay and more importantly they have a clearer path to advancing their careers based on the clearly structured AfC pay band system, but this is not the case for the HCA, unless they aim to further their careers into nursing.

In most of the instances in the study, the HCA however depicted the notion that they were not necessarily forced into taking on extended roles, even though through some of their responses such as *'we have to do what is needed in the unit, at times we have no choice but to handle the situations as they come (HCA Org. B)'* this reference depicted a sense that there was some obligation into taking on the extended roles, and this was not a secret during the interviews as is reflected in some of the responses captured here. The workforce felt they had no other choice but to engage in extended roles, especially when there might be no one around to take on those roles. The HCA reflect on extended roles as work that has and needs to be done and this has been reflected in the data analysis, based on the examples of responses captured. The next section further reviews some of the experiences expressed by the respondents especially on the issues around extended roles.

There was also an example of a senior staff nurse explaining the roles that their HCA perform and it is based on the training that they provide to them, such as cannulate and venepuncture.

The quote below narrates the extent to which HCA take on extended roles.

The CSW in our acute assessment unit can cannulate and they can treat a patient for us and we have to countersign their job, just check it once they are done. I mean, qualified nurses have to teach them how to do it. We nurses will do them if we have time but mostly we tend to give it to them for them to assess the patient. RN Organization B

In the explanation above on the extended roles that the CSW perform, the nurse goes on to say that they teach them to perform the extended roles, especially when the nurses are unable to perform them as they take on other tasks, but they always have to double check their work, to make sure it is done properly and that the patients are well assessed. It also highlights that there is a form of regulation to the HCA role by the qualified staff.

The tables 5.6, 5.7 and 5.8 clearly shows that there were extended roles taking place and that HCA have very distinct extended roles that they performed. These examples illustrate the specific identified extended roles that HCA took on within their different units. There is some variation in the roles which means that some HCA took on more extended roles than their counterparts from other organizations. It also portrays that given the difference in the roles within units, HCA therefore took roles that were outside of their scope of training or ordinary roles.

Table 5.6: HCA Extended roles in the Elderly Wards

Organization A	Organization B
Acute Medical /Elderly Ward	HDU/Elderly Ward
Observations	Observations
Blood pressure taking and monitoring	Blood pressure taking and monitoring

Recording ECG	Recording ECG
Taking out venflons/cannula on patients	
Venepuncture	
Taking a catheter specimen of urine (CSU)	
Support new staff and students	

In the medical elderly wards from each organization it shows that there are some roles that HCA from both organizations took on the same such as patient observations and blood pressure taking and monitoring. It also shows that HCA from organization A took on a few more extended roles than those at organization B, these include taking out venflons/cannulas from patients, performing venepunctures, taking CSU and supporting new staff and students. This also portrays the relationship between the HCA and the qualified staff. It shows that the HCA were trusted more to take on more extended roles, within organization A. This was brought out in one of the responses from the HCA interviewed in this organization. The respondent stated that, there was more trust in their ability to take on the roles once they received training from the nurses.

*We do observations, and other extended roles, which have now become routine task. We have formed a relationship based on trust after our training with the nurses. They therefore let us get on with the work. **HCA Organization A***

In the Assessment units as well there was a HCA who made the comment that, once they have been trained and the job needs doing they have to take part in the role, reference below. To the extent that they take on extended roles that are not even on their job description also re-iterates the fact that extended roles have become common place, management and senior staff also acknowledge this fact.

Sometimes you might get asked to do jobs that aren't on the job description, but basically, I don't mind doing them. Once trained in doing the role, then it has to be done when asked. Sometimes we might have to be asked to swap shifts, these changes

*were not mentioned on the contract. Sometimes we work over the actual finishing time, and we don't often leave the ward on time and we have to extend our time. **HCA Organization B***

The same picture was drawn in the other units as well. It was therefore common in both organizations for HCA to participate in extended roles as assigned to them only that there were some differences in the extended roles that HCA took on in the different units and within the different organizations. This proves that extended roles as they may be taking place, different HCA take on different range of extended roles depending on the specialism as well as in different organizations.

Table 5.7 (page 160) depicts the extended roles that HCA take on within the Acute Assessment Wards in both organization A and B. It shows some of the extended roles that were similar across both organizations, but it also shows that the HCA in organization A, took of a few more extended roles than those from organization B. These roles included taking specimen, taking and recording the patient's vital signs and conducting phlebotomies. It is a similar trend as was seen in the Elderly wards, which leads to the observation that in organization A, the workforce, might engage in more extended roles in general than in organization B.

Table 5.7: HCA Extended roles in the Acute Assessment Wards

Organization A	Organization B
Acute Assessment Unit	Acute Assessment Unit
Observations	Observations
Monitor blood Pressure, temperature, oxygen	Monitor blood Pressure, temperature, oxygen
Taking specimen	
Take and record vital signs	
Phlebotomy	

Table 5.8: HCA Extended roles in the Women and Children Services Ward

Organization A	Organization B
Children and Women’s Services	Children and Women’s Services
Prepare birth plans	DVT out-patient service
Support women in clinic	Breastfeeding guidance and support
Monitor babies	
Phlebotomy	

This was also the case in the women and children services wards in both organizations. These observations show that the type of extended roles that HCA engage in differ within specialisms. This therefore raises the question, on regulation and how it should be done. Whether it should be done per specialism within different organizations or that their extended roles should be standardized depending on the specialism or units in which they work. That is to standardize roles and ensure that the skills that are needed within a specialism whether from different organizations should be the same.

5.5.2. Defining the HCA role based of research context

The role of the HCA, came from the three descriptions of the HCA roles that emerged and were analysed responses. The author finds it important to further group them into three categories that define the three different groups of HCA that can be found within the healthcare setting. These three categories are referred to as disengaged, engaged and very engaged. The following section details the author’s take on how the HCA roles should be categorized.

Disengaged Category:

In the first group of HCA, their main concern is with the patient's care and indeed doing what is necessary in the interest of the patient and not much more. The author finds the commitment to the patient's care needs as the driving force behind this group of HCA, and while they are committed to their role they are not interested in further engaging in other aspects of their role, whether it be in further training in order to take on more roles, or simply to do more than what is ordinarily required of them. The HCA that fall in this category are defined as disengaged. Here disengaged means that the respondents lack enthusiasm in their role. In the sense that they have no specific interest in their role and are often indifferent to particulars of their role, they do not wish to do more than what is required of them. They view their role just as prescribed, doing nothing more and nothing less than what is stipulated in their role. Whereas there might be room for this group to get into other areas of practice so that they may be able to improve on their roles and scope of their work, this group of HCA do not have the intention of acquiring those skills. To them the HCA role should not be equated to the nurses' role because it is their feeling and understanding that there is a significant difference between their roles and those of the qualified staff, and they would not like to engage in roles that may upset that balance (Guest, 2004). Of the 35 interviews carried out, the responses from 6 people fell in this category with an even split of 3 per organization.

Engaged Category:

The engaged category describes HCA that have accepted taking on extended roles mainly because they view their role as adhering to what is asked of them by the qualified staff (Kessler et al. 2012). The HCA that fall within this group also view the patient as the most important part of their job and taking care of their needs is viewed as sacrosanct. This is what makes their role even more important because they take on extended roles which require doing more than what they have to do for their patient. For them taking on extended roles reflects on the deeper

meaning which was alluded to earlier as ideological currency. They feel that there is more to just doing the job, there is the obligation to the patient and ensuring that the duty of care is adhered to till the end.

The HCA in this category appreciated the fact that they were considered for in-house training to learn extended roles. They took part in this in order to assist in the more efficient running of their units. The main difference between the disengaged and engaged category is that, with the engaged category of HCA they are willing to take on extended roles and even additional training to enable them to fully participate in their role. The HCA in the disengaged category will not venture in training that would eventually lead to taking on extended roles. In the interviews carried out, 20 respondents fell in this category, of which 14 people were from organization A and 6 respondents were from organization B.

Very Engaged Category:

The group of HCA that fall in this category take on extended roles mainly out of their own volition. They are defined thus because they willingly accept taking on extended role as part of their role and just as the HCA in the engaged category, their reasons for accepting extended roles vary. Chief among them is that they view the patient as the most important aspect of their job and secondly because of that they wish to not only take up extended roles, but pursue further avenues to progress their careers. They especially hope to get into proper nurse training to become fully qualified in performing those aspects of their jobs. For most members that are in the very engaged category, their ultimate aim therefore is to become registered nurses. From the 34 interviews carried out for the study, only 3 people fell in this category, two were from organization A and the other from organization B.

An interesting characteristic of this group was that all three were young in age, between the age ranges of 19-29. This is quite different from the other two categories in which the members seemed to be of a more mature age group ranging from between 35-65. This difference was significant because they felt they had the time to chart their careers into nursing. This was unlike the other more mature HCA from the two other categories who stated outright that they had no interest in further pursuits into their careers, they rather felt content with the roles they participated in already (Kessler et al. 2012).

The HCA in the very engaged category assume the role of taking on extended roles quite willingly and with a natural sense that those roles are their duty. It is even important to note that the qualified staff recognises their value and input in care delivery is important. It is however, difficult to measure but nonetheless very much valued as the HCA assist them in making sure that care is properly administered. Table 4 summarises these three categories of HCA as defined by the author based on the responses given by the respondents, including some of the roles that were also described which form some of the categories in tables 3, 5 and 6. It

is worth noting that there might be some HCA that belong to more than one group by virtue of their personal preferences of what their role is and should be. This therefore allows for some overlap to occur as some respondents made it known about what they felt their role was within the unit, therefore this table acts as a guide because it offers suggestions based on the data gathered. As the in the example below, the respondent shows the willingness to take on extended roles and to even get into nurse training in order to gain more knowledge and skills that will enable then to take on more roles.

So now I'm looking forward to other goals, which include really to continue in what I am currently doing and gain more knowledge and acquire more skills. What I would really like is to get onto the nurse training. I like the fact that I will be able to learn more and then do more once I'm fully qualified. HCA Organization A

Table 5.9: Summary Characteristics of HCA Staff Categories

Disengaged (Titleds)*	Engaged (Benevolents)*	Very Engaged (Equity Sensitives)*
Age between 30-65	Age between 30-65	Age between 19-29
Most don't perform ER	All take on ER	All take on ER
Not interested in ER	Interested in extended roles to the extent that it is related to care for the patient	Interested in extended roles in pursuit of qualification as RN
Not necessarily content with their role, they already feel that they do a lot of work and are not willing to do more	Accept their role and are not interested in career advancement	Motivated by career advancement and achievement of qualifications, they want to achieve more in their role
Not interested in further training	Not interested in further training	Interested in further training to advance careers

* Categories defining individual's equity sensitivity preferences discussed in chapter 2.p 58.

The table depicts the summary of characteristics of HCA that belong to the three categories given by the author, these were based on the responses of the interviewees on the role of HCA.

It is especially important to note that a research done by Kessler et al. (2012), found a particular finding that is similar to the one in this study. That is the fact that the length of time one has in the role as a HCA, determines whether they are willing to take up further training to qualify as nurses. This was identified as well in this study as only 3 interviewees out of the total 34, showed the interest of becoming a nurse, and these three fell in the very engaged category, they were all young, and had only been in their role as a HCA for 2 years or less.

5.6. Why do extended roles occur?

In this section the second part of the first research question, why do extended roles occur is explored. The core role of HCA as was mentioned and depicted by most respondents seemed to be as to take care of the patients' needs and to assist the registered staff, and also take on extended role. Now both of these two statements on the core role can mean anything. The first implies taking care of the needs of the patients based on their abilities to do so. Second is that of doing what was asked of them by the qualified staff. Therefore, what had been taking place was that the organizations faced with tough choices most often due to budget restrictions as some lamented, then resulted in the organization offering in-house training for staff willing to learn new skills, and in doing that made it possible for the workforce to train in roles that might be out of their jurisdiction.

Doing the in-house training then allowed them to perform those roles as part of their core duties once they qualified through in-house training for the said roles, these roles then eventually become referred to as extended roles as they often are out of their scope of practice. As this is done it in a sense has led to the legitimization of extended roles. The author describes this as a short-cut to employing a highly skilled workforce. The only option left is to substitute the highly skilled more expensive workforce with the cheaper less qualified but capable workforce that can take on the said roles (Grimshaw, 1999). This is because they can be trained to perform

the highly skilled roles that are outside of the scope of their roles at a cheaper cost to all persons involved.

The results of this study also show that the continued employer strategies of skill mix through the recruitment of HCA has enabled the managerial tradition of 'grade dilution' which then acts against pressures for occupational closure in the nursing profession. Grade dilution simply refers to the way in which the state has used the notion of gaining skills in nursing, to an extent that the grades and boundaries within nursing have been redefined to encourage and enable the substitution of the more qualified and higher grades in nursing for cheaper labour and less expensive grades (Thornley, 1996; 2000). This has made it possible for the fluid nature and blurring of roles between qualified and non-qualified nursing staff to persist, as the contentions between experience versus formal training continue unresolved. In the study this was evidenced by the fact that that in four of the six units in which the study was conducted, HCA and even management admitted to extended roles taking place within their units. The roles that they described and are indicated in this chapter, show clearly that some defined nurses roles, were being taken on by HCA, such as observations, venepuncture, phlebotomy, cannulation and so on.

It is the view of the author that the role of the HCA was viewed as that of the assistant. The assistant roles have been positioned by policy makers as members who reduce 'burdens' of professionals so as to allow the professionals to focus on their core duties and this means taking on extended roles. This notion sums up the wider view of literature on occupations about the support worker role. The support worker role has often been seen as taking part in the professional project by taking on some roles that have been taken from professionals. This involvement still ensures that the professionals have continued control of their domain of expertise as the support role is part of a pawn for the professionals (Larkin, 1983; Witz, 1992; Abbott, 1998; Kessler and Bach, 2006). This view however, takes away from the focus on the

role of support workers and especially their perspective of their function and their engagement in extended roles. The response therefore remains that HCA will always remain under instruction from management, who will use their position to stretch their role, thereby they are left to function just as workers engaging in extended roles and nothing more.

5.7. Discussion and Conclusion

In conclusion, this chapter shows the two case studies and provides some proof that extended roles were taking place in both organizations, at varying degrees between the different unit specialism. It also offers new evidence on extended roles such that it shows that HCA within the same type of specialism may be involved in varying extended roles, such as in the case of the Acute Assessment Units in the two organizations sampled. In organization A, the HCA had more and varied examples of extended roles than in organization B, depicting the way that both organizations determined the extended roles that their HCA workforce could undertake. Being that it was the same specialty, the extended roles for both groups ought to be the same. In organization A, three other extended roles that were identified as being taken on by the HCA staff, and were stated as including taking patient specimen, taking and recording the patient's vital signs as well as doing phlebotomies.

Given this fact then it is clear that there are specific examples which explain and describe extended roles taken on by HCA. It is therefore, to be expected that as the HCA role becomes part of a vehicle pursuing various public policy objectives, other aspects of the role become overlooked. The key policy of focus in this study as mentioned earlier is AfC, and as its implementation was mentioned by both organizations as part of their organization's focus in initiating changes such as improved skill mix through extended roles, it was worth investigating to what extent the change made a positive or negative impact. This will be mentioned in the following chapter which further explores the findings in this study including more empirical evidence from the study.

CHAPTER 6

FINDINGS

6. Introduction

In this chapter the research findings are further discussed as the aim is to explore the answers to the second and third research questions. Why do non-professionals or HCA participate in extended roles and whether this participation can be explained by the engagement in of the AfC policy initiatives? This section goes back to the research questions and uses the responses provided from the interviews to provide an overview of the research narrative. It reviews the research questions and addresses the responses gathered as well as insights into emergent questions from the study which is part of an approach recommended for qualitative research (Gephart, 2004). Whereby an in-depth analysis of the interview data and the themes relating to the research questions are explored.

The main research questions therefore as pointed out in earlier chapters were to investigate;

- ✓ What are extended roles and why do they occur?
- ✓ Why do HCA participate in extended roles?
- ✓ Can policy changes explain the use of extended roles; Agenda for Change policy?

This section therefore begins by exploring the second question. It would then be rational to explore why extended roles were left to persist and the consequences to the continued existence of extended roles. This would enable finding out from the respondents why they took on extended roles and their reasons for doing so

6.1. Why do HCA participate in extended roles?

There are several reasons that ensure that HCA participate in extended roles. Some of the ones found in the study and are similar to some findings that have been made in previous studies are stated here. First, is cost effectiveness, because the role of HCA is viewed as necessary as and cheaper to employ than that of qualified staff (Grimshaw, 1999; Nancarrow and Borthwick, 2005). The second, is the fact that there are fewer qualified staff within units and this makes for flexible working such as expanding and extending roles, a notion mentioned as grade dilution (Thornley, 1997; 2000). The lack of qualified staff has been attributed to budget constraints and the fact that there are fewer numbers of students enrolling into nursing. This was also bore out in the study, as some respondents suggested that they would still participate in extended roles even though they were unwilling to further train to be nurses (Bach et al, 2007)). Another is that the workforce often has no other choice but to take on extended roles, and this might be because roles have over time been re-created either by re-labelling the tasks that were already within the organization. Such that there is a new service, but not new workforce to take on the new tasks (Bach and Kessler, 2007). This is also bore out through the engagement in skill mix, which is exemplified by changes in roles (Buchan and Dal Poz, 2002; Crossan and Ferguson, 2005).

The other reason for HCA engaging in extended roles, comes from the author's identification of third party obligation within psychological contract (Rousseau, 1995). Here the author suggests that the HCA take on extended roles out of their obligation to the third party, here being the patient. This is because they view their role and duty to the patient, requires them to take the responsibility as part of a greater course that they aim for, thus extending their roles to take on tasks that assure the best care for their patients, make them oblige into taking on extended roles. They become willing participants of extended roles. This notion is further explored in this chapter, as it forms the crux of the theoretical contribution of this study.

6.2. Agenda for Change and Regulation of HCA role.

In this section the significance of the AfC is reviewed and then analysed in the context of the study. The research question being investigated in this section is, whether policy changes and specific to this case the AfC policy could explain the use of extended roles. The regulation of the HCA role is also discussed including a section on how the HCA view the regulation of their role especially as they take on extended roles.

AfC is important in defining extended roles and how extended roles have been put into action within healthcare organizations. AfC has been the policy together with its programmes that have encouraged extended roles in the NHS, therefore understanding its goals as well as its aim in the healthcare context is important (DoH, 2004). As was stated earlier in chapters one and three, AfC, was not only meant to streamline the roles and remuneration of the workforce, but it was to make changes to job roles in order to enhance the contributions of the various groups of workforce especially the non-professional staff involved with the provision of care (DoH, 2004). A particular aim of AfC and one of its pillar's is the KSF, the framework evolved around ensuring that artificial career ceilings were broken making it possible for the workforce to not only break down traditional role barriers, but encourage them into new roles including extended roles.

The previous chapter highlighted the HR strategy of each organization in which the strategy details of each organization was reviewed. The aim of the question in this section therefore is to review how much the members understood the role that policy played in how they engaged in their roles and participated in their work. It was important to establish whether policy had in effect been part of the reason why extended roles occurred and whether there was a support system in place in terms of both the intended and unintended consequences of following through with policy directives. To this end the interviewees were asked specific questions on

whether they were familiar with some policy terms that are at the core of defining AfC – skills escalator, lifelong learning and KSF- these have been mentioned in chapter 3. These are the structures that have been put in place to facilitate the success of the policy. They encourage the employees to be more engaged with their work in order to enhance their own skills as well as to provide the needed quality care for their patients. In reviewing the way the policy is meant to work, it was also of interest to gauge how well the respondents identified with the regulation of their roles, especially as they took on extended roles.

6.2.1. Agenda for Change (AfC)

In both organizations, AfC was sold to management and the workforce as a way forward for every employee, it would be able to monitor and chart the progress of the employee, assuring them of pay increases based on the skills that they held and or further acquired. But the emphasis during the implementation phase showed a different focus. The need seemed to be to phase all the workforce into the new pay scheme, and therefore the efforts were on categorizing the current roles of the workforce and group them into neat sections that denoted the roles that members needed to have to progress on to different pay structures, and not necessarily focused on the career progression of the workforce. This caused confusion because it was solely based on the individual being interviewed about their role, and specifically on what they did in their current role, and later on when others found out what the aim of the process was which in a way was to determine at which pay level the roles were to be set at, some decided to inflate the roles that they did perhaps in the hopes that they would get more or better pay.

It was surprising the numbers that did not understand the basics of the policy let alone mention some of the pillars of the same, even some managers were completely out of touch with the premise and requirements of the policy. Most responded by saying that they did not know pillars of AfC, neither did they know anything more about what it was meant to do. This has therefore led the author to suggest that some of the breakdown in communication with some of

the workforce was due to non-compliance with some of the policy directives. Examples include the following response with regards to the types of training provided by the organization. Higher levels of management understand what the policy is about, but they admit to the lack of communication of what is expected of the workforce. The training provided is not evaluated and feedback and options are not given to the workforce in terms of what should happen next to their role.

'I think we are very good at providing both internal and external training, but I don't think we evaluate it as well as we should. It is all about getting people to the training but it should be about what's the feedback and does it get back to the organization, how does it change jobs. Everyone that wants to go on training we encourage it and expect that there is a win win solution. I don't think that we evaluate to chart progress. Assistant HR Director Org. A

Even with the knowledge that feedback is not given to the workforce, management still acknowledge that more ought to be done in terms of promoting development within the workforce. Making them aware of the options they have in order to advance their careers.

'We promote training and development and are a strong developmental organization, but I don't think we have been big on exploring the options that these come with that strength. Some of our workforce stay on the same job description for long time and we should promote them re-evaluating their career options. We ought to communicate it better to them. HR Director Org. B

There was an instance in which a HCA in Organization B stated that his manager was not supportive in providing avenues for them to enhance their career. He stated that:

'I've asked her several times if I can go on the course of taking blood, but most of the time she ignores me and up to now she has never given me a response, I take it that she does not care and does not want me to get on the course'. HCA Org. B

This example shows as mentioned earlier that management did not take the career paths of other work groups more seriously. The promise of the skills escalator which is one of the four pillars of AfC, is to offer the opportunity for 'making the NHS a model employer, providing a model career by gauging the process of the individual, improving staff morale and building people's management skills', this motto does not seem to translate well with management in

both organizations (DH, 2002:7). This raises the issue that management are not supportive to their workforce even though part of the policy is to encourage the enhancement of roles for the workforce. The result has been that the workforce are not given the opportunity to advance their skills and when they do, they are not actively supported to chart and advance their careers.

The feedback stated that during the preparation phase for integrating the workforce into the new pay system, certain stages were overlooked, which made it more difficult to correct the oversight later on in the process. Examples were given such as the way in which roles were to be defined for specific jobs in the various pay bands was not done properly. This meant that some roles were either dropped or added to some jobs without the right consideration. An example of this is stated in the following quotes:

'AfC was meant to provide clarity between all roles in a hospital or trust environment, between the staff especially the nurses and healthcare assistants. Obviously everybody's doing different roles, but the level of technical skill or hands-on and clinical roles anything like that. It was meant to try to get some parity between all roles within the NHS so that everyone gets the recognition and the pay that they deserve.'
RN Organization A.

This issue among others left some respondents feeling dissatisfied and discouraged because this meant that there would be some form of repercussions elsewhere (Guest, 2004). Such as either taking on more roles for less pay, or stuck in job paths that have no further means of advancements. This revelation was significant and telling in that it was an admission that the foremost goal of AfC, seemed to have only been concentrated on identifying and placing the workforce with the job roles that were aligned within the policy framework.

Eventually there were a lot of unsatisfied workers, because the argument was that most were not put in the correct pay band. Others went on to do more than what was then classified as their roles and this made it difficult in many ways for some workers to either up skill or pursue

ways of making a success out of their careers. To some HCA who worked in specialist areas which were involved in higher skills areas, they felt that the HCA roles had been generalised to an extent that most were placed in the same band structure as HCA who for instance worked in general area, whereby there were rarely any instances of extended roles taking place. This was seen as having no consideration into the different roles that HCA take on across different specialty areas within the hospital settings. This is well illustrated in the following quote, in which the discussion is on how the policy targeted the role of the HCA.

'I talked a lot about benefits realisation and about this is your opportunity to skill your staff and gives them a career pathway. Start looking as if you initially have people working at band 2, train your HCA staff to take blood, record ECG, to cannulate, to take some of the qualified nurses work and hand it to them with competency based training. There is a career structure which is a benefit to the member of staff because you retain people and you grow your own people. Because you know with the HCA role there was nowhere really to ever go, so it's all about doing it now.' **HR Manager Organization A**

The interviewee here states that based on the AfC policy framework, there was no clear path to progress for the HCA role. Therefore there was need to create one that was more specific to the HCA role, by looking at their contributions thus far, noting that there is scope to expand their role. With proper training and regulation HCAs can become a qualified workforce with the added value of being the extra hands that get the work done, as so many have praised the current role of the HCA. It is also important to note that other units had taken up the challenge of implementing some aspects of AfC, but without the proper support structures it became difficult to monitor as well as fully implement. There was the urge to train the unqualified staff to take up some of the roles that the nurses did, and to enable the nurses to do other work, often boundary issues within the professions was seen as the obstacle in this case (Bach et al, 2006; 2007). Some members of staff saw the changes as improper, that it was basically allowing unqualified staff to train to take on roles meant for qualified staff, some viewed this as excessive blurring of roles, which meant there was a need to evaluate the roles of HCA. The quote below reviews some of the issues that made it impossible to implement AfC:

Some areas have tried to do it [Implement AfC] in medicine and surgery , particularly the Medical Assessment Unit, Surgical Assessment Unit and A&E. They were all ready with regards to AfC starting to realise that they could use unqualified staff to do some of the task orientated work like recording ECG and doing some other assessments that qualified staff normally do taking blood samples, as long as they went and did the formal training and they were signed off. It was difficult because you obviously had a school of people who didn't think that it was appropriate, you needed to be qualified to take a blood sample, but I said that the pathologist staff that go on the ward and take blood are on band 2 like your HCA staff and they are not qualified nurses, so if we can train them then why is it not appropriate for the HCA to do that. It is just changing people's mind sets, that yes it is okay as long as they go through the proper formal training process they abide by the policies and protocols and they are safe to do certain procedures then they are okay to do it. Assistant HR Director Organization B

It therefore leaves it as the pathways to achieving the stated goals for AfC are simple and general, to the point that many trying to follow the policy feel aggrieved because they take on more roles than what is stipulated as part of their roles. They find it difficult to progress on to other pay band levels, especially because there is no other way out for them. There are no other levels for the HCA to go up to, once they reach Band 3, they are at the final development point within that role, there is nothing further they can do unless they go for nurse training (Buchan and Evans, 2007). This means that there is nothing higher to aim for unless they are qualified staff, in that case there are several levels higher to go, in fact there are 9 bands in total and for the qualified staff this means 6 more levels which vary much more depending on the experience one achieves within the roles. This is because each different level within the bands signifies the different levels in knowledge, skills and effort needed for the job.

There are Job Evaluation Scheme (JES), which are carried out to determine the correct pay band for each post, because each pay band has a number of pay points. As staff successfully develop their skills and knowledge, they are supposed to progress in annual increments up to the maximum of their pay band, which is at two defined "gateway points" within each pay band, therefore pay progression is based on the workforce being able to demonstrate their applied knowledge and skills for the job. A re-evaluation of the structures are in order, so as to make it more specific to the HCA role and redefine and also allow for training to enhance

their role and make it possible for the HCA to make a career out of their role. At the moment, there is no possibility for that as the framework is lacking on how to improve on this group of workforce. Table 4.5 (page 114) illustrates the different salary levels also referred to as pay bands within AfC with the typical job roles assigned to each band.

In this study, two out of three respondents and especially all senior management acknowledged that the AfC policy seemed to have fallen short of its objectives. The evidence of this comes from the way in which its local implementation seemed to have made it difficult for the workforce to identify with the roles that the policy was meant to play in their functions at the organization. This notion has been based on the responses from various respondents; such as their inability to identify what the policy was or what the policy was meant for. According to the following quotes:

'Is that policy supposed to improve our working conditions' HCA Organization A,

'I am not sure what agenda for change means' HCA organization B

These examples are but few of the responses that were reflected from the majority of respondents interviewed. They gave the notion of that they were unaware of the policy itself, stating at times that they did not know neither the objectives nor the intentions of the policy let alone the influence the policy had in the running of the organizations. The response from senior management was much more pronounced, because they identified with the fact that the actual process of implementation made it difficult to further explain the benefits of the policy to the workforce. As depicted in the following quote which also makes it known that the pertinent questions about the policy were never reviewed, both from the workforce and the organization, it simply shows that the policy was issued by government and it had to be implemented, therefore all had to be done in order to make it happen and that any questions that arose were to be asked later.

The aim of the policy was to gauge the amount of people needed to move over to the new AfC pay scale formula, with its terms and conditions. It was more to do with reinforcing and ensuring performance was monitored. We had no need to review benefits to the workforce mostly because the questions were not asked. **HR Director Organization B**

On paper, the ideas behind agenda for changes are quite revolutionary. It proposes to chart out the specific roles of a specific group within the nursing profession and categorizes them on a scale that allows for growth for the individual in terms of career progression and also offers the training requirement for each stage of the process. It relays the information on the expected pay grade depending on the skills that the individual acquires. It seems easy and quite straight forward but why has it not been as successful as it was hoped to be? The answer to this question is well stated in the following quote, in which the respondent offers up some reasons as to the breakdown of the policy's implementation on the ground.

It[AfC] was just for the need to get people moved over, we had the appeals and we got finished, it was never big on agenda we initially had a steering group agenda right thought the implementation. But when it came to the realisation it was just about getting everyone assimilated and when that was done it was over. **HR Director Organization A**

The HR director from organization A, therefore states that the process of implementing the policy seemed to have not been well thought out. It was focused on gauging how many people would be able to be transferred into the new pay system or the AfC pay scale formula with its new terms and conditions. It was based on performance management and not necessarily on ensuring that the benefits were to be passed on to the workforce. The workforce was not properly informed of the benefits of the new policy especially in terms of their career progression, training and pay. Very little was portrayed of the benefits realisation of moving the staff over to AfC, the focus was on ways of working and modernizing into the new scheme without the proper explanations of what it meant to be moving onto AfC.

Highlighting the benefits such as the available training for the purposes of gaining more skills as well as advancing ones career as well as increasing one's remuneration and potential value, all went by the way side as the goal was to ensure that most of the workforce were graded into the new pay scales and that their roles were narrowed into specific categories, this was what seemed to have happened. The benefits of the policy were not readily evident regionally, at least in the organizations in which the research was carried out, as the interviewees were unable to identify with the policy and its purpose. The fact that this policy seemed unfamiliar to most, even to management, implies that even with the noble notions of such policies, they fail due to lack of proper implementation and the inability to address other causes associated them (De Ruyter, et al., 2008).

6.2.2. Regulation of the HCA role.

Regulating the HCA role as was mentioned earlier in chapter 3, has resulted in various debates such as who should be conducting it as well as what exactly the regulation process should involve. These debates have taken place especially because there are costs associated with guaranteeing certain aspects of regulation and the focus has turned on whether there is a need to regulate roles such as those taken on by non-professionals that are termed as having low risk (RCN, 2010).

Regulation is mentioned as designed to control entry into a role and monitor the performance once one is in the role. This might be done in order to ensure the quality of service and adherence to guidelines in terms of acquiring the proper training and skills and continued development within the role (RCN, 2007:6; Kessler et al, 2012).

There are three basic components to AfC, job evaluation, harmonised terms and conditions and the Knowledge and Skills Framework (KSF) (DH, 2002). AfC has in some ways made it

possible for the NHS to deliver the necessary workforce changes that are in line with other policy initiatives in order to advance the modernization agenda (Sandal et.al, 2006). There is still a long way to go in terms of full implementation, as there are some components to AfC, that make it impossible to meet some of its goals, such as career and skill development, reduce role boundaries and better job evaluations.

The AfC, left the onus on the trusts to assess jobs locally and base them on the nationally agreed criteria, which meant that there would be different evaluations of roles performed especially by non-professional staff, because their roles are not clearly defined. This seems to have made it even more possible for extended roles to occur, as different institutions have varying roles for HCA in the same types of units or specialisms, as was also indicated in the study. The AfC is supposed to provide a support system to the workforce which helps to monitor their development and career progression, which is linked to the KSF through the annual developments reviews and personal development plans (Bewley, 2006). This system has been designed to replace demarcations and allow staff to chart their own pathways within healthcare in taking on new responsibilities (NHS Employer, 2008).

The KSF however seems unmatched in terms of the specific job roles set within specific job titles. On one end one might be expected to have very high skills to move up to a specific pay band and yet there might be no more room to advance out of the said paid band. An example is that there are instances in which HCA band 3 in some units take on more responsibilities and even extended roles than other HCA in band 3 in other units. The reason for this can be attributed to the fact that KSF is not specific enough, it is quite generic and at times offers basic roles between the HCA roles. The feeling that was portrayed from the senior managers in both organizations was that the actual implementation of the AfC policy especially the pillars that were to ensure its success such as the skills escalator and the KSF outlines were not properly planned and articulated on how they needed to be reinforced.

The pillars of AfC are meant to work in such a way that the KSF, include detailed job descriptions and evaluation of the roles that are pertained within each job category. In developing skills further under the skills escalator, members would then be able to both gain more skills as they pursued their career paths as well as improved on their remuneration. In reality however, there was really not much room for some groups of workers to progress their roles. There seemed to be a cap within the job definitions and pay band especially for HCA, because there was no further level they would go to past pay band 3. The pay band as has been referenced earlier is the AfC pay band system for healthcare workers in the NHS. It is also important to mention that at the time that the AfC policy was being adopted there was emphasis and push towards modernization which made it focus more on transferring the workforce into new job descriptions and ensuring that they were grouped in the correct pay band, which was also stressed in both organizations. There was not a care as to how the workforce would be affected once the changes were made, hence the constant mention by the respondents, that it felt to them that their roles were not necessarily valued, because management did not make an effort to encourage them into new areas of work and also improve and support their requests for better pay.

The KSF provides the basis for pay progression within the different bands on the AfC and is an integral part of the NHS pay system. It defines and describes the knowledge and skills that NHS staff need attain in order to use within their work and provides a consistent, comprehensive and explicit framework on which to apply their work and base their review and development of staff members (Sandal et.al, 2006). This is more clearly defined for the professional staff who are the nurses, but less defined for the non-professionals. As stated earlier, there are instances in which the roles of HCA vary not only within units in an institution,

but even within similar specialism across different institutions. This therefore means that more ought to be done to align and specify the roles of HCA, and define them better within the KSF, so as to allow for equal roles across similar functions, which will then enable the goal of staff receiving equal pay for work of equal value, which is a goal of the policy.

*KSF outlines are nothing fantastic skills wise or competency wise. They have these core dimensions that you've got to fill in so as to achieve the top end of the career ladder. For HCA and well to move up the band the issue is that there aren't enough band 3 jobs available to move up to. It has come to a point where HCA just say what is the point, because they are taking on extra work and extended roles, but the jobs aren't coming up. **Organization B – HR Manager.***

While the time for bringing on AfC it was sold as if you develop yourself you will be rewarded and that is not what you see in reality. I think there was the enthusiasm to gain more skills, but then when you go for the job matching and evaluation, or what we called re-grading, then it's like it is not a new job description. The managers could change a job description and put it in a job description and uplift them, but they were probably just looking at budgets.

Organization A – General Manager Services

The above quotes highlight and summarise some interesting aspects to the study, in terms of the role of AfC and its consequences to stakeholders. The first is that it seems to support what most other respondents stated that they engage in extended roles without benefits and acknowledgement of their input to care delivery. Also that there are substantial failures that have been brought on by the government's policy on AfC, chief among them being the fact that some of the pillars have not been a central focus since implementation and this has rendered the policies unworkable. It also meant that AfC was not clearly cascaded down to lead managers, hence there was lack of proper follow through. There are no reviews carried out that can chart the progress of the workforce, and with that said some careers are not meant to develop further than what is available on the KSF and SE frameworks.

6.2.3. Local Initiative and Regulation of HCA role.

Organization B, focused only on ensuring that the workforce had completely assimilated into the new AfC pay structures, nothing more seemed to be done in order to monitor the regulation of the HCA role. Especially as management acknowledged that there was a failure in conducting annual reviews of the staff, this meant that there was no way to gauge and regulate the performance of the HCA in their roles. This is also depicted in the following quote:

'We have been so concentrated on trying to achieve our goals for acceptance as a Foundation trust, and we admit there have been some failings, especially inconsistency in conducting PDRs. The online format is not very user friendly, as it is often difficult to manage' **Manager Organization B**

In which the manager admits that other pressures especially the focus of gaining foundation trust status had been a major focus in the organization, making it a failing on their part as management to ensure that these personal development reviews were conducted, hence a better system was needed as they suggest to monitor staff progress.

Organization A, however, took on a different approach to implementing AfC. They developed practice development (PD) an innovative approach to teamworking. PD is a continuous, self-feeding system where healthcare providers working within multidisciplinary teams adopt better ways and methods of delivering health care services to their clients and patients based on their needs, feedback and past experiences. Most of these teams consist of multidisciplinary functions in which healthcare providers come together to perform their different roles and functions (Eve, 2004). PD means that in the units, the team consists of multidisciplinary functions in which the healthcare providers perform their different roles and functions in an approach that synthesizes activities and theories of quality improvement, they mainly engage in teamworking through skill mix, with an evidence based approach to healthcare provision (Page and Hamer, 2002).

Organization A had taken AfC and applied it through the use of the PD method of teamworking. In which PD as some of its definition suggest takes on clear structures of development that can generate changes within the healthcare system to allow for better service delivery, development and the management of healthcare teams (Eve, 2004). The aspects of creativity and innovation are what set PD apart from other models of improvement. PD encourages role redesign, which improves outcomes by ‘changing the way that employees experience responsibility for their outcomes as they have knowledge of their work activities’ (Hyde et al, 2005:698). The model is fundamentally based on patients and clients and the real practical setting where the care takes place. The framework given by the Practice Development Unit (PDU) accreditation programme facilitates the process in which clinical teams suggest and develop their own team models of PD (CDHPP, 2007).

There were interesting comments from the teams in which the PD model was practiced. The communication had improved and this had encouraged members in that they felt more empowered. This was also reflected in the way that members were able to question themselves on how best to perform their work. This reinforced a learning culture in which members engaged with each other to make the team-working processes better and in turn led to high morale and kept members motivated on the job, even when they had to extend their roles. Some examples that illustrate changes in work practices based on this model include the introduction of patient diaries in the wards, not only were these used to inform the patients about their stay in the hospital, but patients’ comments were solicited about their stay, treatment and other general queries. Through such initiatives, the teams got involved in ways of improving the essence of care and subsequently implement those elements that had proven to be of benefit to the patients. Some respondents mentioned that most evident changes since becoming PDU accreditation, was the improvements

in practice and improved attitudes between team members. One particular respondent mentioned that teams set out actions plans together on how to share the workload, and as a result hierarchical structures had been reduces (Coburn, 2006). An example of this is shown in the following quote.

'The hierarchical structures do not exist in our unit anymore. The structures that were here when I started nursing are no longer there. When I started, you could only talk to second year and third year student. We never spoke to the doctors only the sister did. All that's gone. This has really helped because it has ensured that everyone is on board at the same time. We work together and things are better now.' (RN/MG Organization A).

Members therefore learn to take note of their strengths and weaknesses so as to later on concentrate on making those practices better for the patient and for the good working nature of the teams. Through engaging in extended roles and working in teams has encouraged the outpouring of support from the different professional groups and the organization itself. The best response has been in improved training for members in order to improve the skills and knowledge on the essence of best care practice. Therefore, in organizations A, skill mix is being reinforced within these teams as they engage with one another for the best provision of care to their patient. The idea is that the standards of care are maintained through a team that works together to ensure more consistency in delivery of care. The PD framework allows for the mix of skills and makes it open to extend roles so that team members feel that they achieve the necessary training and support to hone their skills to provide the best care through evidence based practice to their patients.

The example from organization A in its innovative approach to team working is directly linked to the organization's HR policy in terms of to its pledges to its staff. That is by providing employment and focusing on evidence based practice and on training and developing the workforce. This can be viewed as an attempt at following through with the premise of the skills escalator, in which the PD teams have the freedom to make inquiries into their progress in the units as well as receive guidance on steps to further their skills and career goals within the

teams and in the organization (DoH, 2004). Organization A, has made an effort to marry policy with practice, in terms of its implementation of the PD which is a form of team working that incorporates skill mix. The next section is on PC, which the author uses to explain why HCA extend their roles

6.3. Psychological Contract (PC)

This section is keen to assess the way in which each individual interviewed perceived their role, their job and in a sense asked the respondents to respond to the question, how they felt about their employer and whether their employer kept their end of the bargain with regards to their employment. This section is directly linked to the question on why do extended roles occur? Rousseau (1989) defines psychological contract as the employee's perception of the reciprocal obligation which exists with their employer, as well as their own obligation to the employer. Central to the employee-employer relationship within the psychological contract is the unwritten agreement on the reciprocal exchange elements existing between an individual employee and the organization (Rousseau, 1995). Therefore the psychological contract consists of the individual's perception of the mutual obligations within the employment relationship and these tend to be bound by the norm of reciprocity.

The question of interest is the issue of why do extended roles continue to occur even though the other issues such as policy implementation, remuneration, career goals and such do not reflect a concerted effort to engage the workforce into ways of extending their roles. Rather what other meaning was sought for the continued extension of roles. This is pursued in this section with the need to engage with the individual, and their own perception of what their role is. This became of interest as the initial interviews were carried out with management, because

the senior managers especially from Organization A, intimated to the fact that HCA took on more roles within their units, and they seem to enjoy engaging in extended roles.

The statement that the workforce enjoyed taking on extended roles, made it necessary to then inquire from the respondents, the reasons why they engaged in extended roles. It was to gauge the reasons they gave as individuals willing to engage in extended roles and whether any changes to their employment situation had anything to do with it and in doing so offer up the real reasons why extended roles continue to occur within organizations.

The researcher asked the respondents whether they felt that their employer had kept their end of the bargain since their employment began. It was curious to note that most of the HCA responded negatively to the question, while most of the nurses responded in the affirmative. The nurses were in agreement that most of their promises had been met upon employment, few noted procedural issues such as lack of PDRs, but this seemed not to be a bother for those that mentioned it. For the HCA however it was a totally different scenario. Most had their reasons and it ranged from not having access to promised training, not receiving a satisfactory wage, not having PDR, being overworked and being asked to do more all the time. The list is overflowing with comments of what the HCA felt was a breach of their psychological contract. But none were able to find a solution to resolve the problem.

The HCA seemed resigned to their fate, even to the extent that some noted that it was just a job. But to those that felt it was more than a job, the breach was devastating to them (Morrison and Robinson, 1997; Conway and Briner, 2005). It meant that they were in a constant state of doubt and mistrust of their employer and senior management. Interestingly this had no effect on their roles, most stated that they really enjoyed their role especially taking care of their patients. The idea that the HCA were dissatisfied with their situation, and that they found no other means to correct it but still accepted their roles, were such defining moments during the

interviews. One after another, most of the HCA responded in this way, and this prompted a review into the theory of psychological contract, mostly the idea behind properly spelling out the parties to a psychological contract and why psychological contracts exist. Hence, the author's suggestion of the third party involvement in explaining the reason why HCA keep on taking on extended roles, which is further explored in the next sections.

6.3.1. Importance of PC and its Impact on Employees

This section reviews the way in which the employees define the particulars of their employment especially their psychological contract. This is in part explored because of the extent in which they perform their roles, the objective here is to gauge their feelings towards their role and employer, what makes them continue to engage in extended roles and what does that mean for their continued working relationship in the organization. According to two out of three HCA that participated in the study, they stated that they take on more roles nowadays compared to when they started working in the role. A classic example of this expression is in the following quote, where the employee stated that the role of the HCA has changed, they actually do more work compared to when they started off working and this is due to lack of adequate staff.

'At times when we have staff shortages we rely on the HCA, unfortunately we can't help it when we have long-term illness which tends to happen a lot. We also have not hired qualified staff in a while, which means that we definitely count on the skills of the HCA, they are part of the workforce, part of the team and they do what is needed' **Sister/Ward Manager Org. B**

The quote clearly demonstrates that many changes have taken place, such as the use of HCA to replace RNs due to the fact that there are no more qualified nurses being hired. This definitely affects the way employees relate to each other and their employers, making them have concerns over their working relationship. As time has gone on nothing much has been done to change the situation, because the work has to go on and as depicted in the following quote, most accept the situation and are often unsure of ways to approach the supposed breach or violation of their

psychological contract and whether there are ways to improve employment relations. Because the employees do not get more hands to help with the work, it makes them feel that they have no other choice but to get on with the work.

I haven't seen my job description for a while, but my current role are different to what it used to be some years ago based on what I do now. When it gets really busy and we have few people to do the work. You have to choose, what do I do my auxiliary role the coffees or do I do the staff nurses' role of observations and roles like that. So in such an instance which role would you do? I'd probably end up doing both actually. I would probably do the coffees and then the observations. I would help with the nurses' roles. In such an instance I have a clear role, but I have to prioritize.

HCA – Organization A

The feeling towards taking on extended roles is personified by the following quote by HCA nutrition support assistant at organization B; it seems the person is conflicted with their feelings towards taking on extended roles. They feel like they enjoy their role, and yet they take on more roles because they feel obligated to the patients, and also as a result of being short staffed the work has to go on. This was often reflected with the following types of suggestions, according to some HCA there is often no other choice but to take on the roles, some say it is due to their enjoyment in taking on the roles, but for others it is because they really have no choice.

*It doesn't bother me, because I enjoy it. Yes, I just love it. Doing things I'm not supposed to do, like during - mid-morning, after breakfast, when patients are wanting the toilet, when the other (qualified) staff are busy, it can be any time, from coming in at seven o'clock to going home at three o'clock. I'm just there, always available to take on any role required. We often extend our roles due to shortage of staff. The amount of work the staff have to get through, and the patients that we have they need more care and we help out whenever needed, which is often. **HCA -Nutrition Support Assistant Org. B***

Taking on extended roles has been a gradual process over the years, but more recently and especially for newly enrolled HCA on some units, extended roles comes as part of the job. Hence they get trained on the job on how to take on some of those roles. At times it is a matter of there being staff shortages as mentioned earlier and therefore more work has to be done by the few staff that are available, the work is shared around and people have to learn how to take

on extra roles quicker in order to provide the continued care that is required for the patients. This is well reflected in the quote following, in which taking on extended roles are part of one's conscience and duty.

*Our role is to help the qualified staff, because quite often we are short staffed. For instance on Sunday two people didn't come in as they should have and there was only 5 staff and with 28 patients, it was really busy. And out of the 5 staff there was only 3 qualified staff. And if you don't do it, sometimes you think to yourself I am not going to do that, because it is a staff nurses' job, but then you look and say if I don't do it, it's the patient that will suffer not the staff nurse necessarily, so it is difficult really. You've got to do it, because it's for the patient's benefit. So if you've got a conscience then you do it. **HCA Organization A.***

As part of one's conscience and duty, the author takes on the debate that doing this is part of one's need for taking on a role with more meaning. Taking on a role that goes beyond looking at what the role does for the one doing it, but rather the reasons that makes one take on the responsibility. Therefore the details of third party involvement as mentioned in chapter 2 are handy in exploring the reason that most HCA continue to take on extended roles. Some of the responses and reasons given by the respondents helped to cement the author's idea of the third part involvement as influencing the continued participation in extended roles, and is discussed in the next section.

6.3.2. Third Party Involvement

In this section the discussion on the psychological contract is continued, but with the aim of further exploring the notion of the third party involvement as a factor in HCA engaging in extended roles. As has been defined in chapter 2, psychological contract deals with the implicit agreements between an employee and employer on the employment relationship. Rousseau aptly defines it as the beliefs and perceptions about the relationship as an employee and employer viewed it and that it was promissory by nature, in her view psychological contract is underdeveloped and misunderstood (Rousseau, 1989).

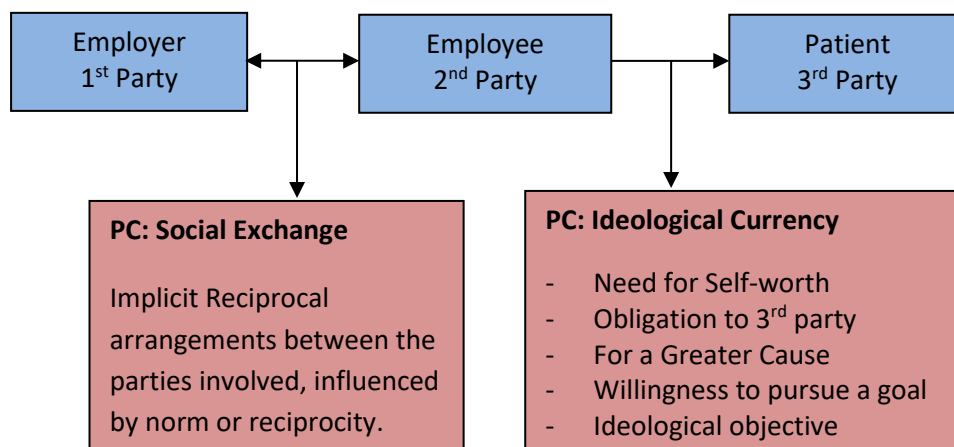
In the study it seemed true that psychological contracts had become eroded, resulting in lower levels of trust, respect, support, commitment and even loyalty from the workforce (Guest, 2004). These changes however, did not seem to have been automatic, but occurred gradually as expectations upon assistants became higher and ultimately increased depending on which sector they were found in. There are some factors that might lead HCA to shape the perceptions of their role. There might be the policies within the trust, the type of unit they are involved in, their colleagues and lastly their individual thoughts on what their role is. All of these options are factors but only one is within the control of the individual HCA and that is their thoughts about their individual role, their ideology. This plays a big part in defining the character of the individual on the job. Watson defined the concept of ideological contract to mean that one's ideological position plays an influence on their judgment in their employment relationship, leading to a formation of the ideological contract. This idea is further highlighted by Thompson and Bunderson's (2003) discussion of a similar concept in which they referred to as 'ideological currency' which they saw as being within the psychological contract. The premise is that ideological currency makes it the core principles by which an individual valued their worth in an organization. It is contextualised as thus within an organization, whereby an organization pursues and formulates an ideological objective. The individual then has the option to review whether the cause pursued by the organization was important to them, therefore warranting commitment from the individual. However, the author takes this notion further, by exploring the idea of ideological currency as that which is based on the individuals perceptions of what their own ideology is and not that offered up by the organization, and that is the difference between what the author is presenting and the view offered by Thompson and Bunderson (2003).

The third party involvement refers to the inclusion of the patient who is the third party into the employment relationship between the HCA and the Organization. The relationship between the

HCA and the Organization is reflected through social exchange, in which both parties to the agreement are obligated to each other in terms of what is called for in the working relationship. The psychological contract is a way of operationalizing the employee-employer exchange through social exchange (Coyle-Shapiro and Conway, 2005). Understanding the employee expectations as it relates to the social exchange enables the identification of the factors that shape the employee's perception of their psychological contract. These main factors as discussed in chapter two are reciprocity and mutual obligation (Blau, 1964; Rousseau, 1995). If any of these are lacking, then the ideological currency is what is left and that is tied to the relationship between the HCA and the third party or patient in this case.

The HCA feel obligated to the third party due to their ideological currency which is the notion that they are performing a role that takes prominence over all else. Whether there are disagreements between the HCA and the organization about the employment relationship, those should not be reflected towards or have an adverse effect upon the third party. This obligation to the third party is sacrosanct and makes the HCA stay on in their roles and keep on extending their roles because of the duty they have towards the patient, they are tied to the welfare of the patients, which is the greater cause that they pursue within their role, - that is their ideology or ideological currency. The figure 6.1 below illustrated this relationship.

Fig. 6.1. Third Party Involvement in PC defined:



Key:

Member
Relationship

Source: Author adapted from (Blau 1964; Rousseau 1989; Thompson & Bunderson, 2003; Cullinane & Dundon, 2006)

In terms of the impact on the organization's HR policies it seemed that there were other factors that made it impossible to follow through on some government initiatives, let alone some of the goals outlined in their individual HR strategies. For instance in Organization A, it seemed that they were successful in at least one unit within the institution in pursuing a goal from the HR strategy. That strategy was meant to develop the skills of the workforce and with that advance the individual career goals of the workforce, to ensure they received the necessary training for their respective roles as well as maintain the standards required for the provision of specialised care for their patients. But just like in organization B, other aspects of the HR strategy such as to ensure and maintain a capable, effective, valued and committed workforce, as well as to avail opportunities to the workforce so that they can advance their careers, received a negative response from all the HCA respondents that were interviewed. Their view was that the organization was not very conscious of the needs of the workforce as the organization put emphasis on ensuring that costs were minimized. This did not necessarily harm the patients in their care, but led to strains within the workforce, the lack of progress in terms of focusing on some of the HR strategies, meant that there was no clear way to follow through on them.

6.4. Discussion and Conclusion

In summary these findings argue that HCA provide more than just basic care to their patients. This has made it possible for them to extend their roles within the healthcare organizations. This suggests that there are broader implications for the continued use of HCA in extended

roles. The current policy mechanism have not been a success in ensuring that HCA receive the training that can safely allow them to take on those extended roles because the proper regulation and evaluation has been lacking. The aims should be to look at the work load involved, the delegation of the work, the training and education needed to perform the work and the people chosen to take up those roles. From the data therefore, the evidence does point to a shortfall in the number of nurses, per patient as required from the standards recommended for nurse to patient (Cavendish, 2013). This also proves the fact that HCA have become available to fill that void. As there are fewer qualified staff as depicted in the study, then the responsibility is passed on to the available staff, who are the HCA.

The impact of AfC upon assessment seemed to have just been a policy on paper but not reflected in practice. There were no measurable impacts of the policy as the evidence on implementation seemed to be lacking. In all but two cases throughout the study were there appraisals carried out. This outcome reflects badly on the success of the policy, because the success is premised among other things on a keen evaluation of the progress of each individual, and based on that the appropriate steps are then taken to ensure that the training for the workforce is enhanced and that they are encouraged to proceed into other avenues within their careers. It is also the view of the author that the HCA role was not catered for in the AfC framework as it was scant on specifics, which meant that there were no further steps to be taken for an HCA to succeed or move on further to enhance their careers, once they reached pay band 3 (RCN, 2012).

Extended roles as mentioned earlier were embedded to the roles of the workforce. The reason for this was not only the failure to follow through with AfC, but other factors such as shortage of staff, which seemed to be the main reason for the occurrence of extended roles. The blurring of roles between the nurses and HCA also meant that there were no clear cut boundaries as to the roles of these two groups of workers, and most often extended roles were let to occur as it

was in the interest of getting the work done within the units. The evidence in most cases was that the HCA had accepted their extended roles, such that extended roles were no longer contested anymore, and they just got on with the job as was required.

The most significant finding in the study is the role that PC has in extending the roles of the workforce. The author has referred to the third party involvement as the driver of this engagement and further highlights the individual's obligation to the patient, as the motivator of engaging in extended roles whether or not their promises are violated by the organization. Therefore as extended roles ask the workforce to engage themselves in more work, the HCA resolve to take the obligation they have with the patient as part of the reason for them continuing with the work that they do. Going beyond their contract to perform what is best for their patients, does not necessarily signify their commitment to the organization, but to their ideology with reference to their role and their commitment to the patient. Without the third party involvement, then the breach of their psychological contract would lead to other options such as negative organization citizenship behaviour, lack of commitment and so on (Tekleab and Taylor, 2004).

In conclusion, financial constraints and policy implications are the two main factors that influence the continued use of extended roles; other factors include: skills acquisition, career progression, satisfaction or achieving some goal and ideological currency. The main impacts of extended roles rise out of the concern for the patients, if there are few people available to offer the services required for their health, those available have to then step up their efforts in order to support that cause. Therefore the result then become both positive and negative, positive in the sense that patient care is still the focus but a negative in the sense that nothing much is done to correct the situation, which most of the workforce see as inappropriate for their working conditions. More HCA are hired to balance the books as well as provide care, but the HCA end up feeling unappreciated while at the same time they are bound with the duty of care

for the patients in their charge. In that sense they feel a violation of their PC, but their obligation to the patients makes proceeding with the job more important than retaliating to the employer.

CHAPTER 7:

DISCUSSION AND CONCLUSION

7. Introduction

The aim of the study was to develop a sophisticated understanding of the causes and drivers of extended roles in all non-professional contexts. Therefore, three research questions were formulated and these were to, first define extended roles, secondly to explore why extended roles persist within non-professional workforce and lastly, whether policy could be used to explain why extended roles occur within this workforce. The study used HCA in healthcare as the illustrative case to explore and address these broader theoretical concerns.

This thesis has therefore attempted to blend theory with practice, so as to underscore the continued use of assistant workers or non-professionals with professionals, and highlight the continued blurring of roles especially in the healthcare setting where the nursing role has continued to perpetuate this phenomenon - continued use of extended roles within the HCA workforce. This has not made better changes to the HCA situation in terms of what their role means and whether there are any benefits to the HCA role. In other words it raises some questions as well as provides some implication for policy and practice as this group continues to extend their roles. The aim of this conclusion, is to provide an overview of the preceding empirical chapters, stating the key findings and also stating the suitability of the methodological approach considered for the study and directions for future research.

7.1 Aim of the Study

This section presents an outline of the aims of the study by presenting the research questions followed by the findings from each research question. At the beginning of this study, the author was drawn into focusing on the boundary differences within the professions in healthcare. But as the study started to gain focus, it became interesting to depict the differences within the

nursing roles and especially the impact that the blurring of roles had on the non-professionals who took on the nursing auxiliary role, and which in the study has been referred to as the HCA role. The main focus of the research then became to examine the role of HCA and indeed explore the drivers and consequences to their extended roles in secondary healthcare. What are their extended roles and why do they participate in extended roles?

7.1.1. What are extended roles and why do they occur?

The first research question was centred on defining the role of HCA workforce. Time and again they have been referred to in different terms even within the organizations that the research was carried out, they were referred to in different names which shows the different names that are given to the members within this workforce, this fact has added to the confusion about the roles that they ought to carry out. The importance therefore was to define their roles and be able to distinguish between their roles and those of the qualified staff, and in doing so be able to ascertain the roles that they took on outside of their roles which would then be referred to as extended roles. These have been described in some detail in chapters 5 and 6. In this study the HCA role is defined as an assistant to qualified staff (professionals) referred to in the study as RN. The HCA take on roles as are advised or given to them by qualified staff. Extended roles on the other hand are defined as members acting in a proxy capacity by taking on different additional roles, which were generally under the preserve of another profession but over time the roles have been delegated to other occupations often as a result of occupational imperialism or necessity.

In the study extended roles differed within organizations and within the unit specialism. In the example set in chapter 5, in the Acute Assessment Unit, it was discovered that even though the specialty was the same, the HCA within these units did different types of extended roles. In fact in organization A, the HCA were left to take on extra extended roles. These included, taking specimen samples, checking and recording vital signs and conducting phlebotomies.

While in both organization the similar extended roles that the HCA performed were patient observations and taking and checking oxygen and blood pressure for the patients. Even as extended roles were taking place in both organizations, the fact that the HCA from organization A, took on a few extra extended roles, made it possible to assess that there were structures within the organization that facilitated and allowed for that to happen. In the children and women's services it was due to the innovation of PD teamworking implemented in the team. The other units it was down to management organizing how team members worked. Management made it possible for the HCA to take on extended roles and facilitated for them to get assistance from the qualified staff. While in organization B, the perception was that there was work to be done and those available had to do it.

7.1.2. Why do HCA participate in extended roles?

The second research question was based on finding why HCA participate in extended roles. There are four reasons singled out in this study for HCA continued participation in extended roles. These were: first, due to financial constraints. This has been echoed throughout, from management to the HCA, it is also a factor mentioned in the literature (Walby et al, 1994; Klein, 1995, Ham, 2004; Thornley, 2008). Budget cuts within organizations are forcing them to re-think the management of the organization including its human resources. Therefore new and innovative ways are being used to this end as the use of skill mix, role-redesign and prioritizing (Nancarrow and Borthwick, 2005; Bach et al, 2007; Kessler et al., 2012).

Second, and which is linked to the first reason is that with insufficient funds it is difficult to recruit and retain the required amount of staff and skill sets, hence the shortage in both. There are few nurses being recruited (Cavendish, 2013) and this has a direct impact on HCA roles as they pick up the shortfall. This was exemplified in the study when the recommended staffing ratio of Nurse to Patient in the UK, was compared to 4 units from the study (H&SCIC, 2012).

The result was indeed that there were more HCA in the units and the recommended ratios were not achieved, meaning that the HCA were being used as substitutes. The HCA end up filling the void that seemed most often to be left by the under sourcing of qualified nurses within the units.

Third, is that other HCA, especially from the category defined by the author as very engaged, are willing to learn and progress their careers, hence they engage in extended roles as a way to gain experience in roles that will enable them to get on to pursue their nurse training. Even though as shown in the study management was not very keen on assisting some HCA, and even failed to avail either the proper training or remuneration for their contributions. This in turn reflects the fact that not so many took on extended roles as part of progressing their careers as there seemed to be a lack of support.

Fourth, comes from the fact that taking on extended roles elicited different views from different respondents. The most significant response was from the HCA that took on extended roles, because they viewed it as a responsibility and part of their duty to ensure that the patients received the care they required. This aspect was raised several times and made it possible to note that often the HCA, felt that their psychological contract did not yield positive outcomes for them. This led to the authors defining this notion of taking on extended roles due one's ideology. Whereby, author describes the psychological contract as involving three parties, and the HCA as the second party, feel that they are obligated to the third party –patient- and therefore, they have to focus on the patient, because their role is to ensure the safety and care of the patient. Which is also the higher cause and purpose of their role. Therefore, extended roles seem to continue within the HCA workforce, because of the notions of their ideology, their having a purpose in their role and that is the obligation to the patient.

7.1.3. Can policy changes explain the use of extended roles: focus on AfC policy?

Changes in societal demands for effective healthcare have had significant implications for healthcare policy, the NHS workforce and healthcare users (McGloin and Knowles, 2005). Policy debates have centred on the need for a healthcare workforce that can deliver quality, through efficient and cost-effective services (Spilsbury and Meyer, 2005; McGuire et al, 2007; Buchan and Evan, 2008). In these debates, there has been the need to maximize the contribution of all staff in the NHS, while requiring staff to have the skills necessary to function within the complex and ever changing nature of the NHS. Moreover, improved service is deemed achievable through policies that increase the involvement of non-professional workers through the extension of their roles (Chang, 1995; Bosley and Dale, 2008; Thornley, 2008). Hence the need to discuss the government's concerted efforts to engage in the policies that foster extended roles.

This research question was specific in that it highlighted AfC, as the policy that was being investigated and the question was whether its implementation could be used to explain why extended roles continue to occur among non-professionals. The findings highlighted the fact that even though AfC policy encouraged skills mix within the NHS, research into the outcomes suggest this approach has not yielded much success (Hancock et al., 2004). The findings stressed that as the policy was being rolled out for implementation within the units studied, the focus was wholly on assimilating the workforce into the new AfC pay grade system. There was no focus on developing the workforce in order to advance their careers through more training and development and eventually assuring better and increased pay as well. This re-reinforced the fact that policy intentions can and often are noble, but lack of proper mechanisms for implementations, means that the outcomes are not assured. Arguably, as this has been less successful, there is a need for a change in approaches to policy initiatives, not only to facilitate better career advancement of HCA as they pursue extended roles.

The AfC policy initiative is of great interest as it focuses on two areas of importance in this study, the role of HCA and Human Resource Management (HRM) initiatives that affect change in an organization. AfC was introduced in 2004, as a new pay system for the NHS workforce (DOH, 2006; Bewley, 2006). It provides a framework intended to form new roles meant to prevent artificial career ceilings and encourage staff to work in new ways through breaking down traditional barriers to extended roles. One of its objectives is to improve the delivery of patient care by enhancing the role of staff (DOH, 2006). A report by Kings Fund (2007) found that the lack of implementation of AfC resulted in failure to deliver on intended benefits to patients. Another objective was to give NHS staff fairer pay and improve their recruitment, retention, and motivation (Crossan and Ferguson, 2005). This has not been a success thus far, because HCA are still lowly remunerated and at the same time they are an unregulated workforce with undefined skills and roles, yet they engage in extended roles as they provide healthcare (Grimshaw and Carroll, 2007).

It has been interesting however in analysing the policy implications, in which it seems that the lessons from the past are yet to be learnt. And as new regulations seem to be on the offing it is important to also note that there are schism between policy aspirations and pragmatic practice responses that make it difficult for these ideals to become a reality. There has largely been a failing which has involved and been experienced by patients, managers, practitioners and policy makers alike. New avenues should be pursued that ensure that policy makers and practitioners are agreed on the way forward. There is the need for real partnerships between those in charge of setting the policy agenda and decision together with those responsible for delivering the policy decisions. This cooperation will help strengthen the ties between these groups as the common goal is to foster an environment in which the care of the patients is important and closely followed by the wellbeing of those providing that care. It would also ensure that the talk about health is translated into a health reality with the workforce enabled

and empowered to deliver quality service to all. In a world that is ever changing, better communication with keen emphasis on involving all players will ensure that the right care is provided with the proper persons for all those in need of it.

7.2. Research Contributions

In this study the research contributions are both empirical and theoretical. The main premise of this study is to advance knowledge and it does so by expanding the knowledge on extended roles, within the context of non-professional in the healthcare context by using the HCA. It also highlights theoretical, empirical and implications for policy and practice on taking on extended roles.

7.2.1. Empirical Contribution.

The empirical contributions are discussed in this section. This thesis offers three. First is that it offers new evidence about the nature of extended roles. Second, this thesis demonstrates that extended roles occur at different rates within different contexts and finally it highlights the fact that policy prescriptions have little salience in supporting extended roles.

The new evidence on the nature of extended roles is that it is first important to note there is variation in the HCA role, and because there is no standardization the core role of HCA can also include extended roles. The evidence of this was clear in both organization from the elderly ward and the acute assessment units, whereby not all roles were similar which also meant that some HCA take on more extended roles than others even within similar types of unit specialisms as the ones mentioned here. Therefore, extended roles differed depending on the type of organization, type of unit, the type of management in the units and organizations and also the type of HCA in these different instances. It would be possible to find HCA in the same unit doing different roles, some engaging in extended roles while others not. In such cases it would be dependent upon the willingness of the HCA to extend her roles. In other units it was

preferred for HCA to extend their roles and get on with the jobs at hand. However, in most instances as mentioned earlier the extended roles were mostly dependent on either the type of unit or specialism, the type of organization and the people who were in-charge of the said units.

The study has also shown that extended roles vary not only within specialism, but also within organization, that is there are different contexts in which extended roles occur. It was found that in same type of unit, from the two organizations, it would be possible to find that there are instances where some roles are defined as extended roles while for other non-professional workers they are defined as core roles, and even further from this spectrum were those non-professionals that did not take part in extended roles at all. This shows therefore that there is a different range in which extended role are experienced, within different contexts (Kessler, 2012).

The study also highlights the notion that policy initiatives have little apparent effect in supporting extended roles. This is because, the policy prescriptions are not being actively implemented. AfC policy has three basic components job evaluation, harmonised terms and conditions and the Knowledge and Skills Framework (KSF). It enables the NHS to deliver the necessary workforce changes that are in line with other policy initiatives in order to advance the modernization agenda (Sandal et.al, 2006).

The KSF is the component that provides a framework for the review of the development of different groups of staff member in the NHS, it also defines their pay and career progression (NHS Employer, 2008; Buchan and Evans 2008). While the Job evaluations were carried out to determine the correct pay band for each post, because each pay band has a number of pay points, upon which staff need to achieve through skills development. Lastly harmonised terms and conditions, which went hand in hand with job evaluations as it outlined the employees employment terms and conditions. The premise was that each employee would have a yearly

review and through that chart their development plan, these simple parts to the whole were not being carried out as the study shows, and therefore benefits of the policy seem to evade most respondents. The policy was meant to redesign jobs and enhance the roles of the workforce by ensuring that more staff worked differently (DOH, 2006). As the evidence showed a lack of commitment to its implementation, by virtue of none of the respondents stating that they had had a personal development review, some for years. This meant that AfC was meant to rhetorically offers endless opportunity at all levels of the NHS workforce, by encouraging career growth while simultaneously filling skills gaps. As these policy offer a blue print on how to develop a workforce, more effort should be made in ensuring proper implementation on the ground.

The aim at the beginning of the implementation phase was to focus on one element of the policy, which was to assimilate the workforce into the new payment structures. But other aspects on training and development, career progression and elements of motivating the workforce were never of focus even as senior management were aware of the policies. Even the fact that the organizations that were selected for the study had stated that they were compliant with the AfC policy. This study provides important and useful information on the lack of effectiveness of HR policies and regulations in the NHS.

7.2.2. Theoretical Contribution

Theoretically this research develops new ways of understanding the causes and responses of extended roles among non-professionals. It offers a novel application of the psychological contract theory in relation to tertiary commitments, which in this case are the patients. Psychological contract deals with the perception of the parties within an employment relationship and entails the reciprocal promises and obligations implied in the relationship (Rousseau and Tijoriwala, 1998). The psychological contract theory is used in this study to

explore and describe the extent to which extended roles occur and the way that the individuals perceive the changes in their roles.

The study came up with the notion of third party obligation to indicate the fact that there are three parties to a psychological contract. Apart from the third party obligation, the study uses the notion of ideological currency as what motivates the employee into committing to the psychological contract based on the third party's involvement. Ideological currency is described as the notion of working for a higher or greater cause (Thompson and Bunderson, 2003). Thompson and Bunderson (2003) argues that psychological contracts are premised on ideological rewards and once an organization represents a worthy cause this alone can encourage employee contribution and commitment as they believe that their work has a purpose. But the author takes ideological currency to be based on the individual employee, actually participating in the worthy cause and not the organization as highlighted by Thompson and Bunderson (2003). Their idea is that ideological currency suggests that the greater cause is attributed to organizations seeking to establish and adopt principle driven missions that may induce greater employee contributions. But the author goes further to suggest that, the search for meaning in the work that they do including the search for a greater purpose, the urge and endeavour to do better comes from within the individual worker.

Therefore, when they are discouraged by the actions of their employer, they persevere because they feel their psychological contract is only half broken. The patient is the primary cause of their role, and their ideology is based on doing more for that cause. This is highlighted by their endurance in the situation they are caught up in and this might include engaging in extended roles and other actions. The involvement of the third party reflects the transition to a new deal as expressed by Burr and Thomson (2002). This has been brought on by the increased cynicism within organizations, in which the workforce searches for a broader meaning in their work. They then tend to re-examine their main purpose at work as they seek to create other

psychological contracts within the organizations because the older notions of the psychological contract no longer exists (Burr and Thompson, 2002; O'Donohue and Nelson, 2005).

This study therefore argues that the individual's ideology or finding that additional pursuit, or a valuable cause or principle within the work is what influences their decision to carry on with the work, because often that principle is related to the third part and not limited to their self-interest. When an individual forms a commitment with the organization through the psychological contract, their ideology and instilled notions of the contract reflect their beliefs (Roehling, 1997). Whether or not the organization provides for an environment in which their value can be utilised, the cause they support is greater and therefore they pursue it because they are bound to a third party within the contract (Coyle-Shapiro and Parzefall, 2008). Under these circumstances, the psychological contract was therefore defined as involving three persons, the employer as first party, the employee as third party and lastly the patient as the third party.

The most significant finding in the study is the role that PC has in extending the roles of the workforce (Rousseau, 1995). Change within organizations as stated earlier may lead to transformations that alter employment agreements that then try to fit into those changing circumstances (Guzzo and Noonan, 1994; Knights and Kennedy, 2005). But as Conway and Briner (2005) state that earlier research depicted the PC as being focused on expectations within the relationship while Rousseau highlighted the notion of obligations, whereby obligations come from the perception that there are future promises and expected actions and outcomes to be made within the relationship. Rousseau (1989) emphasised the notion that psychological contract was inherent in the individual, emphasising individual expectations rather than matching expectations of both parties to the exchange relationship. Focusing away from what had been common in PC research of two parties. The move to the individual's perception of the obligations of both parties to the exchange relationship has been a distinguishing feature of Rousseau's work (1989). However this study goes further to suggest

that not only is that relationship based within the individual, but because there is a third party to the PC, then the individual is obligated to the third party as well.

Hence, the author has referred to the third party involvement as the driver of this engagement and further highlighted the individual's obligation to the third party which in this case was the patient, as the motivator of engaging in extended roles whether or not their promises are violated by the organization (Morrison and Robinson, 1997; Conway and Briner, 2005). Therefore as extended roles ask the workforce to engage themselves in more work, the HCA resolve to take the obligation they have with the patient as part of the reason for them continuing with the work that they do (Kessler et al., 2012). Going beyond their contract to perform what is best for their patients and that does not necessarily signify their commitment to the organization (Roehling, 1997; Coyle-Shapiro and Parzefall, 2008). But commitment to their ideology with reference to their role and their commitment to the patient. Without the third party involvement, then the breach of their psychological contract would result in negative organization citizenship behaviour such as lack of commitment and so on (Tekleab and Taylor, 2003; Conway and Briner, 2005).

7.2.3. Implications for policy and Practice

This section reviews some of the recommendations that have come about as a result of the study. As was mentioned earlier, great success for the role of the HCA depends on regulation. The key goal of the NHS has always been to focus on the patient, to serve them and put their needs, their voice and their choice ahead of all other considerations (DoH, 2013). Therefore for the safety of patients there ought to be a code of conduct for the HCA workforce that follows the same recommendations as those of the qualified nursing staff. A code of conduct would be a welcome addition as it would focus on the standards of conduct, attitudes and behaviours that the public and people in need of healthcare should expect of the healthcare workforce. It therefore would ensure that the HCA take ownership of their role, they would then be therefore

considered a valuable and important contributor to the delivery of care. This is indeed what the HCA have been clamouring for, some recognition and for it to be available to them means that they would have to abide by the rules that come with it. It would then enable them to have a special cause and reason for to extend their roles, as it would finally be moving towards making their extended roles somewhat official. This means that the roles that HCA will perform will be more scrutinized to ensure that they are able to perform the roles that will then be part of their duty as they will be viewed as performing the roles they are qualified for. As this is not set in stone, it might happen that nothing changes even as a result of this and everything stays the same, either due to other factors mainly lack of resources or lack of available staff to join the healthcare workforce, but if these factors are not an issue then this would make some kind of change in the way the healthcare workforce is organized (Thornley, 2008; Buchan and Evans, 2008).

The purpose of the code of conduct should therefore be to highlight their responsibility for the patient (DoH, 2013). The HCA ought to ensure that whatever they do does not adversely affect their patients and fall below the standards that are detailed in the code of conduct. This would basically mean that they not only have a responsibility to their patients, but that they are also bound to certain tenets and rules of care. The importance of having a code of conduct is that it would trickle down to other aspects of their duties. Such as the fact that there will be a keener focus on staffing levels, whereby there will be need for staff to deliver high quality care, but with the appropriate skills and support available to provide the same. This will ensure that the skills they use on the job are evidence based and that guidance is offered so as to ensure that they utilise the needed skills for the care of the patients which will reinforce the appropriate use of skill mix as advised by the Francis Inquiry (2013). This is the appropriate way to approach skill mix just as was reviewed from the units in which Practice Development was taken up. There appeared a proper balance in the way that the members in the units utilised

skill mix to assess the health needs of their patients. Also important will be the need to assess the staffing numbers and ratios that make it possible for successful provision of good quality care, this would therefore mean that more care will be taken to assessing the care needs of patients but also the numbers required to fulfil that requirement, that is the proper skill mix to provide the proper care needed for the patients. As depicted in appendix G, table 1 and 2 (page 226), this gives the number of the qualified staff and HCA in the units. It puts them in ration format so as to make comparisons with the recommended staffing level ratio. It shows that there was an imbalance in the recommended rations versus the fact that there were more HCA than qualified staff in the units examined, which strengthens the case that HCA indeed extend their roles as a result of the shortage in number of qualified staff.

As with any new approach, it is important that the review process be successful so that any problems once identified, can be rectified and a better revision of the approach can be adopted. As with the recommendation of a code of conduct for this workforce, there is the added advantage to ensure that the staff receive the proper training and skills for their jobs (RCN, 2007). The need to train and equip your workforce with the necessary skills is key to improved healthcare delivery. If this is achieved then it can be reflected in the end result by having enough staff with the necessary skills to cater for the needs of the patients.

A lot has been mentioned by the HCA of their feeling undervalued and also that this was reflected with their complaints about the compensation they got for the work that they did. It seems that it is important to distinguish between the different roles within the HCA workforce. As has been reviewed before, there are some groups of HCA that do not perform clinical types of roles, that is, they have no direct links or contacts with patients. But the fact that they have no contact with patients and may only be involved in roles that may involve cleaning and not necessarily in the units but outside the unit and on the grounds of the institutions. This questions the validity of the current running of the HCA role, there is a feeling that a better split of the

roles of the HCA should be conducted. This would also reflect the types of roles that they take up and their remuneration further determined by the skills they exhibit. It should not be as it currently is that HCA that have no contact with patients get the same pay as those who perform cleaning duties on the grounds of the institution. The fact that they exhibit different skills within their roles should be reflected in the pay they receive, and therefore there is the need for a review of the wage that is given to this group of workforce.

There ought to be a more specific way to judge the skills of this workforce, so as to distinguish between those who work with nurses directly and in turn have access to patients and those that do not. The AfC policy was supposed to offer a straight forward way of not only ensuring that staff got the training that they required based on the career paths they wished to follow, but there would be a clear path to their career of choice, with all the necessary training that is required clearly stipulated in their personal development plans. As the responses from the interviews showed, it seemed that this process had not been passed on to the workforce, and most seemed unaware of what was available for them. As the policy still exists, there should be a better way of integrating the provisions of the policy and making the workforce aware of the benefits that are to be gained by charting their career with the help of their ward managers. It is important to give this some investment in terms of time and resources. It is important to encourage the workforce to get training that will not only improve their skills sets, but will advance their career trajectory. Most of the benefits of the current AfC band system suggest that it is more helpful if one follows the path to becoming registered nurses, as there are more options for them but even with that being the current state of the situation there ought to be room to improve the role of the HCA. It is therefore important to recommend a thorough review of the AfC band structure to further categorise and improve on the roles and skills that can be attributed to the HCA role. This would not only require resources as stated earlier, but a clear approach of what roles need to be passed on to HCA, and what training would be required for

them to gain access into those skills (Thornley, 2008). This is important because, HCA already take on extended roles, but in order to safely guard their ability to perform those skills they ought to receive training that is tailor made to assess their abilities for those roles and finally qualify them in a way that will let everyone know that they are competent at taking on those roles. It is not simply because they already take on extended roles that they should continue to do it, but there should be the care and safety of the patients as the ultimate goal. There ought to be a way that HCA are entrusted in those roles once a specific process is put in place to ensure that all involved are aware of the consequences of HCA taking on extended roles.

Currently AfC calls for the unit managers to be responsible for carrying out PDR, this has been reviewed in the study as having been unsuccessful due to the nature of the PDR forms and the process of collecting and inputting data into the various forms available to generate a review for the employee. A recommendation would be to suggest that the process needs to be streamlined into including only the essentials. Covering simply the current role of the worker, what their goals are for the future, such as the training that they feel they require so that they can be able to accomplish more roles and duties. Roles that they would like to get into in order to advance their skills and at the same time be able to chart a path for them to achieve their set goals with proper timelines to gauge their progress throughout. The PDR are a vital part of developing the role of the HCA, therefore the HCA need to get the proper training to carry out their roles effectively. It is instructive that the new training standards that form part of the Francis Inquiry (2013) offer a symbolic mirror that reflects the image of what the HCA role should be like. It essentially asks HCA to take responsibility for their role, develop their role, respect their co-workers and their patients and ensure that all aspects of care including health and safety, effective communication, equity, diversity, inclusion, duty of care, safeguarding, person centred care and support as well as handling information is adhered to (Buchan and Evans, 2008; Francis, 2013). It is not only the role of the HCA to take responsibility for the

development of their roles, but a key part should be the responsibility of the institution in which they are as well as the managers who ensure that they are able to take part in the development of their skills and roles.

7.3. Methodological considerations

In this research, case study approaches that were used proved quite useful in exploring some of the complexities involving investigating the roles of HCA workforce. This would not have been as successful were quantitative methods used because the interviews together with the secondary data, ensured that detailed information was provided. The choice of comparative case study method also added to the usefulness of the study as the researcher was able to make comparison within both organizations and contrast the responses that were given from the respondents.

Case studies are beneficial in that they illuminate on the specifics of ones' research interest, in this case it was to asses through in-depth interviews from the respondents, and explore more on the specifics of the research questions. The idea is not to find generalizability, but to be able to assess the information given and establish parameters that can establish acceptable results based on the research objectives. Analytical generalization is the term offered here, as the goal is to illustrate from the research findings that a different form of reality came from the cases. A reality that uses the findings to generalize to some form of broader theory and as in this case to predict similar results as a literal replication (Yin, 2004).

The study made an attempt to ensure the accuracy of the data presented in this thesis reflected the cases, even though researcher bias would form some concerns in the research process. This was however eliminated through the use of data triangulation, in which the interview data was gathered from different groups of respondents at different times and in different units and organizations which brought in different perspectives. The interviews were also triangulated

with other documents and observations. These reflected on the use of different sources of evidence in order to review the different lines of enquiry, thus ensuring that the case study would be informative, convincing and accurate.

The report was written to ensure that the evidence was portrayed based on the research questions, making it possible for the reader to make their independent judgement based on analysis. The research process also made the effort to relate conclusions from the study back to current literature, even though this issues seems to be evolving daily. However, this study presents a novel notion of explaining the reason why non-professionals engage in extended roles. The study also raises some questions for future research which are explored next.

7.4. Future research direction

In this section the future research direction is reviewed. This study was conducted within limitations provided by case study research, because the study could not be understood out of its social context (Ghauri and Gronhaug, 2002). The research was carried out and prepared carefully with the aim of reaching its intended goals, however there were some aspects of the study that were unavoidable. The first was that the study was limited in time this meant that it only allowed for two studies to be carried out within the North region in England and more specifically in the East and West Yorkshire areas. In spite of this, the cases selected did provide for what has been referred to in the study as an illustrative case. Second, it turned out that psychological contract played a major role in the decision to extend roles. This study provides some insights into the parties that are involved in this type of employment contract, and introduces the third party element as a valid member in reviewing psychological contracts. However, the study did not focus on the changing nature of the psychological contract. This opens up the area for research into the importance of the role that psychological contracts plays over time as the employment relationship evolves. Therefore, reviewing the role that

psychological contracts have on the individual over the period that the employment relationship evolves would be interesting for future research.

The study also mentions enabling and restrictive strategies that either upgrade or downgrade the labour process and employment relationship in chapter 2. At the centre of these two notions is gender, but gender was not a point of focus that was explored in this study. In addition, it would be of interest to explore the fact that more females are hired into the HCA role, how much has that got to do with either of these two strategies. Therefore, exploring the gender aspect when engaging in extended roles and the dynamics of involving staff in different roles, would be an interesting topic to research. This would help to investigate what aspects gender has in influencing the role of HCA, whether it has an influence on who gets to be a HCA, and what impact this has on the labour process. Hence, it would be interesting to review the role that gender plays within this type of research.

Another interesting aspect mentioned briefly in chapter 6, is to fully investigate the high skills that qualified nursing staff perform as part of their roles and a form of regulation for the HCA role. This would not only help in identifying the areas or roles that can be delegated to HCA, but also provided for a better framework that charts out the training needed for HCA to attain the proper steps for those specific skills. It will be interesting to identify from all the different specialist units in healthcare the areas into which HCA extend their roles. It might be, as was found in certain units in both organizations A and B, that there were no areas into which HCA could extend their roles, and as in some other units there are indeed areas that they can extend their roles. This would help in charting a proper profile which would device a way into HCA progressing further in their careers, and this would be still be tied to AfC but making it more specific to the HCA roles. Thus, review the best way to regulate the HCA workforce would be interesting research, the various debates about this has yielded some pilot project of how this can be run, which is a good start (DoH, 2009; Kessler, 2012). However, what is needed is a

body that can fully analyse the roles that HCA take on and chart them into a clear path for role development as well as monitor and evaluate their development into those roles. Essentially, what is required is a body that will be able to evaluate the performance of HCAs and offer up rewards for their effort as well as chart a path for their growth.

In conclusion, this research most importantly set out to investigate the extended roles of HCA and the resulting drivers and consequences of the same. The primary objective of the study was to get a personal view from the respondents on their role and other aspects including their involvement in extended roles. This study was approached by supposing that investigating the individual perceptions would highlight the reasons that led the workforce to engage in extended roles. Therefore, using the theory of psychological contract was deemed the most appropriate as it dealt with capturing the views of the individual about their employer-employee relationship. In the end it became important to review the general feeling of the employees of what their roles have become, especially whether the promises they were given at the beginning of their employment stayed the same and whether taking on extended roles had changed anything in terms of assurances they had at the beginning of their employment (Hiltrop, 1996; Hendry & Jenkins 1997; Guest 2004). This was because this was the key to exploring and defining the reasons why the HCA employees continued to engage in extended roles. As has been reviewed earlier, the third party within the psychological contract became the theoretical link to the reason why the employees engaged in extended roles.

*We now stand on the threshold of a new age – the age of revolution.
In our minds we know the new age has already arrived; in our bellies we're not
sure we like it.... For change has changed.*

No longer is it additive.

No longer does it move in straight lines.

In the twenty-first century change is discontinuous, abrupt, seditious...

Today we live in a world that is all punctuation and no equilibrium.

Hamel, 2005.

APPENDICES:

APPENDIX A : Project Proposal

PROJECT PROPOSAL

Project Proposal - Version: 001

Date: 16/12/2008

Reference: 08/H1304/135

NHS REC Application form – Version 5.6 AB/144485/2

Extending the Role of Healthcare Assistants in the NHS

CI Name: Ms. Barbara Deschilder-Omoró

Project Proposal

The purpose of this research is to investigate the drivers and consequences of extending the roles of healthcare assistants (HCA) in secondary care in the National Health Service (NHS). This research is of interest because the increased involvement of HCA has been linked to evidence that suggests that changes in skill mix can deliver improved results (Lankshear et al, 2005; Bosley and Dale, 2008). The literature on skill mix has highlighted issues such as the contribution of non-professional staff, the quality of care, extending roles, role boundaries and the cost-effectiveness of such measures (Buchan and Dal Poz, 2002; Crossan and Ferguson, 2005).

Skill mix in healthcare is described as re-distributing of care tasks and responsibilities across different types of staff within the workforce (Adams et al, 2000). Skill mix has been associated with the need for cost reduction, by cutting expenditures on staff rather than a planned approach to introduce multidisciplinary healthcare teams.

Different aspects of skill mix within healthcare have been investigated; however few of them have focused on the impact on HCA. Furthermore, the role of policy on this dynamic and their effects on practice have not been investigated. To bridge this gap, this research will use the theory of social closure to frame and analyse these shortfalls in research.

In addition, the research will also adopt an intensive case study approach within an NHS Trust hospital. The NHS Trust chosen will be one implementing the Agenda for Change (AfC) policy as an initiative to facilitate the development of extended roles for HCA through a skill mix mechanism.

This research will address the following questions:

What are the roles of HCA and what are extended roles?

What are some of the local initiatives/drivers at Trusts level that extend the roles of HCA based on the current policy initiatives?

What are the factors that affect the process of extending the roles of HCA?

What are the impacts on or consequences for HCA and other stakeholders based on these changes?

Research Design

This research will employ an intensive case study based research strategy, which will use qualitative data collected to investigate the current research interests. This will be done by conducting individual face-to-face interviews with participants. The questions will include general demographic questions to more specific open-ended questions on their individual perceptions of the role of healthcare assistants (HCA).

Research Work Plan

The proposed period for data collection for this study at the NHS Trust is approximately 7 months. The data collection will be in two stages. The first, will be a pilot stage from January to February 2009, the second stage will be the main data collection stage of in-depth interviews from March to July 2009.

The main participants for this research are healthcare assistants, nurses, and managers within the different NHS units that will participate in the study. Before commencement of the interviews all participants will be informed of their right as informants and of the ethical guidelines underlying the study. The goal will be to assure participants of their right to give the information based on their perception of their work, no pressure will be put on them to provide information they will not be at liberty to give. The researcher's goal is to alleviate participant's mistrust and fear of research, by anticipating these concerns and addressing them at the beginning of the process.

The data analysis will be conducted between the months of July to October 2009. This will consist of the data transcribing, coding, and analysing. The proper procedures as required by the NHS Ethical guidelines and the University of Leeds research guidelines will be followed.

APPENDIX B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Participant Information Sheet (PIS) - Version: 001

Date: 16/12/2008 Reference: 08/H1304/135

NHS REC Application form – Version 5.6 AB/144485/2

Extending the Role of Healthcare Assistants in the NHS

CI Name: Ms. Barbara Deschilder-Omoró

Study Title: Extending the role of healthcare assistants (HCA) in the National Health

Service: Drivers and Consequences.

I would like to invite you to take part in a research study. The aim of the study is to examine the role of healthcare assistants (HCA) within healthcare and to especially identify the factors that lead to them extending their role in their environment. The study is for the purposes of a PhD study into the role and involvement of HCA and your participation will help to achieve this goal.

The study will involve clinical healthcare assistants, nurses of different levels and managers within the participating units. The study aims to gain their perceived view of the role of HCA.

Taking part in the research is voluntary and identities will be anonymous. I will describe the purpose of the study and go through the information sheet with you. I will then ask you to sign a consent form which shows that you agree to take part in this study.

The interview will last about 45 minutes and will be conducted in the interview room within the unit. The aim of the interview is to gain your own perspective of the HCA role and any relevant information that can provide a better understanding of their involvement within your unit.

Your confidentiality as a participant will be safeguarded during and after the study. All the information collected through interview and recorded will be subject to the Data Protection Act of 1998, which as a Student Researcher from the University of Leeds needs to follow. Codes will be used to identify participants, hence to make the data anonymous. All data will be held on a password-protected computer known only by the chief investigator.

Once the data has been collected and analysed. A thesis will be presented to the University of Leeds, and a report issued to your institution upon request. A transcript of this interview can also be provided upon request.

APPENDIX: C Research participant consent form

RESEARCH PARTICIPANT CONSENT FORM

Research Participant Consent Form - Version: 001

Date: 16/12/2008 Reference: 08/H1304/135

NHS REC Application form – Version 5.6 AB/144485/2

Extending the Role of Healthcare Assistants in the NHS

CI Name: Ms. Barbara Deschilder-Omoró

CONSENT FORM

Please initial box

1. I confirm that I have read and understand the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I acknowledge the aim of the study and the particulars have been explained to me.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

3. I agree to take part in the study.

Participant ID

Name of Participant
(Person taking consent)

Signature

APPENDIX D: HCA Interview Schedules

INTERVIEW GUIDE: A - HCA/UNQUALIFIED STAFF

SECTION A: BIOGRAPHICAL INFORMATION

1) Name :.....

2) Age 15-20 21-25 26-30 31-35

 35-40 41-50 51-55 56-60

3) Gender Male Female

4) Ethnic Origin Asian Asian Other
 Black African Black Other
 White White Other
 Mixed Race Other (Please specify)

5) Job Title

6) Team identity

7) Are you a healthcare assistant (HCA)? Yes No

8) What is your HCA title?

9) How many years of experience have you had in your role?
3 years 4 to 6Years 7 to 9 years 10 or more years

10) How long have you worked in this hospital?
0 to 1 Year 2 to 4 years 4 to 6 year
6 to 8 years 9 or more years

11) Have you held any other job previous to the current one? Yes No

12) If answered 'Yes' in Question 11 what are some of the details of the job i.e. title, industry, etc

13) How did you get this job?
Promotion Training Other

14) What is your level of qualification in your current role?
In-house training NVQ Level 2
NVQ Level 3 NVQ Level 4
RN
Other

Please explain?

15) How many people work in your unit?

16) How many are HCA?

SECTION B: OPEN ENDED

A. Terms: What do you understand by the following terms?

- 1) Agenda for Change (AfC)
- 2) Knowledge and Skills Framework (KSF)
- 3) Skills Escalator (SE)
- 4) Teamworking.

B. HCA Role :

- 1) What is your role within the unit?
- 2) Are there clearly defined tasks for your role within the team?
- 3) What are some of these roles?
- 4) Have there been changes to the way in which you perform your role?

C. Defining changes in HCA roles

- 1) Have there been initiatives to emphasize and enhance your role?
- 2) What are some of those initiatives?
- 3) Has the AfC policy influenced some of these changes?
- 4) If so what are the changes?
- 5) Has the KSF and the SE led to any changes in your role? Have these had any impact?
- 6) Do members in your unit work as a team?
- 7) Have there been drivers to enhance the team working within your unit? If yes what have those been?
- 8) What has happened to your role as a result of these changes?
- 9) What have been the benefits to your role as a result of these changes?
- 10) Are your roles clearly defined within the team?

- 11) How is your work or role supervised?
- 12) What is your responsibility in the unit in relation to your job description?
- 13) What aspects of your role would you like to see improved and why?
- 14) Do you feel policies issued by government restrict your role? If yes which ones and why?
- 15) Do you feel your organization restrict your work or role? If so why or how?
- 16) What are your career goals?
- 17) Do you get support in your job?
- 18) Who recognizes the training that you require?
- 19) What motivates you in your role?

D) Extended roles

- 1) Do you work beyond the call of duty? (Do you take on extended roles outside of your role?)
- 2) What sort of roles might these be?
- 3) Are you supervised when doing those roles?
- 4) When do you take on such roles?
- 5) Are you trained to perform those extended roles?
- 6) What factors lead to you extending your roles within your unit?
- 7) Are extended roles encouraged within your unit?
- 8) What are the benefits of working in a team? Are there any disadvantages?

APPENDIX E: RN/Qualified Staff Interview Schedule

INTERVIEW SCHEDULE B: RN/QUALIFIED STAFF

SECTION A: BIOGRAPHICAL INFORMATION

1) Name :.....

2) Age 15-20 21-25 26-30 31-35

 35-40 41-50 51-55 56-60

3) Gender Male Female

4) Ethnic Origin Asian Asian Other
 Black African Black Other
 White White Other
 Mixed Race Other (Please specify)

5) Job Title

6) Team identity

7) Do you work together with healthcare assistant (HCA)? Yes No

8) What is your title?

9) How many years of experience have you had in your role?
3 years 4 to 6Years 7 to 9 years 10 or more years

10) How long have you worked in this hospital?
0 to 1 Year 2 to 4 years 4 to 6 year
6 to 8 years 9 or more years

11) Have you held any other job previous to the current one? Yes No

17) If answered 'Yes' in Question 11 what are some of the details of the job i.e. title, industry, etc

18) How did you get this job?
Promotion Training Other

19) What is your level of qualification in your current role?
In-house training NVQ Level 2
NVQ Level 3 NVQ Level 4
RN
Other

Please explain?

20) How many people work in your unit?

21) How many are HCA?

SECTION B: OPEN ENDED

- 1) What is your role within the unit?
- 2) Do you have clearly defined roles? If so what are they?
- 3) Are you supervised in your roles?
- 4) Do you receive training for your roles? If so what kind of training?
- 5) Do you work beyond the stated roles?
- 6) What are examples of those extended roles?
- 7) What initiatives are in place to enable you to work beyond your stated roles?
- 8) What motivates you in your role?
- 9) What are your career goals?
- 10) Do you receive support to achieve those goals? If so what kind of support?
- 11) What have been the changes brought on by these support initiatives?
- 12) What other changes can be made to enhance your role?
- 13) What are the differences between your role and that of the unqualified staff/HCA?

APPENDIX F: Observation schedule guide for the study

Activity	Guide
Handover	Observe how handovers are carried out and then follow-on to see if any staff will remember what they are required to do.
Interactive Routines between Staff and Clients	Note specific tasks and time that they are performed, how staff perform these tasks, issues that are noted when they are performing these tasks, Interactions with patients and with colleagues.
Clients: Dignity, Rights, Stigma	Note how staff relates to residents in communication – how they address them, give them care, inform them of what their choices are, help them make the choices, treat their family, visitors and other key persons

APPENDIX G: Tables and figures

Table 1 : Qualifications of Workforce in Organization A

Role	AfC Grade	Time in role	Highest qualifications attained	NVQ 3
HCA	Band 2	15 years	In-house Training	No
HCA	Band 2	15 years	In-house Training	No
HCA	Band 2	9 years	NVQ3	yes
HCA	Band 2	3 years	In-house Training	No
HCA	Band 2	4 years	In-house Training	No
MG/Senior S.	Band 7	18 years	School of Nursing	N/A
MG/RN	Band 7	10 years	Registered General	N/A
HCA	Band 2	25 years	In-house Training	No
HCA	Band 2	9 years	In-house Training	No
RN	Band 5	4 years	BSc	N/A
HCA	Band 2	6 years	In-house Training	No
HCA	Band 2	6 years	In-house Training	No
Clerical/HCA	Band 2	5 years	In-house Training	No
MG/RN	Band 6	26 years	Registered General	N/A
HCA	Band 3	10 years	NVQ 3	yes
HCA	Band 3	3 years	In-house Training	No
HCA	Band 2	3 years	In-house Training	No
HCA	Band 2	7 years	In-house Training	No
GM	Band 8	5 years	BA/ Healthcare Management	N/A
As. HR Dir.	Band 8		N/A	N/A
MG/HR	Band 7		N/A	N/A

Table 2: Qualifications of Workforce in Organization B

Role	AfC Grade	Time in role	Highest qualifications attained	NVQ 3
MG/RN	Band 6	3 years	BSc	N/A
CSW	Band 3	5 years	NVQ3 In-house Training	Yes
CSW	Band 2	4.5 years	In-house Training	No
CSW	Band 2	4 years	In-house Training	No
RN/Sister	Band 7	3 years	Registered General	N/A
S. Staff Nurse	Band 6	4 years	RN/BSc	N/A
MG/Sister	Band 7	4.5/18 yrs	Registered General	N/A
CSW	Band 2	4 years	In-house Training	No
RN/T&D	Band 5	4 years	Registered General	N/A
Matron	Band 7	3 years	BSc	
Auxiliary N.	Band 2	6 years	NVQ3, GCSEs	
HCA	Band 2	5 years	In-house Training	
As. HR. Dir.	Band 8			
As. RN. Dir.	Band 8			

Table 3: Summary of Extended Roles as depicted in the study

EXTENDED ROLES	HCA	RN	M/Wife	M/W HCA
Patients Observations	x	X	x	x
Blood Pressure	X	X	x	x
Temperature	X	X	x	x
Oxygen Levels	X	X	x	x
Taking specimen	X	X	x	x
Monitor Patients Diet	X	X		
Nutrition Score	X	X		
Weight Patients	X	X		
Taking and Recording Vital Signs	X	X		
Support Women in the Clinic			x	x
Prepare Birth Plan			x	x
Breastfeeding Guidance and Support			x	x
Phlebotomy *	X	X	x	x
Breast Milk Collection			x	x
DVT Out-patient Service (Deep Vein Thrombosis)			x	x
Monitor Babes			x	x
Teach mothers how to express and store Milk			x	X
Blood Pressure Taking and Monitoring	X	x		
Venepuncture	X	x		
Cannulise Patients	x	x		
Taking and Recording Blood Level	x	x		
Recording ECG	x	x		
Taking Out Ventfluns	x	x		
Taking a CSU - Catheter Midstream	x	x		
BM - Blood Sugar Monitoring	x	x		
BM - Blood Sugar Reading	x	x		
Support new staff and students	x	x	x	X

Key Specialism Areas

Women and Children's Unit	
A&E and ICU/HDU	
Acute Medical /Elderly Unit	
Surgical Ward	

Note: These are extended roles for the HCA and HCA to the mid-wives, however they are regular roles for the qualified staff both nurses and mid-wives.

Table 4: Characteristics and conditions of employment of sampled respondents in Organization A

Title	Gender	Ethnicity	AfC Grade	Work Hrs.	Shift Pattern	Qualifications	Clinical Area	Length at Unit	Experience
HCA	Female	White	Band 2	FT	Morning	In-house Training	HDU/Surgical Ward	15 years	31 years
HCA	Female	White	Band 2	FT	Morning	In-house Training	HDU/Surgical Ward	15 years	15 years
HCA	Female	White	Band 2	FT	Morning	NVQ3	HDU/Surgical Ward	9 years	20 years
HCA	Male	White	Band 2	FT	Afternoon	In-house Training	HDU/Surgical Ward	3 years	3 years
HCA	Female	White	Band 2	FT	Afternoon	In-house Training	HDU/Surgical Ward	4 years	4 years
MG/Senior S.	Female	White	Band 7	FT	Day	School of Nursing	HDU/Surgical Ward	18 years	24 years
MG/RN	Male	White	Band 7	FT	Day	Registered General	Acute Medical/Elderly	10 years	25 years
HCA	Female	White	Band 2	FT	Morning	In-house Training	Acute Medical/Elderly	25 years	28 years
HCA	Female	White	Band 2	FT	Morning	In-house Training	Acute Medical/Elderly	9 years	9 years
RN	Male	Asian	Band 5	FT	Evening	BSc	Acute Medical/Elderly	4 years	10 years
HCA	Female	White	Band 2	FT	Afternoon	In-house Training	Acute Medical/Elderly	6 years	11 years
HCA	Female	White	Band 2	FT	Afternoon	In-house Training	Acute Medical/Elderly	6 years	6 years
Clerical/HCA	Female	White	Band 2	PT	Afternoon	In-house Training	Acute Medical/Elderly	5 years	5 years
MG/RN	Female	White	Band 6	FT	Evening	Registered General	Acute Assessment Unit	26 years	26 years
HCA	Female	White	Band 3	FT	Evening	NVQ 3	Acute Assessment Unit	10 years	10 years
HCA	Female	White	Band 3	PT	Afternoon	In-house Training	Acute Assessment Unit	3 years	7 years
HCA	Female	Asian	Band 2	FT	Day	In-house Training	CWS	3 years	3 years
HCA	Female	White	Band 2	FT	Day	In-house Training	CWS	7 years	7 years
GM	Female	White	Band 8	FT	Day	BA	CWS	5 years	9 years
As. HR Dir.	Female	White		FT	Day		TRUST		
MG/HR	Female	White	Band 7	FT	Day		TRUST		

Table 5: Characteristics and conditions of employment of sampled respondents in Organization B

Title	Gender	Ethnicity	AfC Grade	Work Hrs.	Shift Pattern	Qualifications	Clinical Area	Length at Unit	Experience
MG/RN	Female	White	Band 6	FT	Evening	BSc	Acute Assessment Unit	3 years	5 years
CSW	Female	White	Band 3	FT	Evening	NVQ3 In-house Training	Acute Assessment Unit	5 years	9 years
CSW	Male	White	Band 2	FT	Evening	In-house Training	Acute Assessment Unit	4.5 years	7 years
CSW	Male	White	Band 2	FT	Afternoon	In-house Training	Acute Assessment Unit	4 years	5 years
RN/Sister	Female	White	Band 7	FT	Morning	Registered General	Acute Assessment Unit	3 years	21 years
S. Staff Nurse	Female	Asian	Band 6	FT	Morning	RN/BSc	Acute Assessment Unit	4 years	19 years
MG/Sister	Female	White	Band 7	FT	Morning	Registered General	CWS	4.5/18 yrs.	33 years
CSW	Female	White	Band 2	FT	Afternoon	In-house Training	CWS	4 years	10 years
RN/T&D	Female	White	Band 5	FT	Afternoon	Registered General	CWS	4 years	33 Years
Matron	Female	White	Band 7	FT	Evening	BSc	HDU/ Medical Elderly	3 years	25 years
Auxiliary N.	Female	White	Band 2	FT	Evening	NVQ3, GCSEs	HDU/ Medical Elderly	6 years	10 years
HCA	Female	White	Band 2	FT	Evening	In-house Training	HDU/ Medical Elderly	5 years	5 years
As. HR. Dir.	Female	White		FT	Day		TRUST		
As. RN. Dir.	Female	White		FT	Day		Nursing		

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