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Occupational closure in nursing work reconsidered: UK health care support workers and assistant practitioners: a focus group study

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Abstract

In healthcare, occupational groups have adopted tactics to maintain autonomy and control over their areas of work. Witz described a credentialist approach to occupational closure adopted by nursing in the United Kingdom during the 19th and early 20th centuries. However, the recent advancement of assistant, 'non-qualified' workers by governments and managers forms part of a reconfiguration of traditional professional work. This research used focus groups with three cohorts of healthcare support workers undertaking assistant practitioner training at a London university from 2011-13 (6 groups, n=59). The aim was to examine how these workers positioned themselves as professionals and accounted for professional boundaries. A thematic analysis revealed a complex situation in which participants were divided between articulating an acceptance of a subordinate role within traditional occupational boundaries and a usurpatory stance towards these boundaries. Participants had usually been handpicked by managers and some were ambitious and confident in their abilities. Many aspired to train to be nurses claiming that they will gain recognition that they do not currently get but which they deserve. Their scope of practice is based upon their managers' or supervisors' perception of their individual aptitude rather than on a credentialist claim. They 'usurp' nurses claim to be the healthcare worker with privileged access to patients, saying they have taken over what nursing has considered its core work, while nurses abandon it for largely administrative roles. We conclude that the participants are the not unwilling agents of a

managerially led project to reshape the workforce that cuts across existing occupational boundaries.

Keywords:

UK; focus groups; nursing; healthcare support workers; NHS; profession; credentialism

Introduction

The ‘modernisation’ (Department of Health, 1997) of the UK National Health Service (NHS) included strategies to reorganise its workforce. A significant part of this move has involved making space for a new flexible worker, the assistant practitioner, designed and trained in terms of specific skills considered to be required for efficient patient flow through NHS organisations. There is a growing literature on the definition of, training for and impact of assistant practitioners within healthcare and particularly its implication for nursing work and nursing’s professional identity (NHS Education for Scotland, 2010). The introduction of the assistant practitioner in the UK can be seen as cutting across previously established occupational roles and demarcations in nursing work and can challenge the professionalization strategies of other occupational groups. So an examination of the role and perspective of the assistant practitioner in the context of a rapidly changing healthcare market can give us insight into the negotiation of professional boundaries and professional strategies of demarcation in the caring occupations.

Within the division of UK healthcare labour, medicine has traditionally been rewarded with high status and professional autonomy, whereas ‘carework’

has been devalued (Davies, 1995). Careworkers, who are predominantly female, can be divided according to their occupational credentials and level of formal education and training: ‘professional careworkers’, nurses and other qualified groups, ascribed with relatively high status (within carework), and ‘careworkers’, health care assistants, and social care carers ascribed with relatively low status (Davies, 1998). The ideology of professional nursing has traditionally advanced hegemonic ideas of morally fit ‘white middle-class women whose activities uphold western interpretations of healthcare work’ (Wrede, 2012 p. 483) adding to a segmentation within this group of careworkers.

A feature of healthcare organisation from the 1980s onwards is that work traditionally associated with more highly rewarded professions has migrated across occupational boundaries to be taken up by lesser skilled and lower paid groups. There are changes initiated both by professions themselves by means of traditional delegation, and, increasingly in the UK with its strong control over a centralised healthcare system, state-sponsored and managerially implemented initiatives with a more radical aim of reshaping the range of workers working in healthcare organisations. The shift of work from medicine to nursing and from nursing to assistant careworkers has been extensively examined, e.g. (Allen, 2001), and among the findings has been what many commentators have seen as nursing’s constant struggle for professional status (Law & Aranda, 2010). Its challenge is to take on previous ‘medical’ work without understanding this simply as delegation while simultaneously passing much direct patient care work to assistants while emphasising their own continuing accountability for such work.

This paper reports on focus groups conducted with healthcare support workers (HCSWs) enrolled on a university course leading to assistant practitioner status with, in most cases, an associated rise in pay. In a way perhaps not apparent in the shift of some medical work to other groups, the promotion of the assistant practitioner role puts the traditional notion of 'nursing work' into question. A similar point has been made about the introduction of support workers into podiatry and occupational therapy (Nancarrow & Borthwick, 2005) raising the issue of 'paraprofessionals' which we return to later. We explore this question by revisiting Witz's (1992) conceptual model for analysing occupational closure, a model that we wish to remind readers, grew out of a specifically UK context.

Witz developed a neo-Weberian conceptual model by drawing on and redefining concepts for analysing occupational groups' strategies of occupational closure, most notably Parkin's (Parkin, 1979) and Larson's (Larson, 1977). Witz's major contribution was to use the model to capture the historical configuration of the gendered politics of occupational closure in medicine, nursing, midwifery and radiology in the UK (Witz, 1990, 1992). She described the relationships between dominant and subordinate occupational groups by distinguishing between intra-professional closure strategies, exclusion and inclusionary usurpation, and inter-professional closure strategies, demarcation and dual closure (usurpation *and* exclusion). Further, by drawing on a previous distinction made by Murphy (1988) between different types of usurpation, Witz distinguishes between 'inclusionary usurpation', a strategy aiming at inclusion in the present structure, and 'revolutionary usurpation', a strategy aiming at changing the structures *per se*.

Witz showed how nursing's professional project involved a dual closure strategy in the attempt to establish a monopoly over the provision of skills and competencies in a market for services in the face of patriarchal forces in the occupation's formative years of the 19th and early 20th centuries. She details how the reward of the thirty-year campaign for registration in the UK (finally achieved in 1919) was control over the supply of nurses by including only those who had gone through a uniform system of education and excluding others. In other words, this involved a typical credentialist claim for nursing work. Registration would provide, according to Witz, the socioeconomically privileged leaders of nursing the opportunity to reshape the profession along class lines. Registration would also enable 'self-government' as opposed to the 'subjugation' of nurses by medical men. Although Witz presents such a project as evidence that women can mount effective challenges to patriarchal systems, challenges, which have the potential to liberate women from the label of 'semi-professionals', she does not conclude that nurses were successful. She noted that many unqualified workers continued to do work that could be defined as nursing work and that nurses themselves engaged in duties that could be considered as supporting or auxiliary work (Witz, 1992). Subsequent history may have shown the border between medical and nursing work to be permeable but many have concluded that the character of 'skill' in nursing is highly nebulous, to the extent that this vagueness can be exploited by the state and local managers by redefining grades and their boundaries (Thornley, 2000).

Background

Modernisation and managerialism

Since the 1980s many countries have worked to bring public sector spending under control. In healthcare this has involved challenging the traditional power and independence of doctors. While in more deregulated countries, such as the US, it has been employers and insurance companies who have attempted to challenge medical power (Marmor, 1994), in the UK it has been governments that have adopted a succession of strategies within a centralised system. This has included the introduction of general management in the mid-1980s (Harrison et al., 1989), the 'internal market' in the early 1990s and, under New Labour during the late 1990s and beyond, a series of initiatives scrutinising medical performance and 'modernising' the delivery of healthcare. Prominent within the transformation of healthcare delivery has been the 'modernisation' of the workforce. This has been manifested in an interconnected range of initiatives that focus on the flow of work deemed necessary and an attempt to match workers with appropriate skills to each part of that work. For example, the NHS Plan (Department of Health, 2000) described 'traditional hierarchical ways of working' as a major hindrance to efficiency and innovation in the NHS. Research has shown that nurses at all levels have been enrolled within this managerialist project, sometimes in order to be seen as credible 'corporate players' (Traynor, 1999).

The rise of the Assistant Practitioner

An essential part of this tendency for work to migrate from the highly trained to the less skilled worker has been the proliferation in number of workers who have an assistant or auxiliary role to registered nurses. This has been accompanied by an increased policy and research focus on these workers as well as their promotion (Kessler et al., 2010). Unqualified support workers have nearly always worked alongside qualified nurses and in the past, student and auxiliary nurses have carried out a great deal of the direct patient work (Allen, 2001). However, more recently much of that work is carried out by a growing number of HCSWs. Over the years, the health service has relied on these workers partly for demographic reasons, when it has been difficult to recruit nurses, but more obviously because these workers are not only cheaper to employ, but quicker and cheaper to train, and easier to dismiss (Kessler et al., 2010).

The phased admission of support workers into membership of the UK Royal College of Nursing between 2001 and 2011 and the creation of their own special interest group within it gives an indication that nursing sees this expanding part of the workforce as an opportunity for the kind of occupational control that characterised medicine's hegemony within healthcare work and its historical relationship to nursing. Locally it has often been nurses who provide training to this group of workers and this has sometimes been used as an opportunity to educate support workers regarding their assisting role to nurses and to warn them not to think of transgressing the boundary between the two occupations (Allen, 2001).

It is unclear whether HCSWs and assistant practitioners should be understood as an occupational group distinct from nursing or as objects in a dynamic struggle where nursing is attempting to incorporate them as paraprofessionals. If nurses can successfully enrol HCSWs and assistant practitioners as paraprofessionals to nursing they may avoid the risk, described by Nancarrow and Borthwick (2005), of permanently losing control of the work they 'discard' and pass on to them.

UK workforce policy has been contradictory regarding professional demarcation. On the one hand it has emphasised, when discussing assistant roles, their relation to qualified nurses as one of accountability and support. On the other, overarching policy concerning the preparation of this worker has reflected a broadly managerialist approach, which conceptualises healthcare work in a way that sees 'quality' and patient experience as a product of a managerially driven organisation of skills and workflow rather than proceeding from a professional ethic.

Nursing as policy instrument

Finally, a great deal has been written about the operation of professional power in healthcare and much of this approaches from the starting point of medicine as an exemplary profession, successful in achieving professional closure, shaping policy around health, attempts to subordinate other professions and receiving substantial rewards (Freidson, 1970). It has dominated UK healthcare, particularly in hospitals, unchallenged until the rise of managerialism in the mid 1980s (Strong & Robinson, 1990). Many writers have seen nursing as mimicking medicine's strategies in the hope that some

of its prestige would follow (Rafferty, 1996) and most agree that this has not happened (Law & Aranda, 2010;(Chambliss, 1996), some specifically analysing the part played, in the UK, by gender in this failure (Davies, 2002). In recent years, where nursing has encroached upon some of medicine's work and a little of its power, it has tended to be not a result of the profession's own strategies but following government initiatives aimed at dealing with contingencies such as the European Work Time Directive which limited junior doctors' hours (NHS Employers, 2011), or efforts to improve patient throughput and organisational efficiency (Department of Health, 2000, 2003, 2010). This direct intervention of governments renders models of professional closure, like that developed by Witz, for example, in need of further elaboration.

Nursing, perhaps more than ever, faces contradictory pressures on the nature of its work and its professional identity. On the one hand, from at least the introduction of changes to nursing education in the 1990s, Project 2000, where student nurses became 'supernumerary' to the workforce and were educated within universities, a government response has been to enable and encourage ways of strengthening a division within nursing work by the promotion of assistant roles that would replace qualified nurses (and previous 2nd tier nurses) in the nursing team. The emphasis has been on ensuring that the increasing skills of nurses are not wasted on 'routine' work. On the other hand, public exposure of an apparent lack of caring shown by nurses, most notably at Stafford Hospital in the UK (Francis, 2013), alongside government moves to be seen to tackle this problem (Secretary of State for Health, 2014) have placed a countervailing pressure on the profession to stay close to, or

reclaim, its ‘core identity’ of a direct and compassionate involvement in basic patient care. This ‘core identity’ of what is often claimed to be nursing’s unique closeness to and orientation toward being an advocate for the patient is emphasised by a great many documents produced from nursing’s UK professional body, the Royal College of Nursing (Royal College of Nursing, 2012; Royal College of Nursing, 2003) and its regulator in that country the NMC (Nursing and Midwifery Council, 2008).

This paper examines the new forces operating on occupational boundaries by means of a focus on health care support workers’ perspective on their work and occupational role in UK healthcare workforce.

Aims of the study

1. To gain insight into the character of the present day healthcare workforce in UK by examining how HCSWs aspiring to become assistant practitioners positioned themselves as health care workers and accounted for occupational boundaries. 2. To discuss how the emergence of the assistant practitioner reshapes notions of professional closure.

Methods

The research involves a series of focus groups with students from a range of healthcare courses and is aimed at exploring motivations and experiences in the workplace. We have run six groups involving healthcare support workers (n=59). This paper examines the data from these groups. The healthcare support workers were working within a number of London NHS organisations, both physical and mental health, and were sponsored by their organisations to

undertake training to become assistant practitioners. Therefore they were likely to be more concerned about career development than their colleagues who are not involved in such education. HCSWs take a one-year course leading to a Certificate in Higher Education with an option to take a further year to gain a Diploma in Higher Education, an option which most take. Students are taught clinical and study skills as well as ethics, law and professional issues. The courses are full-time, with students studying in blocks of learning across the academic year whilst continuing to work in their employing organisation. The tutors are nurses who also teach on nursing programmes and the course is described as addressing the needs of the healthcare sector. Graduates of the course expect to be appointed as 'assistant practitioners' on a higher pay band. The interactional features of focus group conversations, where the analyst can expect views to be immediately challenged, corroborated and/or marginalised, made it an appropriate approach to exploring the occupational group's discourse and identity (Bloor et al., 2001).

Procedure

All healthcare support workers who started training to become assistant practitioners between 2011 and 2013 were invited to participate in the study (see a description of the three cohorts of students in table 1). There was no attempt to strategically select participants from the cohorts. The first (group 1 & 2) and the third (group 5 & 6) cohorts participated near the end of their first term while the second (group 3 & 4) cohort participated shortly after the start of their second year.

The groups were facilitated by MT and CL who also took notes. MT and CL designed a topic guide with questions addressing three broad topics:

1. The participants' motivation for taking the course;

2. The participants' view of the character of their work and of their workplace;

3. The participants' understanding of clinical decision-making.

The participants' responses were followed up with prompts and requests for examples if needed. However, facilitator involvement was deliberately low in order to give the participants opportunity to respond to each other in reciprocal debate. The focus groups, which lasted approximately 50 minutes, were audio recorded and transcribed verbatim by a professional audio typist. MT and NB checked accuracy of the transcripts against the audio-recordings and added transcription symbols indicating basic conversational interaction.

The university's ethics committee gave permission for the researchers to approach the trainees. All participants volunteered and gave their signed consent to participate. Data were handled confidentially and the data extracts presented in the following sections have been made anonymous by the use of pseudonyms.

Analysis

Our intention was to combine a thematic analysis with a subsequent analysis of how the themes were negotiated in the conversational interactions (Halkier, 2010; Morgan, 1997). First, we coded (Coffey & Atkinson, 1996) the thematic content of the transcripts inductively and identified three main themes.

Second, we considered conversational interactions to identify how speakers presented and negotiated different aspects of the thematic content (Morgan, 1997), though in practice high degrees of concensus in the groups meant that the interactional dynamics were less pronounced than anticipated. The two initial steps of analysis were made by MT and NB working shoulder-by-shoulder to promote nuanced discussions of the significance of the data. These discussions were important parts of validating the initial interpretations as they challenged the analysts' taken-for-granted perspectives on the dataset. At this point we searched for 'deviant' contributions. What we believe we identified was rather a range of comments along various continuums, rather than deviant cases as such. Third, we brought to bear the issues from the policy and professional context to the inductively derived themes and developed the final themes, which are organised below. We then further explored and described the characteristics of the themes through systematic comparisons of the thematic content, and the three themes were linked to exemplary data extracts. Finally, we re-examined the original audio recordings and the transcripts to determine whether the three themes and the data extracts represented a nuanced and balanced interpretation across all of the groups.

Findings

The groups accounted for 67%, 80% and 91% of their respective cohorts, and it is possible that the non-participants could have added or emphasised particular issues in the groups' discussions. Though we did not record the participants' ethnic background, all the groups were multi-ethnic, with

participants from the UK, Ireland, Eastern Europe, Africa and Southeast Asia. Approximately 40% of the sample as a whole worked in mental health settings while the remainder worked in physical health. Their years of experience in health care assistant roles varied significantly from 1 to 20 years. Men made up approximately 25% of the cohorts.

The numbers participating in each group, broken down by gender, are provided in Table 1.

[Please insert Table 1 around here]

Interactions were very similar across the six groups. They were relatively formal as they tended to feature rather lengthy and uninterrupted responses to the moderators' questions. Sometimes, individual speakers put forward a particular point to which they would return several times despite the group's discussions having moved on.

The participants were highly heterogeneous, and therefore we were only rarely able to discern the specific influence of age, work experience, gender and/or ethnicity on the group interactions, though often participants would explicitly position themselves by emphasising their experience or age. For many participants, English was not their first language and some used English awkwardly.

Our analysis revealed a complex situation in which participants described a readiness to formally take on new tasks, most of which they believed they were already undertaking informally. The participants positioned themselves as delivering basic care and nurses as preoccupied with administrative tasks

away from the patients. This was the topic where the strongest consensus was expressed across the groups. Their occupational responsibilities were defined locally and the participants articulated their competencies as personal and as a radical challenge to the credentialism at the heart of the professional claim. In the sections below, we will describe these three issues in turn.

1 The readiness to formally take on new tasks

Nearly all participants talked of a high personal motivation to take on more varied, technically complex tasks. Taking on new tasks was in most situations linked to their personal aspirations for advancing their competencies and their positions within the hospital hierarchy. At the core of explanations of what they had learned from participating in the course was the gaining of new knowledge that would provide a basis to the clinical work they already undertook. In the following data extract, one participant emphasises how having knowledge about everyday procedures boosts her personal confidence and makes it easier to explain procedures to patients.

> Moderator: In what ways do you expect this course will change the work that you do?
>
> Mandy: I feel it's already changed my practice at work. I feel that instead of carrying out procedures I know have more knowledge behind it. I feel more confident carrying out procedures and I'm able to explain to patients what I'm doing, why I'm doing it and I feel a lot better about it now. (Group 1)

All the focus groups touched on this issue of carrying out tasks without having proper insight into the underlying principles, and some participants spoke of the course functioning as a powerful eye opener, in particular because most participants had worked as health care assistants for several years.

Despite the significant personal change experienced and expected of the course, most participants did not expect major changes to their clinical work. This contradiction emerged because they believed that they were already doing more than was included in their formal job descriptions. In the following extract, Henry starts by explaining that he would never overstep the formal legal boundaries of his role but his impatience to take on additional technical procedures and his orientation to work in terms of its component tasks is apparent. In groups that were often competitive about the scope of work they were each allowed to carry out, it would still not be acceptable to claim to have acted beyond their legal scope:

> Moderator: So how do you think this course will change the work you do?
>
> Henry: I don't think it will… I don't know, I think a lot of us pretty much do a lot of above what we should be doing anyway. Nothing illegal, nothing like giving medication or anything like that! But um, I don't know, maybe just request it. But the thing is in my job, I don't get to do catheters; I never do catheters. That's something I want to be able to do. (Group 1).

The participants were motived to ‘further’ themselves through formal education and expected to gain clinical insight and recognition although their work routines would probably not change significantly.

2 Providing the most basic care

If part of nursing’s professional project has been to differentiate professional nursing from unqualified care work, nearly all of our participants did not believe in such a distinction, or rather they were aware of a distinction but spoke about it as a purely legal or formal barrier. There was nothing about the character of ‘nursing’ work that meant that they were not already suitable workers to carry it out. A consistent narrative was developed across all groups that featured some degree of resentment of registered nurses’ apparent status, a status that is, according to many participants, undeserved because they see the work of nurses as very similar to their own. In the following extract two participants reflect on the differences between nursing staff in everyday work:

> Gloria: I think most of the time, I see myself as a nurse, but as an unregistered nurse, yeah, not recognised nurse!
>
> (…)
>
> Marja: You don’t see the difference between you and them really because what they do and you can’t, what they are doing, I’m doing the same thing. So, how you call it, I participate in care plan, you can tell the patient, everything they are doing, I can see myself doing it, trying to involve myself in the medication,

> you know. So maybe from next year, I will try starting taking the blood so maybe like Gloria was saying we're not registered nurse but we're really involved from A-Z. (Group 3).

In line with Gloria and Marja, the group members talked at length about status differentials and their own aspirations, claiming that they were 'the same and not the same' as registered nurses: the same in the work they did, not the same in the status they were accorded.

One of the key occupational claims made by registered nurses has been their role as the healthcare worker with privileged—intimate, relational and continuous—access to patients, as 'patient advocate' (Nursing and Midwifery Council, 2008). Our participants across all years were unanimous that they had 'usurped' this traditional nursing position. They spoke of having taken over nursing's 'core work' while nurses had abandoned it for a largely administrative role. A participant expressed it this way:

> Barbara: I think we have a lot more contact with the patients because we have to do everything with them, even down to the observations. We have sort of now got an unofficial rule that at the end of each shift, the nurse has to do the patients' observations because without us, they do not know when those patients are getting ill and they can get ill very quick. I mean we are sometimes mistaken as nurses by the patients because we have more to do with them. Some nurses are very good, especially the older ones who actually don't have degrees; they did the diplomas and have been nursing for a long time whereas

> some of the newer ones, have like almost a ‘keep the patient distant from me and if it’s bodily fluids, I’m not here’ approach, you know, they won’t have a lot of patient care. Some nurses are terrible with patients – I keep on feeling, ‘please do not open your mouth and speak because whatever you say does not come out very well’ and I think, you know, we, as healthcare assistants are very patient-focused and which is why I would not go on and progress to become a nurse in case I became unpatient-focused! Because I enjoy being with the patient, even if it’s listening to their life history. Quite often it’s interesting and they’re lonely, a lot of them. (Group 4).

Barbara displays a strong moral sense regarding who is willing to do basic care procedures. She speaks highly of nurses who take part in basic care and is derogatory towards those who seemed to avoid these tasks, ‘including bodily fluids’, typically the young and more highly educated. The need for the healthcare worker’s knowledge is emphasised along with the similarities between the groups highlighted by the fact that patients often confuse them.

In the following extract the participants, from a mental health setting, claim that their place in the ward hierarchy means that they are positioned to notice details about patients that qualified nurses do not. They are less overtly critical of nurses than the previous speaker:

> Hyacinth: In some cases, we do, we’re more, what can I say, more hands-on with the patients. In that respect, we do quite a

lot more. We observe a lot more things sometimes than the qualified; they do other procedures and stuff like that.

Moderator: What do mean you observe a lot more?

Ivy: We're more like interacting with the patient, we go out more with patients [on] leave and you know, with their families and things like that so we notice a lot of things what they might, although they're busy schedule, they might oversee. I think we, our role's quite very important, I think.

Henry: The qualifieds actually they spend more time in the office, doing all the documentation, and risk assessment and you know but the NAs [Nursing Assistants] don't do much documentation; you just report what you see to them.

Kimmi: We are more connected to the patient. (Group 2).

Ivy and Henry's argument depicts the nurses not as 'bad', but as 'busy'. This creates a legitimate claim for taking over the role and Kimmi draws on traditional nursing discourse of 'connection' with patients. There is no consideration about the formal competencies linked to 'observation'; observations are taken at face-value and the potential loss of the qualified staff's observations is not articulated. The participants described their occupational status as based on human compassion rather than clinical competency.

When asked about what differentiates their work from nurses' work, drug administration was the most commonly mentioned differentiator.

Nevertheless, despite their expressions of resentment toward nurses, about half of our participants spoke of a desire to train to be nurses in spite of repeated claims that nursing work had become too administrative and less patient-focussed.

3. The support and trust from local managers, supervisors and colleagues

According to participants, their scope of practice is based not on a recognised qualification but upon their managers' and supervisors' perceptions of their individual aptitude for particular tasks. Many participants have a highly local orientation and a realm of capability built on 'experience'. In the following extract, Liza describes her decision-making as a combination of experiential, local knowledge but bounded by her place in a hierarchical system. The need for formal education becomes absent in the light of her repeated experiences of assessing the same type of patients:

> Liza: (…) My decisions are made in conjunction with what's in front of me, my knowledge and obviously what my boss says as well. I'll speak to her.
>
> Moderator: And how have you got that knowledge?
>
> Liza: Just I've been there 10 years. I'd have to be really thick not to have understood something by now, seriously! I definitely would have got to this point. So yeah, it's just experience, your experience with things, you know, being. We see probably 50 patients a day that come in for different types of treatment,

> investigations for bowel problems. I could probably not operate, but I could probably do as good an assessment as my consultant can and kind of gauge what the problem is as what the consultant can do who's trained for god knows how many years and works their way up, but that's because I've been exposed to it all for a long time. (Group 1).

This claim, that they already have the necessary knowledge to undertake nursing work, was made by a great many participants across all the groups. Unlike a professional qualification—even a medical qualification in the extract above—it seems that it is local discretion that is required to take on certain work. In the following extract, the participants explain the system of trust between healthcare workers and their supervisors/managers when it comes to flexibility, learning local procedures and being awarded the concomitant locally rooted competencies:

> Rose: But I think with the assistant practitioner's role, it's just going to be assessed; not standard but it's got to be different for different areas because our training needs are very based on where we work, so I think although it's not going to be every day, "oh, this is what you're going to do", the nurse on the ward will know that this is within our remit of work and, although they're supervising us, that that work has now been delegated down to us. Does that make sense?
>
> Moderator: And that's a common experience?

> Belinda: It's just like an unspoken word between me and my boss that I can do certain things. She knows I'm capable of doing them and I'm safe to do them, although maybe once upon a time it would be what she would have done, when I first started working with her, she wouldn't let me do it, that's my job now. (Group 1).

Rose and Belinda regard their future role as assistant practitioners as flexible and based on their individual capabilities. While most participants endorsed the idea of taking over more work and being able to voice their opinions to colleagues, a few participants stated that it was a problem that they were not formally recognised and paid for the additional tasks they perform.

Finally, many participants emphasised that it was their manager who encouraged them to take up this training, often singling them out from their colleagues and sponsoring and supporting them. Not surprisingly these participants tended to express a great deal of personal loyalty to their managers. It emerged from their accounts that in nearly all cases their managers were nurses, though many participants also told stories of some qualified nurse colleagues refusing their requests to explain procedures or to be given extra responsibility. It is to this paradox—that support for 'usurpatory' roles came from within the 'usurped' profession that we now turn.

Discussion

Witz argued that nursing's professional project involved a dual closure strategy in the attempt to establish a monopoly over the provision of skills and competencies in a market for services. The direct intervention of governments and managers in the organisation of professional work in healthcare renders models of professional closure, like that developed by Witz, in need of update. Witz's model does not include the possibility of local, non-credentialist usurpation of professional work. Our data show healthcare support workers in training for Assistant Practitioner posts as caught up in local managerial projects to reconfigure the workforce in a way where the patient flow tasks required determine specific skills-based training. These individuals who have shown promise and confidence have been sponsored by their managers, often managers who are nurses themselves, to train for roles that take on work previously carried out by nurses. In this way there is no frontal assault on any professional group but the promotion of an alternative and relentless logic to the organisation of healthcare work. It is one that in some respects pays attention to professional power in that assistant workers, as their title(s) makes clear, are organisationally accountable to registered nurses, but at the same time they are placed by managers into positions where they take on previously 'core' nursing work. Indeed, Thornley in 2000 wrote about assistants being 'quietly' substituted for registered nurses (Thornley, 2000). From this perspective, therefore, we suggest that nursing has been unsuccessful in defining its skills in sufficiently specific ways to prevent the encroachment of other workers. The talk of participants mounts a challenge to the distinctness of nursing work and their professional claim. From this

perspective it would seem illogical that nurse managers would facilitate HCSWs' encroachment into nursing work. We propose a number of speculative explanations. Some nurse managers see great potential among some of their support staff and by encouraging them to gain additional qualifications unwittingly participate in the managerialist project detailed above. Some participants indicated that their managers saw their potential to become a future nurse and this was their intention. Ward-level nurse managers may well (believe they) have little control over staffing levels and skill-mix in their their wards while more senior nurse managers may be drawn into managerialist approaches to the division of labour, especially in times of financial pressure, for reasons suggested earlier in this paper (Traynor, 1999). Given this situation it would be in their interests to have at their disposal support staff who are able to perform the widest variety of tasks and accept the widest delegation from qualified nurses. From this point of view enabling HCSWs' role development is a logical way to manage workflow while maintaining local control over their actual work. Dengeling *et al* produced similar findings in their survey of the characteristics of medical and nursing managers and clinicians (Degeling et al., 2003).

In our research most participants made explicit claims that they had moved into the role of the worker with direct and intimate contact and knowledge of patients that had been abandoned by nurses. At times, some voiced strident challenges to nursing's future with the assertion of their own ascendancy. However, these challenges appeared to be based on a surface level understanding of the work of nurses, in terms of tasks undertaken, and there was little discussion of the possibility that the knowledge and understanding

gained from nurses' professional training might give significance to this work over and above that apparent as a range of physical actions. The local orientation of many of the participants may turn out to be a limiting factor in their careers, compared to the access granted to workers with professional qualifications.

However, paradoxically, there is evidence that despite this managerialist attempt to reconfigure healthcare work the power of the nursing profession remains largely intact. We suggest this for two reasons. First, as with Kessler *et al* (2010) who found that about half of their sample of HCSWs had aspirations to be nurses, our data show many participants planning to undertake nursing training and many have already started 'top up' courses to enable this, having realised that despite being engaged in, from their perspective, almost identical work to qualified nurses, they are excluded from its professional kudos. Our focus group participants displayed a strong sense of status. In addition, while some participants voiced challenges to traditional professional structures, many seemed to acquiesce to a subordinate position to nurses who they relied on to supervise and check their work. Second, at a structural level, nursing appears to have made a strong move to configure HCSWs and APs as paraprofessionals. Presently workers in assistant roles do not have their own occupational body by means of which they can articulate collective responses or make their own strategies. Their phased inclusion into the membership of the RCN has been one move that has made this less likely to happen. To date most training of HCSWs is managed by nurses, as is the case with the present study, and the assumption that they are the best group to do this has gone generally unchallenged. As mentioned

earlier, the advantage that the construction of a paraprofessional group has for a profession is that, should market circumstances change, the profession can reclaim work that it had permitted the subordinate group to do. In a similar way some nursing departments in universities may take on the training of AP and similar groups at a time when many healthcare systems are reducing the number of professionals that they are commissioning for training. This can give them stability during uncertain economic conditions so that capacity is not lost should the future be more auspicious for nursing numbers.

The incorporation of HCSWs as nursing paraprofessionals would perhaps be completed if nursing's regulator were to become the statutory regulator for this group too. However despite increasingly urgent calls for this expanding group of workers to be regulated in the light of scandals of poor personal care in the NHS (Francis, 2010; Willis, 2012), no existing regulator has appeared suitable and willing for this responsibility with the NMC strongly opposing the move and any part for itself in it (Santry, 2012).

So, in summary the influence of the state is absent from Witz's model, which does not engage with the possibility of local, non-credentialist usurpation of professional work.

The part played by gender, ethnic background, age and social class in this shifting situation needs further exploration. Because of the complex interaction between these characteristics of our participants we have not been able to attribute any particular response to any of these factors. Historical data as well as some recent contemporary work (Wrede, 2012) emphasises the link between nursing and social elites and between less privileged groups and

less desirable nursing work, for example night work (Brooks, 1999). It could be that a social stratification is apparent between those who train to become nurses and those who work as HCSWs despite the policy emphasis on a single workforce with a continuum of skills levels and our own data which suggest that assistant practitioner training has become an entry route for some into the more privileged realm of qualified nursing.

Limitations

Healthcare support workers sponsored to undertake this course, as our sample was, are likely to be different to those who are not—they certainly described themselves as having been ‘chosen’ by managers for advancement. Therefore our observations are possibly more relevant to those HCSWs motivated and successful in gaining this kind of access. Our sample is from three cohorts at a single university. Focus groups with HCSWs from different settings may have given rise to different findings though many of our conclusions accord with those in the existing literature about this worker. Our focus was on how this group positioned themselves as healthcare workers and this gave us no insight into the actions of others in the workplace or their motivations. Notably, we have no direct insight into the motivation of nurse managers who have encouraged HCSWs to move into roles that appear to encroach on the work of nurses.

Conclusion

In summary, Witz’s model provides a gender-sensitive description of the strategies of nursing and other non-medical professions to establish

occupational closure. However, the market for healthcare delivery has changed markedly since the era in which modern nursing developed. The state and its managerial agents have become far more active in the configuration of healthcare work. UK health policy from at least the last twenty years has sometimes pictured traditional professional demarcations as part of the problem of healthcare organisation. The rise in numbers of assistant grade workers has been encouraged by governments and taken up increasingly by managers, even by nurse managers, in the face of a need to reduce costs. Role migration toward cheaper workers is common. However, policy literature and the findings of our study suggest that the situation is nuanced. Alongside this largely managerialist project, we have noted the apparently relatively successful professional project to incorporate assistant practitioners as nursing paraprofessionals. Alongside this many of our participants talked of their course as a stepping-stone toward a nursing qualification. Though apparently the recipients of strong individual managerial support and alongside expressions of ‘revolutionary usurpation’, many were aware both that they lacked the professional kudos ascribed to nurses and that they wanted it.

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Table 1: Healthcare support workers focus groups

Date of data collection, year and group	n	male	female	Total cohort size
December 2011				
year 1 group 1 (physical health)	9	3	6	
year 1 group 2 (mental health)	9	3	6	27
November 2013				
year 1 group 1 (mixed mental and physical)	12	2	10	
year 1 group 2 (mixed mental and physical)	9	1	8	25
year 2 group 1 (mixed mental and physical)	10	3	7	
year 2 group 2 (mixed mental and physical)	10	1	9	23
	59	**13**	**46**	**75**