

Managing Health Care Assistants?

The Frontier of Control in NHS Modernization and Skill-Mix Strategies?

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Abstract

NHS modernization aims to make hospitals more flexible, modern and private sector like for patients by cheapening the costs of nursing care and re-allocating these distributive gains internally at the workplace. Based on sixty interviews and structured questionnaires completed by in one NHS Trust this study asks three research questions. First, how do HCA's experience modernization where the frontier of control has moved decisively in favour of management? Second, how do locally contingent approaches to HCA's and equally contingent resistance strategies provide organizational context to workplace control regimes? Third, are absence and job satisfaction understood as resistance strategies which structure antagonism within NHS modernization? Absence appears as a form of resistance to work intensification and associated management demands but is tolerated because it does not formally threaten the managerial prerogative. HCA's retain intrinsic job satisfaction by marginalizing aspects of their role particularly hands-off patient care and secure distributive gains by imposing this loss on those they seek to help. At the macro level HCA's retain intrinsic job satisfaction in a contractual approach where they dissociate use of absence from its effects on patients and colleagues.

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Introduction

For the past thirty five years Conservative and Labour governments have sought to re-structure professionalized bureaucracy models which have sustained clinician dominance in the National Health Service since its creation in 1948. In the 1980s' Thatcherite reforms focussed on, (what is now termed), new public management which aimed to dilute clinician dominance and introduce a strong performance management culture. Moreover, 'new' public managers were increasingly steered to focus on the rhetoric of patients as customers and service provision as a quality experience but one in which customer expectations were managed (see Bolton, 2004 Hartley and Skeltcher, 2008 and Ferlie et. al. 2013). In 1997 New Labour announced, (what was seen at the time to be), a more strategic approach to workforce management, (Bach, Kessler and Heron, 2008). This included a ten year NHS investment plan which tied higher spending to an explicit modernization and reform agenda, (DE, 2000). Initiatives such as the NHS human resources plan, (2002) and 'Agenda for Change' implemented a service wide job evaluation scheme which sought to modernize work practices and associated pay grading. The combined aim of these reform strategies was to create a division of labour wherein health care professionals became subject to control by hospital managers. One innovation which has continued un-interrupted through the Thatcher, Major, Blair, Brown and Cameron governments is the development, extension and further development of Health Care Assistants (HCA's) in NHS hospitals.

An extensive literature has grown to follow the development, role, status and controversies which surround the HCA role. Recently published official contributions to this literature seek to clarify the strengths and weaknesses of the HCA role with much of this clarification prompted by the failures in nursing care at North Staffordshire hospital, (Cavendish, 2013,

Francis, 2013). This paper contributes to the literature by developing a theoretically informed empirical conception of how HCA's experience the macro modernization agenda in a large teaching and university hospital, (TUH), as both individuals and as a sectional work group. The paper divides into four parts. Part one outlines what HCA's are and reviews the literature on the emergence and use of HCA's. Part two further divides the core research question on the work experience of HCA's under modernization into three component parts. Part three then outlines the research design, details how the empirical evidence was constructed to inform a critical case approach and reports the findings from this study. Part four contains a discussion and conclusion which identifies the contribution of this study in respect of the research questions outlined in part two.

1, Health Care Assistants and the Literature on Health Care Assistants

1.1 Health Care Assistants

Recruited as unqualified support staff the term HCA describes staff who may work toward NVQ level two or three in healthcare, however, study for this qualification is not compulsory or a requirement of the job. HCA's provide the bulk of hands-on care in hospitals and make up a third of all caring staff in hospitals. In 2012 there were between 106,500 to 270,000 HCA's in the UK providing support to doctors and nurses. There are however, over 60 job titles which may or may not cover HCA's hence the wide span of possible numbers, (HSCIC, 2012, Cavendish, 2013:6,15). HCA's undertake nursing duties and direct patient care under the delegated guidance of registered nurses. HCA work is divided into routine tasks; making beds, helping patients with bathing and eating, monitoring and recording glucose levels, taking patient temperature and pulse, weighing patients, checking patient respiration, managing patient dressings and escorting patients around a hospital. HCA's can also undertake more advanced tasks such as catheterisation, cannulisation, complex dressings,

machine monitoring and responses, injections and taking blood, ECG tracings and care planning. In addition to these roles HCA's perform hands-off caring roles previously associated with nursing auxiliaries such as talking to patients and their relatives and helping to make them feel better. The Cavendish Report makes it clear that medical advances, the emergence of a management scheduling culture, an ageing population and the effects of the EU working time directive may witness HCA's undertaking invasive procedures – advanced tasks - which were previously the preserve of doctors and registered nurses. There is no consistent or compulsory training programme for HCA's neither is there a nationwide job description, therefore training, job descriptions and job design are locally contingent. Pay wise, whilst originally outside the collective bargaining framework, HCA's are employed on bands 1-3 in the agenda for change framework whereas band four represents an assistant practitioner grade. Nationally 56% of HCA's are paid on band two. Indeed registered nurses and HCA's are seen as separate sources of labour and the decision to make nursing an all degree profession has had three impacts on HCA's. Firstly, on the role – HCA's argue they are overlooked and undervalued. Secondly, on HCA status – lowly paid, unskilled and unqualified, that is, not professionally qualified to the standard of physiotherapists, registered nurses and social workers. A third effect of all graduate entry for registered nurses falls on the labour process of HCA's, much of which is delegated to them by professionally qualified staff often on a task-by-task basis.

The development and diffusion of the HCA role poses several challenges to hospital managers, ward managers, regulators, patients and HCA's themselves, for example, public safety and job performance. There is no minimum standard of qualification or any language requirement for entry to HCA grades neither is there a register of HCA's. Similarly, for job performance – the absence of clearly defined job descriptions may stretch inclusions in routine and advanced tasks beyond the competence of HCA's. Here major infection risks

flow from poor practice in catheterization and complex wound dressing. Despite the negatives outlined above many HCA's retain intrinsic job satisfaction whilst recognising that caring may not have a non-graduate career pathway.

1.2 The Literature on Health Care Assistants

In recent years there has been a considerable amount of research undertaken on HCA's and more recently important policy work has been published too. To make sense of this extensive literature the review divides into sub-sections which identify specific issues that the literature highlights. This will avoid what might amount to one long list of literature, hence contributors to the literature can appear under more than one heading.

Modernization and Skill Mix

Daykin and Clarke (2000) provide a qualitative study which examines modernization and skill mix as Fordist strategies sponsored by the state and formulated by hospital managers that aim to de-skill and routinize elements of nursing work. As an internal division of labour the modernization agenda sees qualified graduate nurses move away from the delivery of care towards administrative, technical and supervisory roles. Aspects of nursing work became routinized, that is standardized and de-skilled and in effect delegated to HCA's. Daykin and Clark (2000) found that whilst registered nurses held ambivalent attitudes towards modernization HCA's saw modernization as an opportunity to develop knowledge and skills and increase their workplace independence and level of job satisfaction. Moreover, the attitudes of both groups enabled hospital managers to further diffuse modernization as an internal division of labour to reduce reliance on agency and bank nurses in favour of HCA's and therefore contain costs. Spilsbury and Meyer (2004) provide case study findings on the changing role of registered nurses and evaluate the impact of this change on the delivery of

nursing care, that is, the role undertaken by HCA's. The study finds that whilst HCA's complement, supplement, replace or substitute for registered nurses HCA work is confined to direct patient care whereas registered nurses concentrate more on housekeeping, administrative and scheduling duties. This strategy often has the effect of ignoring HCA 'local knowledge' of patients and seeks to demarcate and restrict the work of HCA's to reflect explicit and implicit efforts towards occupational closure by registered nurses. One result of closure is that HCA's spend more time with patients dispensing routine nursing care than registered nurses, (see Spilsbury and Meyer, 2004).

NHS modernization in the form of skill-mix strategies re-defines health care professionals as managers with the effect of dividing health care professionals into competing groups and creates new roles for ward managers and registered nurses. The focus of modernization is individual hospitals as workplaces where one lasting effect of skill-mix is the creation of a division of labour wherein 'health care professionals' are now subject to control by hospital managers rather than clinicians. Within new public management managers increasingly focus on the rhetoric of business networks and partnerships, patients as customers and service provision as a quality experience. These roles centre on leadership, empowerment and delegated support for HCA's who are increasingly responsible for direct patient care, (see Bolton 2004, Ferlie, et.al. 2013). More specifically still this division of labour has changed the role and status of clinicians and hospital workers, for example, charge nurses are now termed ward managers whereas nurses are now termed graduate or registered nurses. As Bolton (2005:6-7) observes these changes have the effect of making-up managers in the NHS. Policy wise both the Cavendish report, (2013) on HCA training and development standards and the Francis report on mid Staffordshire hospital, (2013) identify the limitations of modernization and skill-mix for HCA's and patient safety.

Flexibility and De-Skilling?

The customer-quality-care theme follows from the strategic approach of the New Labour government to the NHS workforce where flexibility or the intensification of nursing auxiliary roles into HCA's reflects this ambition, (see Dept. Health, 2002). For example, since 2000 UK health policy has emphasized flexibility in the context of labour shortages and the performance management requirements of enhanced patient care – 'the care as a quality experience for patients as customers theme', (Dept. of Health, 2000, Bolton 2004, Bosley and Dale, 2008). Despite this ambition contributors to the literature report that whilst the promotion of more flexible work practices was, in the abstract rhetoric of change management, designed to improve employee motivation and job satisfaction, HCA's may experience this rather differently. Bach, Kessler and Heron, (2008) identify variability of experience in the detail of HCA's roles to highlight competing approaches to and models of nursing care. More recently Cavendish, (2013:36) referred to these differences directly as the absence of national standards for training, development and HCA supervision in the delivery of routine and advanced tasks. Other contributors emphasise how flexibility of this type stems in part from registered nurses focussing their work time on the management of compliance in medication its associated paperwork and scheduling, (Hancock and Campbell, 2006, Bosley and Dale, 2008:119). More specifically Hyde et. al. (2005:704) examine the manner in which role re-design in the health service degrades nursing care wherein HCA's substitute for registered nurses. This theme is also highlighted by Nancarrow and Borthwick (2005) who report that unskilled, that is unqualified non-graduate, HCA's now undertake tasks previously performed by registered nurses. This evidence base also demonstrates that the work activity of many registered nurses is focussed beyond direct care, in routine and even advanced tasks.

In turn this focus beyond nursing activity results in both components of nursing care becoming de-skilled and routinized to focus a legitimate subordinate group below registered nurses. Whilst promoting flexibility the focus on HCA's as a subordinate group has the effect of maintaining occupational closure for registered nurses. Thornley (2007) examines the flexibility which flows from skill mix and modernization in the context of occupational closure strategies. Within these flexible and across-boundary working between nurses and HCA's has been presented as a self-proclaimed policy achievement, (see Saks and Allsop, 2007). Whilst cross-boundary flexible working may operate HCA's do however, perceive themselves as substitutes for registered nurses and initially accepted this degradation on the basis of promised progression opportunity and appropriate training opportunities to secure progression. Moreover, Thornley argues that modernization and skill-mix strategies secured de-skilling and routinization by cheapened nursing care. So whilst hospital managers, ward managers and registered nurses each concentrate on what flexibility means to their interests, these interests have displaced effective HR policies for job re-design, organizational change and decision making. In turn the effects of this displacement mean that HCA's can experience flexibility as intensification (the encroachment of advanced tasks over routine tasks), degradation (they are untrained) and de-skilling, (they are unqualified), (see Cavendish, 2013:36-48, McBride and Mustchin, 2013).

Contradictory or Unforeseen Outcomes?

The conclusions presented by Thornley (2007) are further confirmed by Bach et.al. (2007) who argue that HCA's operate in a largely substitute supportive capacity defined by the wider goals of public service delivery in particular cross party fiscal prudence and efforts to retain recruited labour in the context of tighter labour cost budgets. Empirically, however, registered nurses and HCA's play out ill-defined blended but co-professional roles resulting

in potentially contradictory outcomes for both groups, specifically the manner in which HCA's replace auxiliary nurses, (Bach et.al. 2008, 2012). Because the work of HCA's is poorly defined occupational boundaries and therefore efforts to secure occupational closure by registered nurses in particular become blurred. Both registered nurses and HCA's seek to identify their specific contribution to health care and define its boundary. However, registered nurses define HCA's as helpers viewing the educational credentials they possess as marginal differentiating themselves from HCA's in terms of technical competence and a distancing from de-skilled delegated 'dirty work'. In contrast to this, HCA's view themselves as providing hands-on care and emotional support for patients stressing the similarity of their contribution to that of registered nurses. Blended outcomes are contingent on local contexts and these situations prevail because of the absence of a clearly defined workplace role for HCA's, in turn this absence impedes more strategic efforts at job re-design across the health service. Kessler et. al. (2013) report that changes in the role of registered nurses has created a space for HCA's. However, the absence of a clearly defined job role for HCA's in the skill-mix modernization agenda creates the potential for overlapping HCA typologies ranging through 'bedside technician', ancillary, citizen, all-rounder to expert. More significantly the study found that HCA's who occupied citizen and all-rounder roles possessed high levels of personal confidence in their role and abilities, that is were comfortable in performing advanced tasks. In contrast to this it is likely that HCA's who occupy other three typologies demonstrate experience and capability but are unlikely to go beyond routine tasks. Hence the key issue in defining the role of a HCA is human agency in a wider pattern of structured antagonism and the manner in which this interacts with organizational structures. Kessler, et. al.(2012) takes this analysis further to demonstrate that any strategic underpinning in the utilization of HCA's varies across trusts leading to a variety of outcomes for stakeholders including HCA's themselves. A key argument developed by these authors is the absence of

sustained strategic thinking in the utilization of HCA's which in turn leads to significant variations in the role of HCA's and the work they undertake, training for it and resourcing of the role.

2, Research Questions - How Do HCA's Experience NHS Modernization?

The literature review revealed three broad summative issues which inform the research questions asked by this study. Firstly, HCA's experience NHS modernization where the frontier of control has moved decisively in favour of management. Secondly, the absence of national standards for HCA's stimulates the creation of locally contingent approaches which provide organizational context to informal workplace control regimes. Thirdly, the attitudes and behaviours of HCA's towards absence and job satisfaction stimulate resistance strategies or a 'structured antagonism' below the more abstract diffusion of NHS modernization.

2.1 Modernization and Management:

The deployment of HCA's and any strategic underpinning related to this is very variable. This results in a variety of issues and consequences for patient care, cost effectiveness and HCA's too. Specifically, whilst HCA's are a distinct group of other, that is, are different to qualified staff, different models of HCA practice across the routine and advance task boundary are in evidence. These outcomes are the (un)-intended and contradictory consequences of modernization and flexibility, (see Kessler, Heron and Dopson, 2012). These outcomes are likely to reflect an incomplete frontier of control where resistance is mobilized in a variety of ways. Hence the first component of the core research question on HCA experience of modernization centres on how do HCA's experience modernization where the frontier of control has moved decisively in favour of management?

2.2 A Locally Contingent Workplace Control Regime

The contradictions and consequences flowing from modernization are now significant issues because the 'regulatory space' which modernization and skill mix strategies created has been occupied informally by management fiat rather than being effectively grounded by HR initiatives in terms of national standards for job re-design. That is, the frontier of control has moved decisively in favour of management but in locally contingent approaches to HCA deployment and management, (see Bolton, 2005, McBride and Mustchin, (2003), Cavendish, 2013 and Francis, 2013). Here the structure of work systems and management ideas imported from the private sector require consistent quality of service delivery in formal structures. Locally, in NHS trusts and within these at ward level agency exercised by HCA's confronts modernization and associated informal structures. Hence, a second component to the core research question centres on how do locally contingent approaches to HCA's and equally contingent resistance strategies provide organizational context to workplace control regimes? This is particularly important in this case because the locally contingent mode of control is responsible for re-allocating distributive gains from HCA's to registered nurses. For a broader discussion of the relationship between modes of control and allocation of distributive gains see, Belanger and Edwards, (2013:437).

2.3 Local Resistance: Absence and Job Satisfaction

Even though the frontier of control has moved in favour of management in hospital trusts and on wards at TUH use of absence and job satisfaction express both conflict and re-structure antagonism in the HCA labour process, (see Taylor, et.al, 2010, Belanger and Edwards, 2013). At TUH a failure to ground regulatory space by formal and standardized management initiatives reinforces the indeterminate nature of management control in modernization where 'being short staffed' and the resultant effects of this appear to represent the substance of

management control strategies. Hence, a third component of the core research question centres on are absence and job satisfaction understood as resistance strategies which structure antagonism and misbehaviour within NHS modernization? It is however, one thing to identify consequences as contradictory and un-intended it is another to subject them to detailed empirical evaluation, (McGovern (2014:31). Accordingly, part three provides detailed empirical evaluation of how HCA's express conflict at TUH.

3. Research Methods and Empirical Findings

Contributions to the labour process debate and labour process theory subject abstract changes in capitalist political economy to interrogation in workplace studies by examining the effects of these changes on work systems and strategies and practices of managers and workers in the employment relationship. In this case how NHS modernization is focussed on making NHS hospitals more flexible, modern and private sector like for patients but by cheapening the costs of nursing care and re-allocating these distributive gains internally. The study provides a credible account of the manner in which HCA's experience workplace modernization in three ways. First, through interviews with HCA's, second, by observing HCA's at work and in their relations with nurses and managers and third by reference to policy and review documents on the role of HCA's. The research examines the aspirations and frustrations of HCA's at work under modernization at TUH measuring these experiences qualitatively in a locally contingent control regime where absence and job satisfaction structure workplace conflict.

3.1 TUH

TUH is a large teaching and university affiliated hospital trust and employees nearly 8,000 people over two large sites. The hospital has over 1,000 in-patient beds, 30 operating theatres

and a 100+ bed critical care unit and is recognised as one of Europe's leading hospitals with an international reputation for care quality, informatics and clinical training and development. TUH was one of the first hospitals to secure NHS foundation trust status in 2004 and currently treats over 90,000 in-patients a year. Despite its profile TUH was in 2013 one of thirteen hospitals named by Dr. Foster Intelligence (HSJ, 2013) with a greater than acceptable mortality rate but the hospital now self-reports no MRSA cases for over a year, (anonymised hospital web-site). The hospital has an in-house call bank for HCA's and in addition to this often calls in regular external agency staff. In-house bank HCA's either work very flexibly at short notice as a form of zero hours spot contracting or permanent HCA's do bank work as a form of over-time.

3.2 Research Methods

By using mixed methods the research combines primary and secondary research and builds on a pilot study which revealed that absence rates for HCA's are significantly greater than the average absence rate for all non medical hospital staff at TUH but that high absence rates did not convert into quit rates. For this more substantive project the main research method was sixty semi-structured interviews conducted with HCA's supported by a structured questionnaire completed by all interviewees. Interviews averaged sixty minutes in length but some were as long as ninety minutes. Thirty of the HCA's at TUH are positioned on band three (£16,110-£19,077) of the pay scale and the other thirty are on band two (£14,153-£14,846) and the head of delivery confirmed that no HCA's were remunerated on band four. In comparison the minimum starting salary for registered nurses in 2012-2013 was £21,176 placing the minimum starting salary at the bottom of band 5, (RCN, 2012). Therefore in 2012 the minimum starting salary for a registered nurse was £2099 higher than the maximum HCA

salary, excluding overtime payments. Table 1 compares key HCA statistics for TUH to the national picture detailed in Cavendish, (2013:15)

Key Statistics for Health Care Assistants

	Cavendish Review National Numbers	TUH Numbers
Average Age	45	38
Gender	84% Female	96% Female
Average years in Post	4.1 in England	6.1 (TUH is in England)
Pay	56% on Band 2	50% Band 2, 50% on Band 3

Interview transcripts were coded against the three research questions and findings were further informed by material gathered in the structured questionnaire. The pilot study was conducted in April 2012 and the main fieldwork interviews were undertaken in two batches of thirty over three weeks in July 2012, that is, before the publication of the Cavendish review. Whilst the main research method is qualitative, and bearing in mind that this is a single site study, in some instances these findings are also presented numerically and quantitatively in order to express the significance of particular issues to the HCA constituency at TUH. In summary the research presents a theoretically informed single site case study which has collected data through interviews, workplace observation, documents and other material from the field site.

3.1 HCA's under Modernization and Management?

All respondents both in interviews and in questionnaire transcripts defined themselves as lower cost workplace substitutes for registered nurses and accepted their roles in the

performance of work described as either routine or advanced tasks. Many HCA's did not however accept that routine tasks such as rotation of patients, help with eating and drinking, washing and bed sore control and wound dressing work were de-skilled merely because HCA's performed them rather than registered nurses. Many interviewees argued that whilst routine and advanced tasks were subject to grade degradation this was not the same as de-skilling because the routine tasks cited above and advanced tasks such as catheter maintenance could not be de-skilled in terms of job content. Moreover, forty interviewees argued that this was an inappropriate term to use because many registered nurses, that is, those theoretically more skilled than HCA's, 'won't because they can't' (HCA, 23) perform these tasks. HCA 23 added that this was part of the problem in how they (HCA's) experience skill mix and modernization. Twenty interviewees added that they experienced modernization as 'managing' the effects of managed labour shortages with a further fifteen interviewees stating that they experience managed labour shortages as stress, for example, bullying, delivering cancellation news or missed slot news and having to run to get things done. The regular response reported across the sixty interviews was 'nurses don't help'. Variations on this statement were reported in forty-five of the sixty structured questionnaire responses. So HCA's as individuals and as a work group experience modernization and skill-mix strategies at TUH as staff shortages, related workplace stress and associated pressures from managers and registered nurses.

'..... You spend a lot of time walking around pushing patients, this gets to be heavy work. Sometimes schedules are so tight you are in effect running pushing a patient or running to get a patient' (HCA, 41)

'...slots are missed and they don't get seen or have to wait a long time so you feel you have to get them there but you might not' (It's not always like this but can be) (HCA, 23)

The experiences of HCA's as a work group demonstrate work intensification of routine tasks at TUH resulting from faster patient turnover and greater use of day surgery year on year without a corresponding increase in registered nurse numbers, (see also Bolton 2004:324). The intensification of routine tasks has resulted in the delegation of more advanced tasks both in absolute numbers and in more intensive repetition of routine tasks and some advanced tasks to HCA's who experience this as a subordinate group. More significantly intensive repetition also acts as a form of workplace 'learning by doing'. In addition to work intensification HCA's experienced modernization in other ways. First, staff shortages both intensify work for those at work and are an indicator of stress as HCA's react to work with coping strategies such as calling in sick when they are not ill. Alternatively, genuine absence results from overwork often in the form of back pain resulting from attempting to perform tasks which really require two HCA's. Second, absent colleagues create stress for those who are at work. This is compounded because absence is not effectively managed at ward level. Fifty-four interviewees stated that absence causes regular delays in outpatients and patient care causing TUH to continually fall back on in-house bank staff or external agency staff. All sixty interviewees stated that delays in patient treatment in outpatients and on wards could easily be solved if managers and nurses stepped in to help out. Only thirty interviewees, however, provided corroborative information to support their claims that they had experienced managers and nurses declining to help them where HCA absence caused delays in patient treatment, alternatively delegating instructions to HCA's to do it and leave something else. The depth of the evidence provided and the frequency with which this response was recounted leaves little room to doubt the claims, however, the effects of absence do create extra work for registered nurses. This often appeared to be one reason why registered nurses declined to help as a matter of course. Occupational closure however informal enables registered nurses to protect themselves from work intensification by

demarcating routine and some advanced tasks as HCA work not theirs, that is, protecting their distributive gains derived from a subordinate group. A third way in which HCA's experienced modernization and skill mix was the manner in which it made their role 'a job'. Forty interviewees gave this response in two streams of response one which highlighted limited pay and reward opportunities and a second related response which suggested that promised learning and development opportunities were either limited or non-existent. At TUH HCA's argued that they couldn't really get off grade 3 irrespective of their length of experience, (nine HCA's had more than ten years of experience in the job and four of these had over twenty years of experience). Responses in fifty structured questionnaires highlighted the relentlessness of the three ways in which HCA's experience modernization and the manner in which this gradually encouraged them to see their work as so routinized that it became 'just a job'. In contrast to feeling this all interviewees stated that they had entered the job to help people and get on the nursing career ladder. Whilst a majority of HCA's retain intrinsic job satisfaction many saw a boundary between themselves and registered nurses strictly enforced. HCA's did however appear able to separate intrinsic job satisfaction from the effects of the management control regime and the effects of their own absence on colleagues and patients.

3.2 Local Workplace Controls

At TUH HCA's experience modernization and skill mix within that as a highly localized boundary issue. Intensification of routine and advanced tasks, delays to patient care and use of bank and agency staff to solve delays and cope with absence appear as a locally contingent regime to manage absence from work and its associated impact on the delivery of care. A focus on these issues returned attention to the issue of managers and nurses not stepping in to alleviate HCA staff shortages. In the findings from both interviews and questionnaire

transcripts it proved difficult to find responses that cited or referred to specific TUH policies which defined the boundary between the work of registered nurses and work which was delegated to HCA's. The absence of documentary evidence on this and the absence of denials from additional interviews with the delivery team at TUH led safely (in 2012) as it turns out to the conclusion that the job roles of registered nurses and HCA's had not been formally defined or re-designed to any nationally defined standard. Alternatively, however, the head of delivery confirmed that TUH had recently revised job descriptions for bands two and three but locally which included a guideline for delegation of tasks to HCA's, (see also Cavendish, 2013:68). Questionnaire responses regularly recorded the claim that "They (nurses) just don't do that," in references to activities which registered nurses won't undertake. Many HCA's argued that registered nurses now effectively saw themselves as 'schedulers' and managers to whom it didn't matter if patient care was delayed because it created another 'none nursing' nursing job for them to do which could be massaged and masked in any performance management figures.

'They (registered nurses) don't really care about delays and absences it gives them the opportunity to manage something else. They? (prompted) nurses and the delivery people are like the railways they can always find a good defensible reason to explain why something hasn't been done. The hospital is primarily concerned with A & E targets not what goes on with nurses and HCA's' (HCA 10)

This was one of the most revealing interview responses on the issue of boundaries and closure. Fifteen interviewees stated that job satisfaction at work could be improved by the presence of career incentives such as a career pathway and potential pay band improvement to band four. Those who cited this response were distributed evenly across the range and were not confined to HCA's who cited less than satisfactory or unsatisfactory job satisfaction. Workplace frustration was evident both individually and collectively as a sectional work

group response to the local control regime which centred on closure, demarcation and task-by-task delegation of routine and advanced tasks. Thirty-two interviewees stated that having to manage staff shortages and related workload stress resulting from these shortages, that is absence, was the reason for their own absence from work. Hence, as an individual response HCA's choose absence when they knew there was likely to be a 'shift-shortage' of HCA's, (this phrase was cited by numerous HCA's). By choosing absence HCA's avoided further work intensification of routine and advanced tasks. HCA's taking this course of action were quite happy to admit that their absence intensified the work of their colleagues but defended their position on the basis that it happened to all of them now and then. It follows from this that absence creates 'the script' (HCA, 34) 'we are short staffed' whereas the shortage of staff necessitates what Bolton (2004) terms managers 'making it up'. Within this, managing patient expectations involves 'getting it across early' (HCA 45) that a delay or a cancellation is routine. When this doesn't happen patients feel they have received good service when really it was just a normal service and associated expectation. Only two interviewees stated that lack of career progression prompted their absence. Thirty interviewees stated that delays in patient care and cancellations could be avoided if managers and nurses stepped in to help out. It seems more likely that managers and nurses don't step in for two reasons, one to protect their distributive gains and two because there is no point in doing so if absences are such that they will lead to delays and or cancellations. Alternatively, managers appeared to focus on managing this process, for example, re-booking etc. and assessing the impact on other apparently unrelated cases which are likely to be 'bumped'.

One empirical limitation of this study is its exclusive focus on the views of HCA's and the manner in which they experience modernization. Because of this the reliability of some of the claims made by HCA's might be questioned. Under this heading and others however, the regularity of critically focussed views from HCA's which highlight the subordinate status that

they feel, suggests that the claims are reasonably reliable. Moreover, members of the delivery team choose not to deny many of these points when clarification was sought on the issue of occupational closure and job re-design. This point takes the analysis back to Daykin and Clark's (2000) assertion that modernization represented fordist state policy. The key point is that fordism can only work if it is institutionalized formally at the workplace. Quite evidently at TUH local managers failed to institutionalise modernization detailed in agenda for change and the knowledge and skills framework. Alternatively they appear to have chosen to establish HCA's - a key component of modernization – informally by allowing local regimes of closure and routine and advanced task delegation. In turn they appear to have accepted local responses to this in the form of absence as an individual or highly sectional act of resistance to occupational closure and delegation by registered nurses. The issue is further complicated in the relationship between HCA's and registered nurses. This is so because whilst there is clear evidence of what Edwards (1986:5) terms 'structured antagonism' between HCA's and TUH as their employer, this exploitation operates in two modes. Firstly, in the mode of informal control exercised over HCA's by registered nurses in routine and advanced task-by-task delegation and secondly in the distribution of the 'surplus' created by this mode of control. That is, the cheapened cost of nursing care and price of occupational closure exercised by registered nurses in their wage and status mark-ups over HCA's. In effect it is possible to see the mode of control and distribution of surplus as a form on internal sub-contracting where on one level rigid demarcations are enforced by ward managers and registered nurses as a form of occupational closure. Alternatively, but beyond the view of HCA's absence and shortages create extra work for ward managers and registered nurses. Their reaction to this appears to be selectivity in undertaking routine or advanced tasks on the basis that if delays are inevitable they have to manage them and therefore performing some routine or advanced tasks promptly may be of no value if disruption has to be managed.

3.3 Absence and Job Satisfaction as Resistance?

At TUH modernization is experienced by HCA's as alienation from more traditional auxiliary nursing roles such as bedside care and related aspects of what was often termed 'patient involvement' and a wider degradation of their workplace status. Herein a 'sticky floor' confines HCA's due to limited opportunities and career development. Alienation was manifest as having to act like registered nurses, that is, reducing or curtailing bedside relationships with patients and relatives. This was not necessarily the case because HCA's wanted to do so but felt compelled to do so in order to get the job done particularly in respect of advance tasks. Alienation like this had a double effect; it demonstrated movement from this is a 'caring job' to 'this is a job with some caring elements' but whilst some HCA's felt that they were compelled to act like registered nurses they had "no chance" (HCA 5) of becoming one and some HCA's felt the job was becoming more degrading because of its dead-end status, (see also Wise 2007:478). HCA 5 added that TUH did in the past (before all graduate status) put up to 20 of its best HCA's into nursing programmes annually but now this route had virtually closed down. These frustrations encouraged HCA's to cope by disengaging from caring at work – the 'just a job' response as opposed to 'this is a caring job'. In-effect the demands of the role compelled HCA's to create their own distributive gains which they sought out individually in the workplace, for example, by 'putting the "block-hole" on chat' (HCA, 21) or making patients wait for delivery of routine tasks where the imperative of advanced tasks dictated a priority. Alternatively and in addition to this some HCA's made these gains by strategic use of absence. Protecting their own position appeared to make HCA's increasingly instrumental in the diffusion of an apparently contractual attitude where intrinsic job satisfaction and doing a good job remained high priorities but within a framework which 'unitized' patients as number 1, 2, 3 or 4 etc. A majority of the sixty HCA's demonstrated good motivation in this framework (low absence rates but a

truncated commitment to patients as people) but others were alienated and resorted to absence on a regular basis. HCA's in both groups expressed frustration under this line of questioning to argue that explaining absence or diagnosing why things went wrong was not part of their job. This was the case even though forty-two HCA's were union members many of whom saw recourse to absence as acceptable action in addition to whatever the union might do for them.

Interviews and questionnaires measured job satisfaction across a range of categories and factors; individual HCA's absence rates, propensity to quit, how HCA's rated job satisfaction and how job satisfaction had moved over the past couple of years. Overall, of the sixty interviewees forty-five stated that their job satisfaction was satisfactory or better, nine stated that job satisfaction was less than satisfactory but not unsatisfactory with six HCA's stating that job satisfaction was unsatisfactory. The coping strategies used by this sub-group to sustain intrinsic job satisfaction included being absent from the workplace, whereas longer serving HCA's reminding themselves that they had too many years in to consider quitting. That is, the benefits of a comparatively good pension scheme etc. could not be given up. In contrast to this less long-serving HCA's cited current economic conditions, so to paraphrase Taylor et.al. (2010) at TUH HCA's were not 'too scared to go sick' but used sickness absence as a form of resistance to re-coup distributive gains against the work intensification of routine and advanced tasks. Therein economic fear kept long service and shorter service HCA's in the job.

'this job is not great bit its pay and working terms are in the current economic climate pretty good' (HCA 14)

4, Discussion of Findings and Conclusions

The findings from this study reveal that HCA's at TUH experience modernization substantively but informally within a locally contingent workplace control regime where the frontier of control has moved decisively in favour of management. The experience is informal because of the absence of nationally agreed standards for routine and advanced task delegation and associated levels of supervision. The experience is substantive due to the manner in which modernization has intensified the work of HCA's and stimulated a structured antagonism between ward managers, registered nurses and HCA's. Therein HCA's like registered nurses seek to make up distributive gains which de-skilling and grade degradation impose on them. In these findings the study confirms those of broader studies such as Kessler, Heron and Dobson, (2012) which demonstrate varieties of outcome for HCA's in the modernization process with a variety of consequences for stakeholders and HCA's too. At TUH much of this variety is imposed informally through differences in the scale and scope of routine and advanced task delegation. What, however, is clear, both in broader studies and this one is that HCA's are subject to sustained pressure from senior staff but experience low pay and low status and are not seen as professionals in the same manner as physiotherapists and social workers. The research question asked by this study is how do HCA's experience modernization which is informal yet substantive and what are the unforeseen consequences of modernization and its grounding in workplace flexibility at TUH.? Therefore what this study adds to the stock of literature is an original conceptualization of the consequences of a national failure to institutionalise modernization formally in hospitals and on wards as workplaces. On the first aspect of the research question both modernization as a process and within that management as a function require formal occupation of the regulatory space which is created by the modernization process. An absence of national standards for the regulation of HCA's means that regulation of HCA's at TUH is locally contingent and less formal because of this. Contingency appears to be

particularly present in the relationship between HCA's, registered nurses and ward managers in respect of delegation of routine and advanced task. This is evident first in the manner in which absence intensifies delegation of these tasks and second in the manner which delegation of advanced tasks becomes problematic in respect of supervision and the potential for HCA's working beyond their competence. The empirical material from the case study provides a contextualized approach which reveals information on employee agency captured by interview and questionnaire data. These sources suggest that HCA's are willing participants in their informal regulation but that this informality demonstrates a failure of structure which creates potential space for HCA's to confront locally defined informal structures. Agency of this type legitimizes resistance in the form of a more contractual approach to work. So on the second aspect of the core research question under a locally contingent mode of control antagonism between HCA's, registered nurses and ward managers is expressed in a use of absence but is structured in three ways. Firstly, as a reaction to work intensification or what managers refer to as 'managing shortages'. Secondly, absence appears as a reaction to the further extraction of distributive gains and losses which HCA's self-receive in the form of intrinsic job satisfaction, for example, the squeezing of time for hands-off nursing care. Thirdly, absence like the broader regulation of HCA's at TUH is tolerated but informally so because it does not formally threaten occupational closure and associated distributional gains by registered nurses. Rather, the effects of absence have to be managed in terms of its effects of service provision, that is, potential delays and cancellations.

On the third aspect of the core research question on the work experience of HCA's at TUH local resistance to the demands of managers does not manifest itself as a reaction to the changing political economy of Britain's capitalism. The lack of reference to union activity by those interviewed and in questionnaire transcripts demonstrates the local focus of resistance.

Hence it would be stretching the analysis to see resistance in the form of absence and retained intrinsic job satisfaction as a contradictory outcome of changes to the political economy of British capitalism. More locally the demands of modernization have stimulated pressures for greater management control, yet the frontier of control is incomplete due in the main to the absence of national structures to formally manage the HCA role and guide local contingencies.

In conclusion absence is tolerated by ward managers and registered nurses because it does not threaten the managerial prerogative within the locally contingent regime of control. The use of absence by HCA's is a form of resistance to work intensification and the associated demands of management where the frontier of workplace control appears to have moved decisively in favour of management. In more abstract terms this latter point does reflect contemporary changes in the political economy of British capitalism but is experienced by HCA's, as modernization, that is, all politics are local and HCA's see these changes as the demands of management. At the micro level HCA's retain intrinsic job satisfaction by marginalizing aspects of their role particularly hands-off patient care and therefore secure distributive gains by imposing this loss on those they seek to help. At the macro level intrinsic job satisfaction is retained by a change of mind set towards a more contractual approach where as individuals HCA's appear able to dissociate their use of absence from its effects on patients and colleagues. In terms of un-constructed industrial relations HCA's retain intrinsic job satisfaction by separating this from the locally contingent regime of control blaming their behaviour on this regime and its informal structures.

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