

**Perceptions and Experiences of
Practice Nurses and Health Care
Assistants Following the
Introduction of the
HCA Role into General Practice:**

**A Longitudinal Study using
Constructivist Grounded Theory**

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Declaration

I declare that this thesis has been composed by myself. That it has not been accepted in any previous application for a higher degree. That the work of which it is a record has been performed by myself and that all sources of information have been specifically acknowledged.

S.A. Burns.

Signed:

Date: 3rd September 2012

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Abstract

With increasing demands being placed upon services in General Practice, Practice Nurses' (PNs) roles have expanded to alleviate pressure upon GPs time and Health Care Assistants (HCAs) have been introduced to assist in care provision in Scotland. This development was also encouraged in the Review of Nursing in General Practice (SE 2004). A small initial research project following introductory training for the HCAs (Burns 2006; Burns and Blair 2007) raised further questions about the HCA role and its development: What are the on-going perceptions and experiences of HCAs and supervising PNs? How has the HCA role developed overtime? What factors aid and hinder HCA role development?

A longitudinal constructivist grounded theory study was undertaken in Scotland with the aim of exploring the on-going perceptions and experiences of HCAs and PNs within General Practice following the introduction of the HCA role (Charmaz 2006). Data collection and constant comparative analysis took place within two contrasting regions in Scotland over a 2 year period for each participant with annual personal in-depth interviews of HCAs (n=14) and supervising PNs (n=13) and a 3 monthly postal follow up of all participants. The total period of data collection and analysis was 3 years 2008-2010, each year relating to Phases 1, 2 and 3 respectively in the findings.

On-going data analysis and comparative review of the literature facilitated the emergence and identification of 3 major categories relating to Phases 1 to 3 of data collection and analysis; *getting going and proving worth, building confidence and respect and shifting and shaping roles*. Within the 3 major categories were 7 categories and 28 codes in total. *Team relationships* were very important to the HCAs and their role has grown and developed over time. *Responding to the GP Contract* is of central importance to the HCA role. The *PN* status and influence within the practices appears *pivotal* to the HCA role development as the PNs provided support and mentorship. This emergent theory of HCA role growth and identity was identified: *'The HCA role in General Practice is incremental and is predicated on a search for belonging and occupational identity. It is developed and influenced according to the organisational dynamics and support for learning from within the specific small business environments of individual General Practices.'* The HCA role in General Practice in Scotland has proved unique and separate from other HCA roles in hospital and community. Further research investigating the HCA/Health Care Support Worker (HCSW) role in health care would be advantageous.

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Abbreviations

AP	Assistant Practitioners
BMA	British Medical Association
CCA	Critical Care Assistant
CGT	Constructivist Grounded Theory
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
DoH	Department of Health
GP	General Practitioner
GT	Grounded Theory
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HPC	Health Professions Council
ISDS	Information Services Division Scotland
KSF	Knowledge and Skills Framework
NHS	National Health Service
NES	NHS Education Scotland
NMC	Nursing and Midwifery Council
NP	Nurse Practitioner
nGMS	New General Medical Services Contract
PA	Practice Assistant
PN	Practice Nurse
QOF	Quality and Outcomes Framework
RCN	Royal College of Nursing
SEN	State Enrolled Nurse
SCQF	Scottish Credit and Qualifications Framework
SPSS	Statistical Package for the Social Sciences
SVQ	Scottish Vocational Qualification
UKCC	United Kingdom Central Council
WiPP	Working in Partnership Programme

Glossary

Agenda for Change: This is the 2004 agreement which established the current NHS pay and grading system for staff. This replaced previous separate pay groups and arrangements with 9 new numbered pay bands subdivided into points.

Analysis: the process of organising and synthesising data so as to answer research questions and test hypotheses.

Assistant Practitioner (AP): is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve. (Skills for Health 2009).

Category: organising and recording behaviours and events under observation in qualitative studies, resulting from sorting and organisation of narrative data. In GT –category is ‘A type of concept. Usually used for a higher level of abstraction’ (Glaser 1992 :38).

Coding GT: ‘Conceptualising data by constant comparison of incident with incident, and incident with concept to emerge more categories and their properties’ (Glaser 1992:38).

Concept: ‘The underlying, meaning, uniformity and/or pattern within a set of descriptive incidents (Glaser 1992:38).

Confirmability: a criterion for evaluating the quality of qualitative research, referring to the objectivity or neutrality of data, analysis or interpretation.

Constant Comparative Coding: GT: ‘Fundamental operation in the constant comparative method of analysis. The analyst codes incidents for categories and their properties and the theoretical codes that connect them’ (Glaser 1992:38).

Core category: in GT study the central phenomenon that is used to integrate all categories of the data.

Data: the pieces of information obtained in the course of a study.

Dependability: a criterion for evaluating the quality of qualitative research referring to the stability of data over time and over conditions.

Epistemology: to do with beliefs about how one might discover knowledge about the world.

Ethics: system of moral values concerned with the degree to which research procedures adhere to ethic, legal and social obligations to the research participants.

Experience: may be defined as 'observation of facts or events; practice in doing something; knowledge or skill gained by this' (Oxford Popular Dictionary and Thesaurus 2007).

Focus group: interview with a group of individuals assembled to answer questions on a given topic.

Gerund: is a term to refer to various non-finite verb forms in various languages. As applied to English it refers to what might be called verb action noun, which is one of the uses of the ...ing form.

Grounded Theory: an approach to collecting and analysing data that aims to develop theories and theoretical propositions grounded in real world observations (Polit and Beck 2009).

Halo effect: is a cognitive bias where the perception of one trait (i.e. a characteristic of a person) is influenced by the perception of another trait (or several traits) of that person. An example would be judging a good-looking person as more intelligent.

Hawthorne effect: 'is the name given to the phenomenon whereby people who know that they are participants in a study are likely to behave differently from the way they would behave without that knowledge.' (Powers and Knapp 2006: 77) This can have a positive or a negative effect upon studies.

Health Care Assistant / Health Care Support Worker (HCA / HCSW): 'Those who provide a direct service- that is they have a direct influence/effect on care/treatment to patients and members of the public and are supervised by and/or undertake healthcare duties delegated to them by NMC registrants' (NMC 2006).

Hypothesis: a statement of predicted relationship between variables.

KSF- Knowledge and Skills Framework: dimensions of various roles under new single pay structure for NHS employees introduced under 'Agenda For Change' (DoH 2005).

Lay Health Worker: defined as any health worker (paid or voluntary) carrying out functions related to health care delivery trained in some way in the context of the intervention has no formal professional or paraprofessional certificated or degreed tertiary education (Lewin *et al.*, 2006).

Learning organisation: the intentional use of learning processes at the individual, group and system level to continuously transform the organisation in a direction that is increasingly satisfying to its stakeholders (Dixon 1994:4).

Methodology: the tools and techniques of research.

National Health Service: The publicly funded health care system in the UK.

nGMS- new general medical services contract: The new contract that GPs entered into with the government for provision of services from 1st April 2004.

National Vocational Qualification (NVQ): Work based awards in England Wales and Northern Ireland that are achieved through assessment and training (Kessler et al 2010:10).

Ontology: to do with assumptions about how the world is made up and the nature of things.

Open Coding: GT: 'The initial stage of constant comparative analysis, before delimiting the coding to a core category and its properties- or selective coding. The analyst starts with no preconceived codes- he remains entirely open' (Glaser 1992:38).

Paradigm: is an interpretive framework, a general perspective or world view which is guided by a set of beliefs about how the world should be understood and studied.

Phenomenology: is a qualitative research tradition with roots in philosophy and psychology, which focuses on the lived experiences of humans.

Pilot study: a small scale version or trial run done in preparation for a study.

Practice Assistant: is a term used to describe supporting health care workers who are not professional trained or registered. The role bears comparison to that of HCA.

Practice Manager: person, on behalf of the GPs, taking charge of the day to day management of the general practice and related financial issues.

Practice Nurse: a registered nurse employed within general practice. There are different levels of expertise between practice nurses. These are described at 3 levels in the Framework for Nursing in General Practice:

- 1) Staff Nurse- registered nurse capable of undertaking a wide range of nursing procedures and can see patients self-referring for nursing procedures.
- 2) Specialist practice nurse- is one who has knowledge and experience equivalent to first degree level and considerable evidence of post registration development within his /her chosen field. A nurse at this level may deliver specialist clinics, prescribe and take a leadership role in the nursing team.

- 3) **Advanced practitioner-** is a nurse able to deal with undifferentiated presenting problems, using advanced skills of physical assessment and examination and clinical judgement to form a diagnosis then initiate appropriate treatment. The advanced practitioner may have a more extensive leadership role extending beyond the practice (SE 2004).

For the purpose of this study the practice nurse is the registered nurse who acts as mentor to the HCA, who they report to on a day to day basis.

Property GT: 'A type of concept that is a conceptual characteristic of a category, thus a lesser level of abstraction than a category. A property is a concept of a concept' (Glaser 1992:38).

Prothrombin time (PT) test: standardised as in the INR test which is most often used to check how well anti-coagulant or "blood-thinning" tablets such as warfarin are working. Anti-coagulant tablets help prevent the formation of blood clots (Medical Dictionary 2010).

Pulmonary function laboratories: laboratories specifically equipped and designed to carry out specialised tests to measure lung function levels.

Quality and Outcomes Framework (QOF): The Quality and Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. A points system is in place related to payment. Practice participation in QOF is voluntary but most practices on GMS contracts take part in QOF.

Qualitative research: is the investigation of phenomena in depth and in a holistic way resulting in the collection of rich narrative data. Research design may be flexible.

Quantitative research: research investigation of phenomena that lend themselves to precise measurement and quantification (numerical form).

Quasi-experiment: 'a study involving an intervention in which subjects are not randomly assigned to treatment conditions, but the researcher exercises certain controls to enhance the study's validity' (Polit and Beck 2006:508).

Questionnaire: a method of gathering self-report information from respondents through self-administration of questions in written format.

Randomised clinical trial (RCT) – ‘a full experimental test of a new treatment, involving random assignment to treatment groups and typically, a large and diverse sample’ (Polit & Beck 2006: 508). ‘**Controlled**’ refers to inclusion of a control group- a group containing subjects in an experiment who do not receive the experimental treatment and whose performance provides a baseline against which the effects of treatment can be measured.

Royal College of Nursing (RCN): A professional membership organisation representing nurses and nursing.

Reflexivity: the researcher’s scrutiny of his or her research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interests, positions and assumptions influence enquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports (Charmaz 2006:188).

Reflexive journal: a journal maintained by qualitative researchers during data collection and data analysis to document self-analysis of both how they affected the research and how the research affected them.

Shipman: Harold Shipman was a GP who was convicted of murdering 15 of his patients at Hyde near Manchester. It is likely that he murdered many more patients undetected. Recommendations for procedural change have been far reaching following a public inquiry.

Sample: a subset of a population selected to take part in a study.

Saturation: the collection of data in a qualitative study to a point where closure is obtained because new data yield no new information.

Semi-structured interview: an interview in which the researcher has listed topics to cover rather than specific questions to ask.

SPICE: At the end February 2006, a project looking at Scottish Programme for Improving Clinical Effectiveness in Primary Care (SPICE) data was established. SPICE has been developed by health care professionals to assist General Practices in the provision of effective care and to encourage quality improvement in the primary care setting. It offers practices a voluntary scheme under which they can submit data on their clinical effectiveness and receive feedback on their performance relative to other participating practices. A bi-annual return launched in March 2000, to date 24 sets of criteria have been developed which take account of up-to-date evidence base coupled with the quality indicators of the nGMS Contract.

Spirometric testing: a test to measure respiratory function.

State Enrolled Nurse (SEN): Prior to Project 2000 when one level of nurse training was established, enrolled nurses completed two years of training and became registered as second level nurses (Level one being SRNs with three years of training).

Substantive theory- a theoretical interpretation or explanation of a delimited problem in a particular area, such as family relationships, formal organisations, or education (Charmaz 2006:189).

Survey research- is non-experimental research in which information regarding activities, beliefs, preferences and attitudes of people is gathered via direct questioning.

Scottish Vocational Qualification- SVQ- work based awards in Scotland that are achieved through assessment and training.

Symbolic interactionism: derived from the work of G.H. Mead (1932) and J. Dewey (1922) - and founded on 3 premises:

- I. -the actions of human beings are based on meanings that actors invoke as appropriate;
- II. -meanings are derived from the social interaction with others;
- III. -meanings are dealt with/modified by people through interpretation and social experience (Bryant 2002:35).

Thrombosis: the formation of a blood clot caused by coagulation of the blood usually in a vein, often results from stasis.

Transferability: is the extent to which findings can be transferred to other settings or groups.

Theoretical coding: GT- 'A property of coding and constant comparative analysis that yields the conceptual relationship between categories and their properties as they emerge. Theoretical codes are conceptual connectors to be used implicitly and explicitly in the way and style in which the analyst writes' (Glaser1992:38).

Theoretical Sampling: 'is a data gathering approach used in grounded theory. As data is concurrently collected and analysed, the researcher decides what further data and data sources are needed to develop the emerging theory' (Powers and Knapp 2006).

Theoretical sensitivity: is the process by which analysts can render theoretically their discovered substantive, grounded categories. The research field should be entered with as few preconceived ideas as possible and sensitivity is increased by being steeped in the literature.

Think-aloud method - a qualitative method used to collect data about cognitive processes such as decision making involving the use of audio recordings to capture people's reflections on problems as they are being solved (Gerrish and Lacey 2006).

UNISON – The main union representing support workers in health care in the UK.

Chapter 1

Introduction and background

1.0 Introduction

The stimulus for my study arose from local collaboration with practitioners to develop a course supporting the introduction of the new role of health care assistant (HCA) into General Practice. Locally a foundation course was developed to provide initial education and training for the HCAs upon commencing in General Practice (Burns 2006). The HCA role was completely new to General Practices in Scotland (Scottish Executive (SE) 2004) and findings from small scale initial research (Burns and Blair 2006;2007) indicated a positive response to the HCA role from GPs, practice managers, administration staff and patients. More detail of this baseline study is provided in Section 1.7 of this Chapter.

I considered that the introduction of HCAs into General Practice was worthy of more in depth consideration because of the HCAs' unique and developing role in General Practice in Scotland. Within this Chapter the background to the HCA role generally and in General Practice is considered alongside the background to the developing practice nurse (PN) role and the findings from the initial baseline research are also documented. This Chapter examines the background to the HCA role to date in order to set my thesis in context. A variety of operational definitions and terms are used and these are defined in the Glossary at the front of this study.

I am a Senior Lecturer at the University of the West of Scotland within the School of Health Nursing and Midwifery. I am a nurse with a background in community nursing and nurse management within primary care. I became interested in this research topic after being approached locally to develop and provide training for HCAs in General Practice.

1.1 Definitions of HCA and HCSW

There are various titles, descriptions and definitions of health care assistant and related roles. 'Health care assistant', 'health care support worker', 'lay health worker' 'nursing assistant' 'auxiliary nurse' are terms that have been used. 'Assistant practitioner' is a more recent term referring to a higher level of support worker (Department of Health (DoH) 2005). The following description of the HCA role was provided by NHS Careers (2006):

'Healthcare assistants can work within hospital or community settings under the guidance of a qualified healthcare professional. The role can be very varied depending upon the area in which the person is employed.'

Working alongside nurses, for example, they may sometimes be known as nursing auxiliaries or auxiliary nurses. Healthcare assistants also work alongside qualified midwives in maternity services.'

Details of the duties of a HCA provided by NHS Careers include washing and dressing, feeding, helping people to mobilise, toileting, bed making, generally assisting with patients overall comfort and monitoring patients conditions by taking temperatures, pulse, respiration and weight (NHS Careers 2006).

A definition of the health care support worker role was provided by the Scottish Executive (SE 2006a:3):

'Those who provide a direct service- that is they have direct influence / effect on patient care/ treatment/ relationships- to patients and members of the public. This includes those in support roles to healthcare professions (such as care assistants) and those who provide ancillary services (such as porters and mortuary attendants).'

The Nursing and Midwifery Council, the regulatory body for registered nurses and midwives, described health care support workers as:

'Those who provide a direct service- that is they have a direct influence/effect on care/treatment to patients and members of the public and are supervised by and/or undertake healthcare duties delegated to them by NMC registrants'
(NMC 2006).

Saks and Allsop (2007:165) examined the support worker role in social policy and provided a broader definition of health care support workers:

....'Those who provide face to face care or support of a personal or confidential nature to service users in a clinical or therapeutic setting, community facilities or domiciliary, but who do not hold a qualification accredited by a professional association and are not formally regulated by a statutory body'.

The terms health care assistant (HCA) and health care support worker (HCSW) are used synonymously in the literature. The definition of an HCSW/HCA provided by the NMC is the operational definition used in my study.

The importance of HCAs, who have worked in health services for many years alongside registered nurses, has increased over time. HCAs are the fastest growing workforce in the NHS and in 2005 they formed 17% of the NHS workforce in the UK (European Industrial Relations Observatory (EIRO) 2005). There are more HCAs in the wider NHS than at any time previously as detailed in Table 1.3 later in this Chapter. In the next section I will provide the reader with the historical background up to the present day.

1.2 Historical background to HCA role in UK

Insight into the historical background and factors influencing the development of HCA and related roles helps to illuminate recent events. In the Crimean War nursing aides were recognised as part of the nursing team and Florence Nightingale acknowledged the value of this role under the supervision of trained nurses (Stokes and Warden 2004). Later in 1919 The Health Care Act there was an attempt to establish a boundary between unqualified assistants who were fit to practise and those who were unfit. However, the Health Care Act failed to define these boundaries. In 1955 nursing assistant or nursing auxiliary roles were given first formal recognition in the NHS alongside the role of qualified 'assistant nurse' (Thornley 2000). In 1961 the 'assistant nurse' role was recognised as SEN or State Enrolled Nurses and practitioners were registered on the Roll of Nurses and were referred to as 'second level' nurses.

Later, in 1986, the term 'health care assistant' was first used and developments in nurse education in the form of Project 2000 had significant influence upon this role (UKCC 1986). Project 2000 established only one level of qualified nurse (RN) and moved nurse education from the nursing colleges within the NHS to higher education. Student nurses then had supernumerary status when in clinical areas where they had previously formed part of the duty staff. Thus students were no longer to be viewed as workers but were recognised as students learning under supervision. This change in status led to a shortfall in staffing levels in clinical areas and it was proposed that HCAs would make up the short fall of staff and that they would also free up trained nurses to carry out the more skilled work (UKCC 1986). The numbers of HCAs employed in the NHS increased and in 1988 the UKCC position paper supported the development of the HCA role to assist nurses (UKCC 1988). The National Council for Vocational Qualifications was established in 1988 and national vocational qualifications or in Scotland Scottish vocational qualifications were developed (NVQs / SVQs). In health care levels 1 to 3 vocational qualifications marked the development of competencies of the HCAs and that these should be developed through experiential rather than academic learning (Stokes and Warden 2004).

At the end of the 1980's changes to the way the NHS was set up further influenced the HCA role. In 1989 there was increased awareness of the need for cost effectiveness of care within the NHS when the concept of 'market forces' was introduced to the NHS. Acute Hospital Trusts were set up followed later by the creation of Primary Care Trusts. At this time there was an increased focus upon HCAs to provide cheaper more cost effective care. The 1990 NHS and Community Care Act (DoH 1990) brought to an end long term hospital care for elderly patients and HCAs and other support workers in community teams provided domiciliary care services.

This increased focus upon the HCA role and the introduction of levels of competence for HCAs and NVQ/SVQ training led to some opportunities and the beginning of career pathways for this group of staff.

The Royal College of Nursing (RCN) in 1985 wanted an all qualified workforce but in 1992 they recognised the essential nature of the contribution of support workers to health care professionals (RCN 1985; 1992). Later this change of position was evident when the RCN made HCAs with vocational qualification at level 3 or more eligible to become members of the organisation (RCN 2000). Now if HCAs have health or social care work delegated to them by a registered nurse/midwife or have a qualification in health and care level one of the National Qualifications Framework in England, Wales and Northern Ireland, or level three of the Scottish Credit and Qualifications Framework in Scotland, then they can become full members and 2 seats on the RCN council have been allocated for HCAs (RCN 2011).

A new grading system for all NHS staff was introduced in 2004 with most HCAs graded in Band 2 or 3 (DoH 2004). Band 4 encompasses a higher grade of support worker who have enhanced training and extended roles and are known as assistant practitioners (APs) (NHS Careers 2010). Assistant practitioners work in a broad range of settings for example in radiography departments, occupational therapy departments, theatre and midwifery and they are usually supervised by registered professionals (NHS Careers 2010). AP roles are widespread within the NHS in England and initial pilot sites are established within Scotland (NES 2010). The growing numbers of HCAs and their increasing contribution to practice is signified in the publication of the 'British Journal of Health Care Assistants', a journal specifically for HCAs was launched in April 2007.

In 2004 there was a movement by government to discuss regulation of HCAs, consistency of practice standards and specific training have been recognised as integral to this process (Chatterjee 2004; McKenna *et al.*, 2004; O'Dowd 2004). The Department of Health indicated the year 2007 as a possible date for the introduction of registration for HCAs (DoH 2004). The NMC carried out a scoping study examining regulation of HCAs (NMC 2006a). A wider parallel to this was the consultation regarding the regulation of the non-medical professions alongside the post Shipman enquiry into medical regulation (DoH 2006b).

Storey (2005; 2007) drew attention to the complexity of the debate about the form regulation should take and the concerns expressed by staff-side organisations about regulation that involves employers. The RCN (2006a) expressed the view that as HCAs deliver nursing care they should be regulated by the nursing regulatory body and concern that any other regulatory arrangement would fragment the nursing family and could potentially undermine public protection. Unison Scotland (2006) also expressed concern about employer regulation being potentially damaging to relationships between employer and employee with employers having power and control over present employment and future livelihood.

In 2006 the Scottish Executive undertook a consultation process regarding regulation of HCSWs in Scotland (SE 2006c). This involved a pilot study of 3000 support workers in health care in Lothian, Ayrshire and Arran and Greater Glasgow and Clyde NHS regions and was evaluated by the Scottish Centre for Social Research in order to inform the regulation process for support workers in the UK (SE 2006c). This project set out to test 4 elements of a potential regulatory system, a code of conduct for HCSW, a code of practice for employers, a set of standards for induction to ensure public protection and a centrally held list of HCSW who met the agreed standards (NHSQIS 2008). Birch and Martin (2009) at the Scottish Centre for Social Research published a positive evaluation of the pilot.

Following on from this in Scotland the code of conduct for HCSWs and also standards for employment, induction and education of HCSWs have been published on the HCSW Toolkit website (NES 2010). The Scottish Government made it compulsory for NHS Boards to commit to achieving the Code of Practice for Employers and put in place workplace supervisors and also committed to recruiting HCSW who achieve the induction standards for HCSW and comply with the Code of Conduct by the end of 2010 (Scottish Government (SG) 2010).

Further examination of the regulation of HCSWs was commissioned by the NMC in a scoping review (Griffith and Robinson 2010). The review published from the National Nursing Research Unit in London concluded in favour of regulation whilst indicating that there was not conclusive evidence that a lack of regulation for HCSWs posed a risk to patient safety. The benefit of regulation was identified as preventing health care staff dismissed for misconduct from rejoining the workforce somewhere else. The review indicated the potential risk of some HCSWs who were undertaking tasks that they had not been trained to do. It also recognised that the introduction of regulation would necessitate standardisation of training and education (Griffith and Robinson 2010).

The result of implementation of the European Working Time Directives in 2009 was the restriction of the number of hours that junior doctors were allowed to work and nurses took on many tasks previously undertaken by junior doctors. The supporting role of HCAs to nursing staff thus became of increased value as workload pressures increased in clinical practice (Adams *et al.*, 2000). In 2010 the first large scale study of HCAs in a hospital setting within the NHS was published (Kessler *et al.*, 2010). Table 1.0 provides a summary of some of the key dates in the development of the HCA role in the UK.

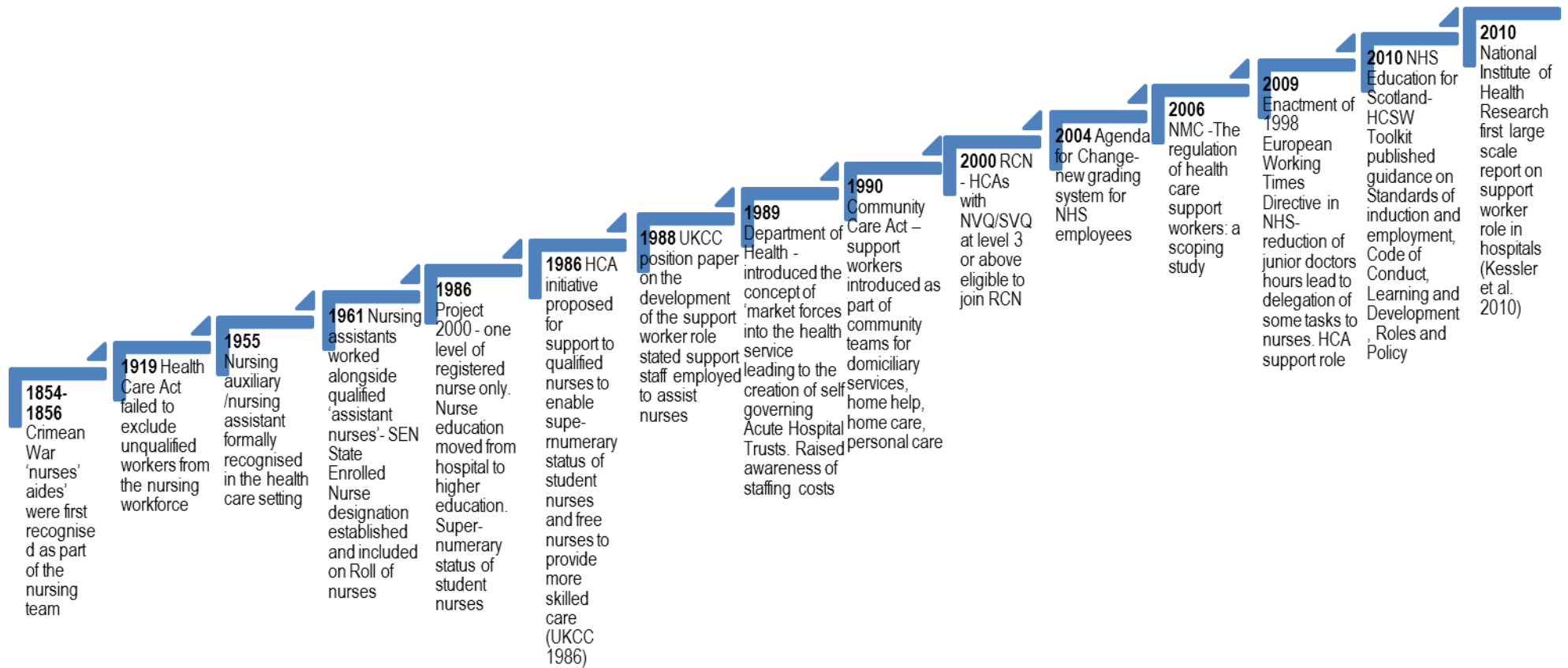


Table 1.0: Summary of key dates in the development of health care assistants in the UK (Adapted from Stokes and Warden 2004)

1.3 The evolution of General Practice

At the inception of the National Health Service across the UK in 1948, general practitioners were resistant to joining as paid employees and so they retained the status of independent practitioners who contracted into the NHS. In 1965 the Charter for Family Doctor Services set up with government assisted GPs to obtain suitable premises and to employ nurses, receptionists and secretaries. In the subsequent NHS reorganisation in 1974 Family Practitioner Committees were set up. Later in 1990 a new GP contract was set up with an increased emphasis on consumer participation, needs assessment, disease prevention and health promotion, primary care led NHS. GP fundholding was set up in 1991 whereby GPs held a budget and were able to purchase some of the services for their patients directly. The end of the internal market in the NHS came with a change of Government in 1997.

The new general medical services (nGMS) Contract came into effect on 1st April 2004 and provided a framework for the improvement of standards of patient care (BMA 2003; DoH 2003; BMA 2011a). General Practices aim to meet targets within the quality and outcomes framework (QOF). Different practices can choose to aim for different targets within four domains: clinical; organisational; patient experience; and additional services and points are attached to various criteria within these four domains (DoH 2003; Tinson and Holland 2004; BMA 2011a).

In England a Government white paper reforming the structure of the NHS was published in July 2010 under which GPs in England are to play a major role in contracting for other NHS services for their patients (DoH 2010). The proposed changes have met with widespread opposition from GPs and other health professionals (BMA 2011b). This controversial paper has been subject to many amendments but a Bill has now been approved by the House of Commons and in which GPs in England will have an enhanced role in contracting other health services for their patients (DoH 2011). Table 1.1 summarises the key changes to General Practice since 1948.

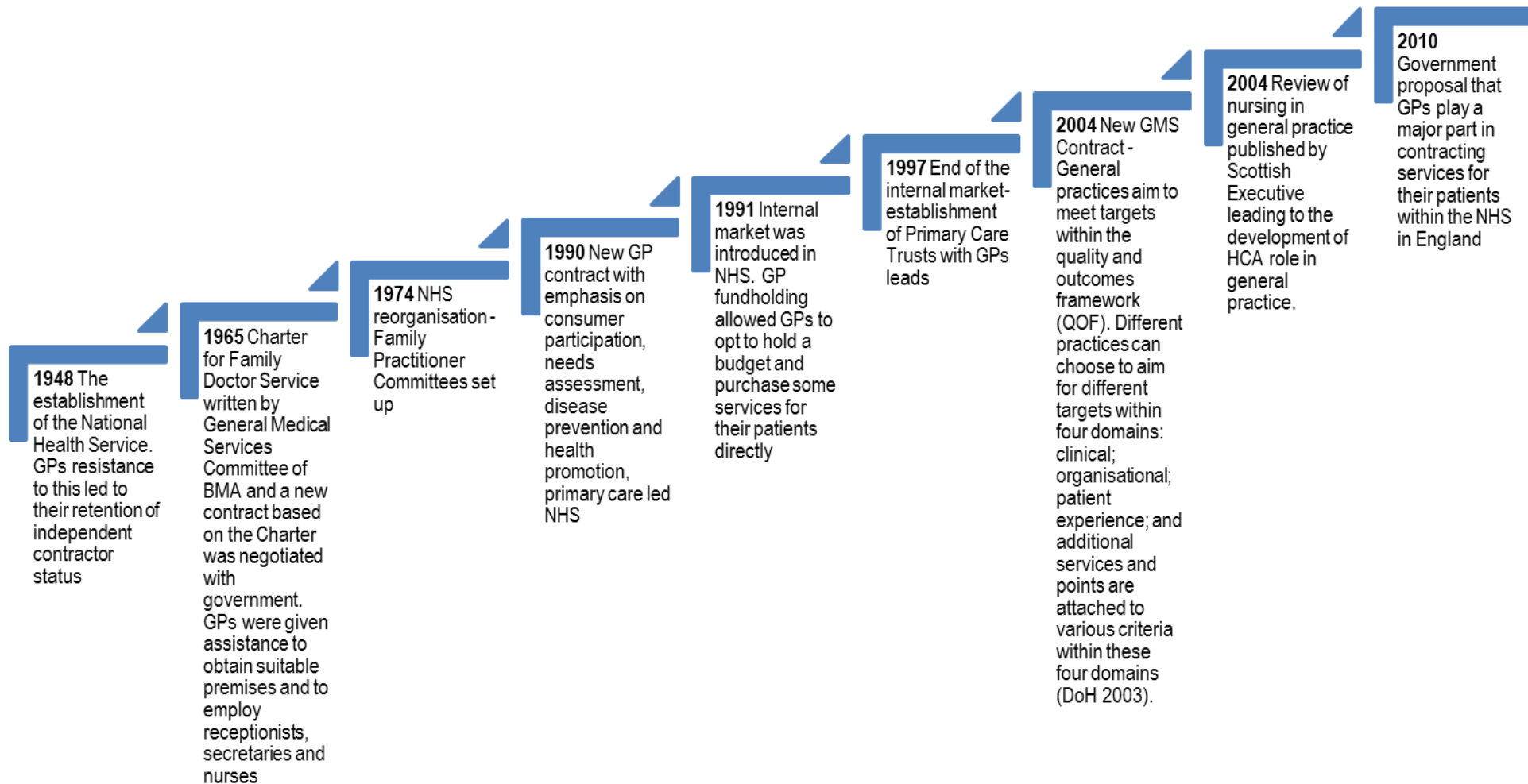


Table 1.1: Summary of key developments in General Practice

1.4 Developments in General Practice in Scotland

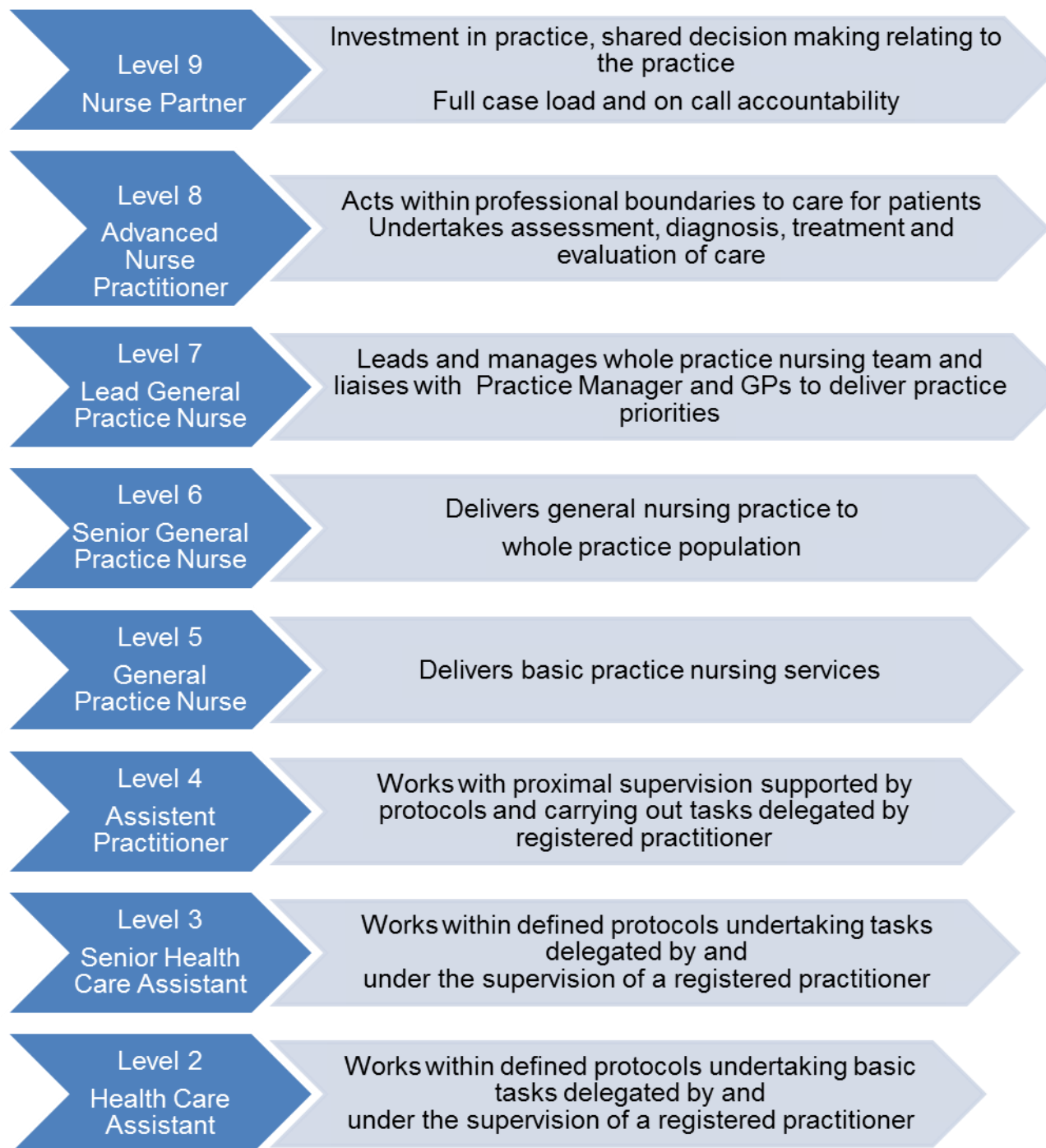
In Scotland, as elsewhere in the UK, the changing demands of health care organisations and the increasing complexity of the work place have resulted in the need for an adaptable workforce (SE 2005; 2006a). The pressure upon resources within the NHS has meant that innovative ways of working and maintaining safe practice are imperative (SG 2007). In Scotland, care provision outlined in the National Framework for Service Change focused on long term conditions and care embedded in communities that is team based and integrated (SE 2005; SE 2006acd; BMA 2009). The Review of Community Nursing referred to an integrated care approach and recognised the supporting role of HCAs (SE 2006b). Primary care developments thus are at the forefront of service development and provision. Likewise workforce development to deliver quality, cost effective and integrated care has been identified as a core priority (SG 2009a).

Within General Practices the new general medical services contract, out-of-hours services and the expert patient agenda have all brought about change (DoH) 2003; DoH 2006a). The role of practice nurses has expanded in order to alleviate pressure upon GPs time (Leese 2007). They provide on-going care for patients many of whom have chronic illnesses. The number of practice nurses (PNs) in Scotland has increased to an estimated 2,140 in January 2009 (Information Services Division Scotland (ISD) 2011). The Framework for Nursing in General Practice recognised the importance of PNs for primary health care provision and recommended a review of the skill mix of nurses working in General Practice (SE 2004). The development of the HCA role is integral to this.

HCAs work alongside PNs in General Practice and their role may also vary in the level skills and expertise employed. KSF levels 2 to 4 highlighted in turquoise in Table 1.2 correspond to the duties of an HCA, Senior HCA and Assistant Practitioner respectively.

Registered nurses duties in General Practice correspond to levels 5 to 9 in Table 1.2. In the KSF, HCAs require to be educated to Scottish Credit Qualification Framework (SCQF) level 6, Senior HCAs to SCQF level 7 and Assistant Practitioners to SCQF level 8 (SCQF 2009). Some registered nurses commence in General Practice working as treatment room nurses (SE 2004). They may then extend their practice and complete a specialist practitioner degree qualification with enhanced knowledge of chronic disease management, disease prevention and health promotion (Gupta 2000; RCN 2010; NHS Scotland 2012). The alternative to this is to study for a nurse practitioner qualification which may be at honours or Masters degree level (WiPP 2008). The nurse practitioner role does cross traditional boundaries between nursing and medicine and can include minor illness and injury management (WiPP 2008).

The different levels of expertise of HCAs and PNs have been set out in relation to the national career framework for the NHS and have been divided according to the Knowledge and Skills Framework (KSF) for NHS staff pay (DoH 2005). General Practices do not however have to apply the national framework and KSF pay scales. The result is that there is a great variation in PN roles and HCA roles that do not necessarily directly reflect those included in Table 1.2 (SE 2004; Crossman 2006; 2008).



**Table 1.2: General Practice Nurses and HCAs Career Framework
Adapted from Working in Partnership Programme (2008)**

1.5 Numbers of HCAs in Scotland

In Scotland the number of NHS staff in Agenda for Change bands 2, 3 and 4 are provided in Table 1.3. The figures represent the latest headcount of staff at 30th September 2010 as published online by the Information Services Division Scotland (ISD 2011). There are no separate workforce statistics available via ISD for HCAs in General Practice as PNs and HCAs form a single classification in ISD data collection. The estimated number of HCAs and phlebotomists in primary care was 725 detailed by the 2009 National Primary Care Planning Survey (ISDS 2011). In contrast in England the estimated number of HCAs in General Practices in 2008 was 6,700 (Bosley and Dale 2008).

A4C Bands	2	3	4	Total
Nursing	12066	5919	509	18494
Midwifery	470	50	79	599
AHPs	231	1276	540	2047
Clinical Psychology and Counselling		7	44	51
Optometry			2	2
Pharmacy	298	45	321	664
Play specialists	2	1	52	55
Emergency care - Ambulance care assistant Technicians	1	880 14	64 945	944 960
Health promotion	6	4	23	33
Healthcare science	627	923	226	1776
Total	13701	9119	2805	25625
HCAs Primary care Estimate (2009)				725
Total				26350

Table 1.3: Information Services Division NHS Workforce Statistics in Scotland Bands 2,3,4 at end of Sept 2010 (ISD 2011). Estimated HCA numbers in general practice from Primary Care Planning Survey (2009) available via ISD 2011

1.6 HCA Foundation Course

As previously mentioned, the local foundation course for HCAs took place after local consultation between educators and service providers regarding educational support for the introduction of HCAs into General Practice. There had already been work undertaken in England to support this development (Bates 2004; Workman 2004). However, in view of the scattered geography of the region and the relative isolation of many General Practices, it was envisaged that a local foundation course could provide the most suitable starting point in HCA education. I took the lead educational role in this working collaboratively with PNs in order to develop a foundation course that was fit for purpose. PNs took on the role of mentor to the HCAs for the course and protocols and procedures were put in place. The course consisted of 8 study days phased over a 3 month period with a follow-up day for review and practise of skills. Sessions taught are summarised in Table 1.4. and included communication skills, record keeping, infection control, venepuncture, chaperoning, vital signs, basic life support, blood glucose monitoring, ECG's, storage of vaccines and recognition of anaphylaxis (Burns 2006).

Summary of foundation course contents	
Communication skills	Record keeping and IT
Roles and responsibilities	Venepuncture
Basic life support	Chaperoning
Vital signs measurement	ECGs
Height and weight measurement	Anaphylaxis
Moving and handling	Urinalysis
Health and safety	Blood glucose monitoring
Infection control	New patient interviews
Healthy lifestyle	Vaccine storage

Table 1.4: Summary of contents of local foundation course for HCAs in General Practice

Eight HCAs commenced the foundation course in January 2005 and they all subsequently completed the course. Information gained from focus groups and questionnaires with HCAs and PNs before and after completing the foundation course helped to evaluate the course and informed the subsequent baseline study (Burns 2006; Burns and Blair 2006;2007). The PNs had initial concerns about being able to continue to provide safe patient care, the extra responsibility of supervising the HCAs and the role boundaries of the HCAs. The views of the PNs are summarised in Table 1.5.

Summary of PN views at foundation course commencement	
Opportunities	
-	to keep providing prompt and effective patient care
-	chance to develop team working further
-	provision of cost effective care
-	Contract points
-	chance to nurture HCA and see career progress
Threats	
-	physical space
-	clarity of line management
-	stress
-	potential lack of protected time together with HCA
-	role boundaries
-	concern regarding best practice and patient safety

Table 1.5: Foundation course evaluation - Summary of PN views

The HCAs evaluated the course positively, they considered that patients were accepting of their role and they expressed satisfaction in developing skills. The PNs who mentored the HCAs during the foundation course viewed the HCA role positively at the time of course completion and felt more confident that the HCAs were referring on issues of concern and that their previous fears about patient safety appeared unfounded (Burns 2006). The HCA role in General Practice was a completely new role within my local region and also nationally, so I considered it pertinent to follow the foundation course for the HCAs with a small research project to gather information about how the HCA role has impacted upon practice. After the initial course evaluation I followed up the HCA role more widely in General Practices locally in the baseline study.

1.7 Baseline study

The baseline study containing both qualitative and quantitative elements commenced immediately after delivery of the foundation course and aimed to explore the role of HCAs in General Practice from the perspective of GPs, practice managers and administrative staff and also to examine patients' experiences of receiving care. The stated aims of the study were:

1. To explore the role of the HCAs working in General Practice from the perspectives of general practitioners, practice managers, and administrative staff.
2. To evaluate the patient experiences of receiving care from HCAs in General Practice.

Three research questions for this baseline study were identified:

1. Are there benefits in the introduction of HCAs into General Practice?
2. What are the views of GPs, practice managers and administrative staff on the introduction of HCAs into General Practice?
3. How do patients view the role of HCAs?

1.7.1 Baseline study design

Self administered questionnaires were planned to explore patients' experiences of receiving care from HCAs. The questionnaires covered the four topics of experience, expectations, benefits and improvement using open and closed questions. The experiences of the practice staff were also to be explored using self administered questionnaires. PNs were not included as they had already provided feedback while acting as mentor to the HCAs. Ethical approval was obtained from the local NHS Research Ethics and Research and Development Committees. The timescale for the distribution of questionnaires was April and May 2006.

1.7.2 Baseline sample and recruitment

The questionnaires were distributed to consenting General Practice areas that employed HCAs who had completed the foundation course locally. The eight General Practices that had trained HCAs locally were contacted regarding study participation and all expressed interest in taking part. However, two practices did not have the HCA working in the practice at the time of the study, either due to absence or vacation of employment. One of these practices undertook to complete the questionnaires for the practice team members retrospectively but patient questionnaires were not completed. The other General Practice did not participate at all.

1.7.3 Baseline study data collection

In the week prior to distribution of the questionnaires all patients receiving care from the HCA were given information highlighting the purpose of the study and the request for patients to participate. During the next week the questionnaires for patients were randomly given by administrative staff to patients willing to participate in the survey. Consent was assumed by completion of the questionnaire. Completed questionnaires were returned to the General Practice receptionist in a sealed envelope or placed directly into a sealed box provided in the practice.

The questionnaire response rate was 50% for patients and 83% for staff. Questionnaire completion by patients (n=60), practice managers (n=5), administrative staff (n=6) and GPs (n=4) giving a total 75 persons taking part by completing questionnaires (n=75). The responses are summarised in Table 1.6.

Summary of responses to questionnaires	
Patients	n=60
GPs	n=4
Practice managers	n=5
Administrative staff	n=6

Table 1.6: Baseline study summary of responses

1.7.4 Baseline study findings

Responses to the open questions in the questionnaires were analysed using content analysis. This involved the analysis of the content of the narrative data to identify themes and patterns predominating within the themes (Polit and Beck 2009). Quantitative data was examined and presented using descriptive statistics.

The findings are presented within the four participating groups, patients, practice managers, administrative staff and GPs. There is also presentation of findings under the themes identified across all the narrative responses.

i) Patient responses

The average age of patients who attended the HCA and responded to the questionnaire was 63 years with an age range of 18 to 83 years. Of the 60 patients who responded 58 confirmed that the attention that they received from the HCA was appropriate. The 2 remaining patients did not respond to the question and so no patients responded negatively.

The reasons for patients attending the HCAs are displayed in Table 1.7. The most common reason was to have blood taken. Frequent attendance at appointments with the HCA was identified and the majority of patients attended regularly.

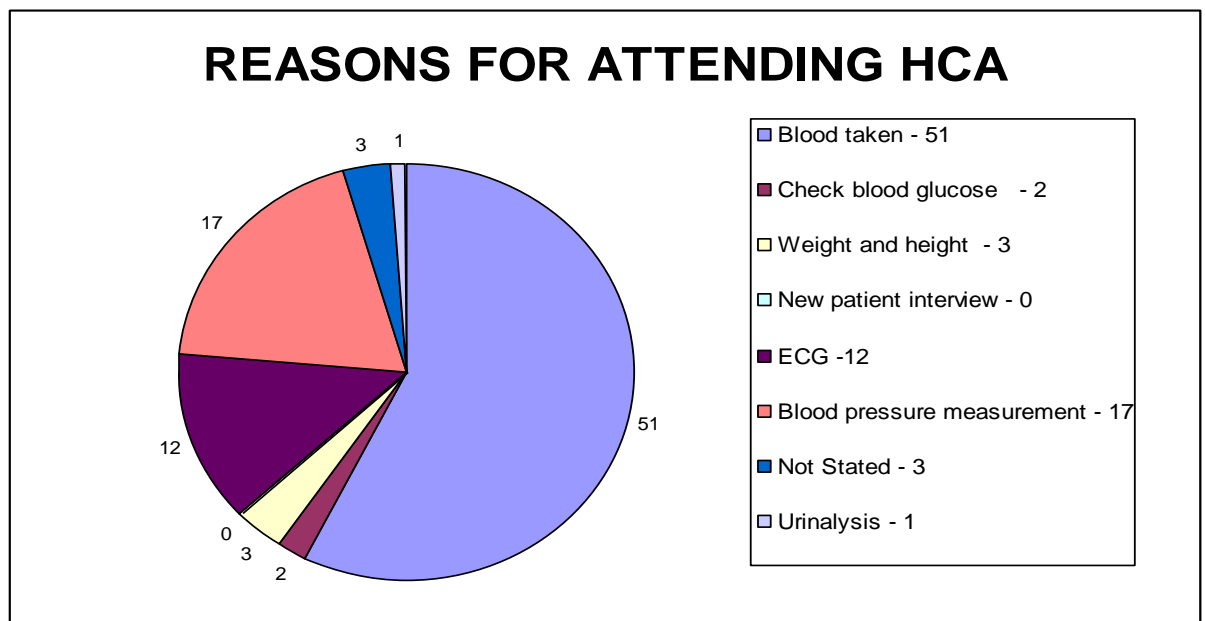


Table 1.7: Baseline study-reasons for patients attending HCA

There was confusion amongst some patients as to whom they expected to see at their first appointment with the HCA, for example while 29 patients expected to see the HCA, 20 expected to see the PN and 5 thought they would see the GP. The patient responses are summarised in Table 1.8.

Patients expectations at initial HCA appointment	
Patients expected to see HCA	29
Patients expected to see HCA or nurse	2
Patients expected to see nurse	20
Patients expected to see GP	5
Patient expected to see GP or nurse	1
Patient expected to see a phlebotomist	1
Patient non response	2

Table 1.8: Patient expectations at initial HCA appointment

The findings highlight the potential problem of the patients considering the HCAs to be a nurse if they are seen by a uniformed HCA and the role is not explained properly.

One patient wrote *'I didn't know until today that the new title was health care assistant.'* Some patients identified that they would have liked more information about the introduction of the HCAs. The patients recognised that the HCAs could attend to the routine appointments and so free up nurse and GP time. The potential benefits of seeing the HCA are summarised in Table 1.9.

Most important potential benefits of HCAs in general practice
18 patients identified getting an appointment more quickly as most important
11 patients identified seeing the same person each time as most important
7 patients identified the HCA taking time with them as most important
6 patients identified that the HCA answering questions as most important
6 patients identified 2 or more of the above as important
There were 12 no responses to this question

Table 1.9: Baseline study – HCAs potential benefits identified by patients

There was patient appreciation of the idea of allowing PNs and GPs to *'spend more time with urgent medical cases'*. Other patient comments included *'a great idea to spread the load'*, *'releases pressure on GPs'*, *'more time for difficult cases.'* In relation to service improvement, one patient wondered if HCAs could undertake dressings, another thought it was desirable for HCAs to interpret blood results, but recognised that they could not expect HCAs to do this and a third stated that they were unsure about the limits of the HCAs expertise. Only two patients expressed some caution about the benefits of introducing HCAs into General Practice: one indicated that there were no additional benefits over and above getting an appointment quickly and seeing the same person each time; the other thought that it was too early to comment on potential benefits, but was satisfied with the service received.

ii) Practice managers

The five responding practice managers commented upon their role in relation to the management of the HCAs as encompassing health and safety, arranging training, and workforce planning. There was clarity about the supervision of the HCAs lying with the PNs. Some HCAs who undertook a dual role and this meant that they were supervised by practice managers directly when in the administrative role and by the PN when working as a HCA.

All five practice managers considered the introduction of the HCA as beneficial. They considered that nursing staff, administrative staff, patients and GPs had all benefitted although the extent of enthusiasm for this agreed benefit appeared to be variable. Cost effective care and continuity of care were mentioned as beneficial. The issue of restricted availability of rooms for the HCA to see patients in was mentioned by one practice manager as a factor influencing the feasibility of introducing more HCA hours into the practice. However two other practice managers had increased the HCA hours.

The practice managers indicated that patient waiting times had significantly reduced after the introduction of HCAs. A key comment from one practice manager conveys the value attached to the HCAs; *'Despite initial reticence by some nurses we all really would not be without the HCAs now.'*

iii) Administrative staff

The six administrative staff who took part in the study responded positively. They all recognised the introduction of HCAs as beneficial in providing more appointments and in freeing up administrative time in that it became less difficult to identify and allocate appointments. Ease of access to appointments, continuity of care and seeing someone who was able to spend time with them were viewed as the major patient benefits by the responding administrative staff.

iv) GPs

The 4 GPs who completed questionnaires acknowledged that the day to day management of the HCA was undertaken by PNs and that the GPs were available should there be any further concerns or issues arising. All the GPs positively reviewed the HCA role. The personal qualities of the individual HCAs were recognised as contributing greatly to the benefits to staff and patients. One GP mentioned that patients who were seen by the HCA may feel more able to give information important to their care and so allowing the practice to expand data for the quality outcomes framework. Two GPs confirmed that they would consider employing more HCAs in future. One GP was uneasy about the dual role of HCA/receptionist and considered that the roles should be entirely separated because the dual role was confusing for patients.

v) Themes

Thematic analysis of qualitative responses across all groups identified 4 broad themes *freeing up time, caring, patient education and collaborative working*. The freeing up of PN, GP and administrative staff time was widely acknowledged across all groups responding. The caring aspect of the HCA role was mentioned particularly by patients. Patient education was recognised by all staff groups and patients as important and that more written information could have been made available for patients regarding the introduction of HCAs. GPs and practice managers identified the importance of education within the practice staff and patients about appropriate choices regarding who patients needed to make an appointment with and defining different staff roles. The need for collaboration was identified across all staff responses as important and most importantly patient collaboration and acceptance of the HCA role.

1.7.5 Conclusion to baseline study

The practice managers, administrative staff and GPs all agreed that the introduction of HCAs had been beneficial and respondents indicated that all staff groups and patients had benefited from the freeing up of time and appointments, although the extent of the enthusiasm for these agreed benefits was variable. The respondents considered that nurses were more able to engage in more preventative care as a result of the HCA support.

All the GPs and administrative staff taking part in the study were clear about the PN having the supervisory role over the HCA. Although it could be argued, as with Keeney *et al.*, (2005b), that responses may only be made up of the most interested parties and so may be somewhat biased. The practice managers had ideas about further development of HCAs and recognised the cost effective aspect of care. Suggestions about possible future development of the HCA role included health promotional and advisory work in smoking cessation and diet and exercise. Allowing HCAs to give flu vaccinations under robust protocols and covered by GP or nurse was also mentioned as a possibility.

However, one GP when considering future development of HCAs wrote:

'...there will have to be some kind of watershed between skills and knowledge for example compared to nurses or even doctors. Areas of judgement may arise.'

This statement seems to catch the essential dilemma in developing the HCA role. The extent to which this apparent initial role clarity and negotiation of role boundaries changes through time and the social and professional situation of HCAs in General Practice appeared important to consider in informing future practice and education.

The baseline study provided some evidence of a positive and collaborative response to change amongst practice staff with the introduction of HCAs.

The initial negative views of the HCA role by some nurses were referred to and to the change in nurses' opinions over time after clear lines of support and accountability were established. The enthusiastic patient response to the service provided by the HCAs is worthy of note as is the evidence of the reduction in waiting times for appointments. The HCAs when commencing the foundation course had named patient acceptance as the factor that was most important to them. The patients responding to the baseline study confirmed acceptance and a positive view of the HCA role.

Hence, the baseline study although limited in size and scope did uncover valuable information about the developing HCA role in General Practice locally. The role of the HCA in General Practice appeared to be evolving differently across diverse practice areas. There was little research available regarding the HCA role generally and evidence from General Practice was particularly sparse. It was considered that it would be interesting and informative to follow-up this subject up further to consider the HCA role as it developed through time and in differing General Practice areas. This baseline research conducted in 2006 served to generate my interest in exploration of the HCA role in General Practice from a longitudinal perspective for my doctoral studies and plans for this further work commenced late in 2006.

1.8 Summary and overview of thesis

This Chapter has set the HCA role in General Practice in historical and contemporary context and has also offered details of baseline research. Work on my thesis began in 2006 and the initial literature review was completed in 2007. The role of HCAs in different settings at this time was generally debated in health care journals (Mountford 1999; Wainwright 2002; Bates 2004; Green and Watson 2007). Some of the general comments upon the HCA role up to 2007 are noted briefly here. The introduction of HCAs has been viewed with great caution as nurses felt threatened and quality of care has been questioned (Gear 2004). Indeed, in order to preserve quality of care, it has been recognised that registered nurses need to have their skills supported by HCAs rather than replaced by them and that roles and responsibilities of each need to be transparent (Wilson 1997). Nevertheless HCAs have also been acknowledged as providing a vital contribution to health care provision (Theze 2004).

The literature review presented in Chapter 2 addresses the research literature available up to 2007 and additional relevant literature has been incorporated within the findings and theory chapters. Chapter 3 details the research design and methods of my study as well as discussing the choice of research methodology in relation to the research focus, aim and questions. The findings fall into three phases broadly related to the 3 years of data collection and are presented in Chapters 4, 5 and 6 maintaining chronological accuracy. Chapter 4 relates to an initial period, Phase 1, over approximately the first year of data collection and analysis. Chapter 5 covers Phase 2, the approximate time period of between 1 to 2 years of data collection and analysis in my study. Chapter 6 relates to Phase 3, the approximate period of two years onwards of data collection and analysis, when many of the remaining second interviews and postal follow-ups were completed. In Chapter 7 the development of my emergent theory of the evolving HCA role identity is detailed, the strengths and limitations of my study are discussed and recommendations for future practice and research are presented.

1.9 Overview of central argument of thesis

My emergent theory is that:

‘The HCA role in General Practice is incremental and is predicated on a search for belonging and occupational identity. It is developed and influenced according to the organisational dynamics and support for learning from within the specific small business environments of individual General Practices.’

As will be demonstrated in the theory the HCA role in General Practice in Scotland has proved unique and separate from other HCA roles in hospital and community. My study has identified growth in the HCA role in General Practice in Scotland and points to the importance of a supportive organisational environment. Initially HCAs sought to prove useful and to belong in their new role within the General Practice teams. Later they grew more confident and were respected by patients and staff and established a HCA occupational identity. Following on from this phase there was occupational role growth for the HCAs. The PNs proved pivotal in their supervisory role with the HCAs they mentored the HCAs and advocated for them. HCA and PN roles grew and developed alongside each other as PNs took on more complex work, reciprocal support was evident.

Chapter 2

Literature Review

2.0 Introduction

The literature review presented here addresses the literature available up to and including 2007 when the initial literature review was undertaken for my study. Subsequent relevant literature has been incorporated within the findings and discussion chapters. My study utilised grounded theory for which completion of an initial literature review is a debated issue and will be discussed further in Chapter 3 in Section 3.9. The relevant literature was identified by conducting an online search of electronic databases. The key words 'health care assistant', 'healthcare assistant', 'general practice', 'primary care' were also supplemented by nursing assistant 'health care support worker', 'support worker', 'practice assistant', 'assistant practitioner', 'lay health worker'. Searches were undertaken within CINAHL, Medline, PsycINFO, EBSCO, AMED to identify research studies and included related terms and dated from 1997 to 2007. Inclusion criteria identified prospective and retrospective studies published in the English language. Exclusion criteria included all material not in the English language, non primary research, studies carried out before 1997. The search was limited to 1997 as indicated in Chapter 1 page 4 the HCA role came into prominence later in the 1990's and research publications predominated during this period. Manual searches of books and journals and also of reference lists from review articles were undertaken in 2007, prior to the commencement of my research study. Within this Chapter the literature relating to the HCA role is firstly summarised in general, then examined within identified themes.

2.1 Summary of the literature

Tables 2.0 and 2.1 summarise all of the literature identified and included in this chapter.

A total of 43 studies were identified and as indicated in Table 2.0, 22 studies used qualitative approaches, 11 used a mixed approach and 8 adopted a quantitative approach. There was also variation in the size of studies with the majority being small scale studies.

An overview of individual studies which are grouped within themes and the key messages from the studies is provided in Appendix I. The themes identified within the literature review summary are systematic reviews, education of HCAs, multidisciplinary HCA/support worker roles, HCAs in nursing homes, HCAs in acute care, HCAs in primary care nursing teams, HCAs in General Practice and these form the subsequent headings of this Chapter.

Themes	Qualitative	Qual/Quant	Quantitative	Total studies
Education of HCAs	8	3	1	12
Multidisciplinary	4	3	1	8
Acute care	3	3	2	8
Nursing Homes	2	-	1	3
Primary Care Nursing	2	-	-	2
General Practice	3	2	3	8
Systematic reviews				2
Total	22	11	8	43

Table 2.0: Summary of number and type of research studies identified

The research studies originated from England, Scotland, Republic of Ireland, Netherlands, USA, Hong Kong, Taiwan, Australia, South Africa and Germany. The majority of publications were from the UK and the majority of the literature is related to training and education and/or acute hospital care. A break down of the number of studies by countries is provided in Table 2.1.

Studies outside Britain and Ireland number only 8 in total and have been undertaken in differing cultures and health care systems and do provide useful background to the HCA role in general but are not directly transferable to General Practice in Scotland.

Themes in the literature	No. of studies	Countries of origin
Systematic reviews (n=2)	1	South Africa / Germany
	1	Australia
Education (n=12)	1	Taiwan
	2	Republic of Ireland
	8	England
	1	Scotland
Multidisciplinary (n=8)	7	England
	1	Republic of Ireland
Nursing Homes (n=3)	2	USA
	1	Ireland
Acute care (n=8)	1	Hong Kong
	1	Republic of Ireland
	5	England
	1	UK
Primary Care Nursing (n=2)	1	England
	1	Scotland
General Practice (n=8)	2	Netherlands
	3	England
	3	Scotland

Table 2.1: Summary of themes and countries of origin of studies

2.2. Systematic reviews

Systematic reviews have been identified as making an impact upon the quality of primary studies for example by inspiring new research questions and allowing in-depth scrutiny of methods (Mullen and Rampirez 2006). Two relevant systematic reviews involving HCAs were identified.

From South Africa with support from within Germany, Lewin *et al.*, (2006) conducted a global systematic review of available research involving 'lay health workers' in primary and community health care in order to try to assess their effectiveness. The definition of 'lay health worker' used by Lewin *et al.*, (2006) does encompass the HCA role. Prior to this review there had only been 2 systematic reviews examining the effects of 'lay health worker' interventions in maternity care and these focused specifically on examining care during labour (Hodnett 2001a; Hodnett 2001b). The inclusion criteria for the systematic review were randomised controlled trials of interventions undertaken by 'lay health workers' to manage or promote health or provide support to patients in community or primary care settings. The authors found 43 studies meeting the study requirements of which 35 were from high income countries. The conclusions from the review were that lay health workers showed benefits in certain health intervention areas for example promoting immunisation uptake, improving outcomes of acute respiratory infections and malaria (Lewin *et al.*, 2006). The authors were unable to make general recommendations for practice from the diverse evidence reviewed for example they were unable to assess the effectiveness of training and intervention strategies and called for more research to be undertaken in this area (Lewin *et al.*, 2006). The direct application of the findings to the more focused HCA role in General Practice in the UK could only be on a very broad level.

A systematic review conducted in Queensland Australia by the Centre for Allied Health Evidence (CAHE) at the University of South Australia reviewed the use of community rehabilitation support workers (CAHE 2006).

The objective of the systematic review was to develop a comprehensive report identifying, appraising, analysing and synthesising literature on the models of development and utilisation of community rehabilitation support workers to inform future service provision. A total of 84 publications were identified of which 29 were narrative and opinion papers 28 were qualitative studies and 22 were quantitative studies, there were also 4 systematic reviews and 1 other paper included, with the majority of publications from the UK (CAHE 2006).

A consistent approach to quality scoring of research studies was undertaken using the NOTARI critical appraisal tool developed by the Joanna Briggs Institute (JBI 2004). The meticulous presentation of tables of all studies indicating quality scores, direct and indirect roles of HCSWs, models of service delivery and outcomes and competencies of support workers provide a comprehensive overview of studies. There was found to be little evidence focused upon support workers in community rehabilitation. This systematic review found there to be broad roles undertaken by support workers in direct and indirect patient care. Training and education was identified as very variable. This systematic review does provide a very useful and unique overview of the research relating to support workers available up to 2006 and the authors rightly identified a dearth of research specifically relating to support workers in community settings and called for more targeted research in this area (CAHE 2006). My research was therefore timely.

2.3 Education of HCAs

I identified 12 studies relating predominantly to the training and education of HCAs and HCSWs and in addition there were other studies presented in this chapter under other thematic headings (multidisciplinary support roles, acute care) that do also have an education related aspect. Education, training and supervision have been documented as important in developing the HCA role (Bates 2004; Hancock *et al.*, 2005; Smith *et al.*, 2006; McNab 2006).

Thornley (2000) reporting on an English national sample survey evidence from HCAs and managers and detailed case studies of HCAs in the NHS and

reported on educational issues. There were national questionnaire surveys in 1997 and 1998 in over 40 NHS Trusts. An equal number of questionnaires were randomly distributed within all Trusts in England and UNISON assisted in negotiations to achieve access to HCAs. Case study interviews took place in 10 NHS Trusts. In the 1997 survey managers (n=70) provided information about HCAs and HCAs (n=1031) responded to the survey giving an estimated response rate of 26-33%. In 1998 HCAs (n=862) responded and the estimated response rate was 22-29%. These make low response rates to the surveys which could indicate response bias in that there could be differences between participants and those who declined to participate (Polit and Beck 2009). However in the surveys accurate calculation of response rates was difficult due to the lack of accurate national statistics for this group of staff at the time (Thornley 2000).

Thornley (2000) provided a useful overview of the role of HCAs by analysing the responses to the national surveys reporting a huge variation in roles, levels of supervision and training. Thornley made a significant contribution to evidence by drawing attention to the great experience, competence and maturity of HCAs contribution to practice and the need for focus upon recognising the roles of HCAs and reappraising them along side registered nurses roles. It was recognised that NVQ qualifications provided potential for formal recognition of HCAs knowledge and experience.

An English phenomenological study into the experiences and perceptions of HCAs trained to NVQ level 3 found that they felt alienated from all grades of nurses but expressed improved job satisfaction (Warr 2002). The study included 6 participants, who had all previously worked as a health care assistant; they were individually interviewed following completion of NVQ level 3 training. The aim and methodology are not described in any detail although Hycner's (1985) 15 stage approach to data analysis was applied. Thematic analysis was verified by other researchers and individual participants so adding to the trustworthiness of the study (Gerrish and Lacey 2010).

Four themes emerged from the findings '*changing role boundaries and lack of clarity*', '*pecking order*', '*being in-between*' and '*real nursing*'. There is great

use of individual quotes from participants within this article which does help illustrate the themes and provide valuable insight into the experience of the participants. The study refers to the hierarchical structure of nursing and the tensions that role development adds to this. He suggest that there are direct parallels between participants and previous enrolled nurses however this is not substantiated by any direct reference to studies of enrolled nurses.

The author acknowledged the limitations of the study due to sample size and call for more research in this area and it would be interesting to discover if there have been any recent changes to the hierarchical structure of nursing brought about by the introduction of the KSF and Agenda for Change (DoH 2005).

There have been a considerable number of research reports regarding training and development of HCAs in the literature from the Republic of Ireland and Keeney *et al.*, (2005a) report on part of the evaluation a national HCA training programme there. In this study, a postal questionnaire returned by 70 managers of health care agencies gave feedback regarding the relevance of a national HCA training programme in Ireland to agency employment (Keeney *et al.*, 2005a). Most affirmed that they would employ HCAs trained in the programme and they also did not believe that the HCA role encroached on that of the nurse or midwife. A study limitation is that the questionnaire was not piloted increasing the risk of written questions being ambiguous or misunderstood (Polit and Beck 2009). It could also be argued that respondents to the questionnaires may be made up of only the most interested parties and so may have created bias in the study however the study response rate was good at 68% so reducing the likelihood of this bias (Polit and Beck 2009).

In another related qualitative research study in Ireland McKenna *et al.*, (2004; 2005) set out to ascertain the views of teaching staff and clinical assessors regarding the national HCA training programme.

Individual semi structured interviews were undertaken with clinical assessors (n=16) and teaching staff (n=26) from across 14 hospital and community pilot

sites in Ireland. Content analysis was appropriately utilised and a lack of experience and preparation for roles was captured. There was evidence of commitment to and value attached to the national training programme but also the frustration of competing demands in practice was evident.

Hancock *et al.*, (2005) in evaluating the impact of a HCA development programme on care delivery in hospital in England and the preparedness of HCAs to take on the training and new roles used a 360 degree qualitative approach to data collection. The term 360 degree approach is most commonly used to inform decisions regarding assessment and performance management and so was an appropriate method (Whitehouse *et al.*, 2002).

The 360 degree approach is used here by Hancock *et al.*, to indicate that different views were taken into consideration, semi structured interviews were carried out with HCAs, their colleagues and patients in order to get an all round view of the HCA role. The inclusion of different parties and the use of interviews instead of questionnaires could be said to provide richer data in this study (Gerrish and Lacey 2010). The study only included 3 HCAs but involved 24 of their colleagues and 9 patients and so the number of participants from the various parties varied and is acknowledged as a study limitation by the authors. Appropriate ethical approval for the study was obtained from the local research ethics committee. The findings indicated that HCAs were taking on roles normally associated with nursing and the ability to apply knowledge to practice was influenced by the culture of the ward in which the HCA worked, for example the existence of trusting and supportive relationships with colleagues enabled the HCAs to develop their role. Hancock *et al.*, (2005) appropriately acknowledged that any educational programme will be very dependent upon the organisational context in which it is used.

A specific skill focused education programme was undertaken by Chang and Lin (2005) who provided a training programme on patient feeding for nursing assistants working in dementia care and tested the effects of the training on knowledge, attitudes and behaviour and the effects on patients of feeding time, food intake and feeding difficulties. A quasi experimental design was used for the study in 2 hospital dementia units in North Taiwan. Sixty-seven nursing assistants took part (treatment group who had received the training n=31, control group who had received no training n=36).

Twenty four (n=24) nursing assistants and patients across both groups were observed during mealtimes to observe skills in feeding. Results showed that the treatment group had significantly more knowledge, more positive attitudes and behaviours and also there was an increased eating time for the patients. This study could be said to be ethically contentious as it has included observation of patients with dementia who would not have the capacity to give informed consent to take part in the study.

However the study was examined and approved by the review board in Taiwan and consent forms were completed by legal guardians of the patients observed. The nursing assistants also completed consent forms. Three of the four instruments used in this study to measure nursing assistants' responses were developed by the investigator but were reviewed by a gerontological expert to provide content validity. The use of previously widely used and validated instruments is highly desirable in experimental studies (Gerrish and Lacey 2010).

Another national educational programme for health care workers, the cleanliness champions programme (NES 2005), on prevention and control of health care associated infections in Scotland was evaluated through a questionnaire survey of participating health care workers from different disciplines and also by interviews with 20 key informants (West *et al.*, 2006). The overall response rate for the questionnaire was 40% of the total programme participants (801/2,025) and 44% (161/367) for mentors.

Sixty five HCAs responded making up only 8% of the total responding programme participants. This is a very low response rate and so could not be said to be representative of HCAs but the study does offer some specific analysis of the HCA responses in that the HCA respondents were very positive about the programme and about their ability to change practice although there was recognition that there were difficulties for them in challenging the bad practices of more senior staff. West *et al.*, (2006) recognised that findings regarding HCAs suggested that the knowledge and skills gained from the programme served to underpin feelings of affirmation and recognition.

This may be particularly relevant when training opportunities in this field for HCAs are often extremely limited despite their important contribution to care provision (Gould 2005).

There has been one significant UK development opportunity for HCAs offering secondment opportunities to some experienced HCAs onto pre-registration nursing programmes. There was qualitative research undertaken in England available examining the role transition experiences of these secondees (Gould *et al.*, 2006; Brennan and McSherry 2007). Gould *et al.*, (2006) conducted in depth individual interviews with 4 newly qualified nurses who had been HCAs and they also interviewed ward managers, preceptors and clinical practice facilitators on the 4 wards that the nurses had been seconded from and had then returned to after qualifying. They carried out a thematic qualitative analysis to explore the role transition of newly qualified nurse who had been HCAs. The findings indicated apparently limited benefits from previous HCA experience in preparing the nurses for registration and the participants described fear of failure as being great due to the public consequence of returning to their workplace as a HCA rather than a staff nurse.

The 4 participating newly qualified nurses came from a group of 11 possible participants and it could be argued that perhaps the study design may have bearing upon the fact that only 4 of the 11 agreed to participate in the study. Perhaps opening themselves up to evaluation by 3 different staff members they had worked with (ward manager, preceptor and clinical practice facilitator) could have appeared daunting to the newly qualified nurses. An evaluation by preceptors only may have yielded more consent to participation and more relevant data. As there is very little research evidence available about the experiences of newly qualified nurses, a comparative study including other newly qualified nurses may be a consideration for the future as it is inherently difficult to identify to what extent former HCA status is a factor in adjustment to registered nurse status. In examining these studies I became more aware of the significance of following up the HCAs over time as they progress in their learning and in their role in General Practice.

Brennan and McSherry (2007) carried out a descriptive qualitative study, in England, with 14 student nurses participants who had previously been HCAs. Four focus groups (FG) were undertaken (FG1 n=4, FG2 n=4, FG3 n=3, FG4 n=3) at intervals throughout their adult nurse education and at the end of the course. Content analysis identified themes of 'culture shock', 'comfort zone' and 'clinical issues' (Brennan and McSherry 2007).

This study is to be commended for using 'member checking' to enhance rigour, a participant from each small focus group was asked to participate directly in identifying the key categories and themes (Holloway and Wheeler 2010). The findings included identification of a retreat of the students into HCA role when under pressure when first attending a new placement and the difficulties of getting relevant experience when forced return HCA role occurred due to staffing difficulties. Individual quotations from the nurses do provide very valuable insight into the experience of this group and appropriately reflect the themes.

Another qualitative study in England by Wood (2006) (n=8) followed the socialisation of seconded HCAs during preregistration nurse training and found this to be very different to other pre registration nursing students. The eight participants formed a purposive sample making up all of the seconded HCAs within a cohort of 14 mental health student nurses. Wood (2006) carried out semi-structured focus groups on a yearly basis during nurse training and undertook thematic analysis of data and identified a unique socialisation process with differing levels of guidance and expectations from mentors and other nursing staff. It could be argued that only yearly focus group follow-up may not equate to adequate in depth data given the constantly changing experiences within nurse education and possible memory decay. However there is no report of any attrition from the group of eight and achieving follow-up of complete cohort overtime makes data collection comprehensive.

Hibbert (2006) conducted a scoping study in England to gain insight into the career progression of HCAs. Hibbert commented that statistics showing HCA secondment and progression rates into nurse education were not easily extracted from other more general figures available. Department of Health information showed overall national achievement of only 37% of target NVQ qualifications for HCAs (DoH 2005). Semi-structured telephone interviews with NHS strategic health authorities and workforce development directorates in England (n=28) were conducted to find out why HCAs did not progress into nurse education and this was compared to actual progression figures. Hibbert (2006) identified the following as factors influencing the low rate of secondment of HCAs: Financial support; low number of available secondments; lack of recognition of existing knowledge; lack of confidence in academic ability and lack of workplace and education providers supportive powers were the influencing factors (Hibbert 2006). The research does shed some limited light upon the figures available regarding secondment and progression of HCAs and called for more robust and transparent systems designed to furnish HCAs with learning opportunities and recognition and accreditation for prior learning (Hibbert 2006).

The training of support workers with more extended roles became the focus of research when trainee assistant practitioners (n=50) who completed a two year Foundation Degree programme in Greater Manchester were consulted by Benson and Smith (2006). The programme was evaluated using both interviews and questionnaires. Thematic analysis of recorded and transcribed interview data was undertaken and descriptive statistics presented from questionnaire responses. The trainees identified difficulties in finding time to study (n=42) and difficulties in gaining understanding of their role in their working environment (n=37). Overall the Foundation Degree was viewed as supportive of the trainee assistant practitioners but there were difficulties associated with securing placements and there was found to be some resistance in practice to assistant practitioner roles.

The above studies serve to highlight the significance of HCA education and the changing role of HCAs. There was an absence of studies examining education for HCAs working in a primary care setting and also only one study identified from Scotland. In relation to my study the lack of evidence reinforced the relevance of following up the HCA experience in General Practice in Scotland and also doing this over time in order to gain understanding of the social processes taking place in General Practice which could inform future educational practice in this area.

2.4 Multidisciplinary HCA roles

The development of the support worker role within nursing has been followed by development of the support worker role within midwifery (DoH 2004). In other health professions the support worker role has developed within physiotherapy, occupational therapy, podiatry, radiography, speech and language therapy and dietetics with some support workers undertaking a generic role supporting more than one professional group (DoH 2004). Examination of the 8 research studies identified in this literature review examined the following roles:

- 1 study exploring community mental health support workers,
- 2 studies of support worker in maternity care
- 1 study of physiotherapy assistant role
- 1 study of occupational therapy assistant practitioner
- 3 studies of generic rehabilitation assistants

It was considered useful to examine the literature around support workers for other professions as it was considered that the assistant role may have parallels that could be applied to the HCA role in General Practice.

Murray *et al.*, (1997) undertook a mixed methods study in 3 stages in England investigating the support worker role in community mental health services. This work from the Sainsbury Centre for Mental Health in London built upon previous reports from the Centre carried out in England that had identified that the support workers were among the youngest and least experienced members of the community mental health teams (CMHTs) who often felt undervalued while carrying the largest proportion of people with severe long term problems on their caseloads (Onyett *et al.*, 1994; 1995).

In the first stage of the 1997 study in order to explore expectations of HCSWs in the mental health field 25 senior professional and user representatives in mental health (n=25) deemed to be experts by the researchers were interviewed individually about the role and function of HCSWs in the community mental health services (Murray *et al.*, 1997).

Choosing participants for a study in this way could be controversial if they are not carefully selected but the experts were identified appropriately because of their exposure to the HCSW role. In Stage 2 the study set out to establish to what extent the experts views explored in Stage 1 corresponded to the everyday practice in the CMHTs and there was found to be some variation. There was a good number and range of staff recruited to the study (n=214) from 30 teams across 25 NHS trusts and 4 local authorities within this sample were 62 HCSWs.

The tasks undertaken by professionals in teams with HCSWs were compared to those undertaken by teams without HCSWs. Stage 3 of the study explored users (n=44) experiences of and views regarding HCSWs. The study concluded that the contribution of HCSWs to CMHTs was greatly valued and should be reviewed by managers with a view to increasing numbers where appropriate. Eight recommendations were made including setting out the need for supervision, appropriate caseload, training and feedback. This study design was broad ranging and has provided some comprehensive basic information about HCSW roles in CMHTs that had been previously unexplored.

I identified two studies examining support worker roles in maternity services, one in the UK investigating the cost and effectiveness of postnatal support workers by Morrell *et al.*, (2000) and another in Ireland examining HCA duties in a maternity department by Hasson *et al.*, (2005). Morrell and colleagues undertook a randomised controlled trial with 6 month follow-up. Ethical approval for the study was given by the local NHS ethics committee. The participants were 623 postnatal women allocated randomly to the intervention group (n=311) and control group (n=312). The intervention was up to 10 home visits in the first postnatal month by a community postnatal support worker compared to standard visits by community midwives. The results indicated that there were no health benefit or cost savings in the additional home visits by the postnatal support workers. It does appear that a further qualitative study to evaluate the postnatal community support workers contribution to postnatal care would have made a useful addition to the evidence presented in this study.

In contrast the other study in maternity care by Hasson *et al.*, (2005) in Ireland was a small part of the research into the national HCA training programme. This exploratory research used non participant observation with six HCAs in a maternity unit to investigate the relationships between HCAs and midwives following HCA training. Findings confirmed that HCAs were working within the scope of their training, were acting to support registered midwives and were undertaking more indirect than direct patient care.

The use of non participant observation may have influenced the practice of participants who could have behaved differently knowing they were being observed and if the observation was undertaken by a familiar person then preconceived ideas may have influenced judgement on practice observed (Gerrish and Lacey 2010). Hasson *et al.*, (2005) called for further research in this area.

Ellis and Connell (2001) investigated the factors affecting the changing role of physiotherapy assistants and sought the views of physiotherapy assistants and their supervisors on future role development. Semi structured interviews were undertaken with a stratified random sample of 18 physiotherapy assistants (n=18) in the South and West England. This sampling technique is useful in ensuring that responses are more likely to be representative of the physiotherapy assistants as a whole (Polit and Beck 2009). Separate interviews were undertaken with the supervising physiotherapists (n=18). The individual interviews are to be commended as they would ensure privacy to disclose individual views (Holloway and Wheeler 2010). Thematic analysis of data in the study identified variation in practice activities and levels of supervision. Shortages of qualified staff influenced practice development. Areas of concern were raised around training, responsibility and supervision levels and also the future introduction of a generic support worker role.

The changing occupational therapy assistant role was studied by Nancarrow and Mackey (2005) who in a qualitative study evaluated the role of occupational therapy assistant practitioners who had an extended support worker role in North Staffordshire NHS Trust in England.

Four focus groups took place one with assistant practitioners (n=5); a second with their supervisors (n=5); a third with managers (n=4) and a fourth with service users (n=3). The size of the focus groups is very small and the total numbers of possible participants were also limited.

There is no agreement in the literature about the optimum size of focus groups, it has been stated to be between 6 and 10 persons (Polit and Beck 2009) but it has also been identified that the aims of the research should dictate the size of the focus group alongside the guide used and level of structure of the group (Kroll *et al.*, 2007). The focus groups here commendably did have a time span of up to two hours; an independent external facilitator; all had the same introductory session and were asked to consider the same key areas thus demonstrating consistency in their approach. The study identified a lack of accessible appropriate training, difficulties surrounding supervision and accountability and a need for career direction for qualified occupational therapists to reduce uncertainty around role transition.

Three studies within England examined the support worker role in rehabilitation services (Knight *et al.*, 2004; Nancarrow and Mackey 2005; Stanmore *et al.*, 2006). Knight *et al.*, (2004) carried out a descriptive evaluation using a case study approach to examine the work of thirteen rehabilitation assistants working in different rehabilitation teams including hospital and community teams, orthopaedic and stroke teams. The authors analysed the daily activity record sheets of rehabilitation assistants and undertook semi structured individual interviews with them. The think aloud method was used by the researchers and this involved participants using audio recordings to talk about their thinking, problem solving and decision making during their working days (Polit and Beck 2009). The study identified that mobility, washing and dressing and activities of daily living constituted most of the average daily activities with nursing and speech and language therapy skills being used less frequently. The rehabilitation assistants were found to be able to consider the reasons behind their activities as opposed to just carrying out tasks (Knight *et al.*, 2004).

Nancarrow *et al.*, (2004) undertook a baseline survey questionnaire in England which collected data from 33 intermediate care services which were involved in an Accelerated Development Programme for support workers. Fifty services actually participated in this programme and hence the 33 responses constitute an acceptable response rate of 66% (Gerrish and Lacey 2010). Responses indicated that there were 794 support workers and 386 professionally qualified staff within the 33 teams. All teams had some form of training available to support workers and in house training and NVQs were the predominant sources of training. In 80% of the participating services at least 50% of the support workers had a qualification. Supervision models varied between mentoring, team supervision and formal and informal line management. This study is significant in that it serves to capture a snap shot of some of the characteristics and diversity of employment of support workers in intermediate care in England.

Stanmore *et al.*, (2006) undertook a qualitative study in one region in NW England to evaluate the impact of rehabilitation assistants from the perspective of patients (n=14), nurses (n=8), therapists (n=9), managers (n=9) and the rehabilitation assistants (n=15). In only taking the sample of participants from one region in England the study has a more limited general application than a broader sample would offer. Fifty five individual semi structured interviews were undertaken and subjected to thematic analysis. Patients, professionals and rehabilitation assistants expressed satisfaction with the rehabilitation assistant role but ward routines and organisational systems were found to interrupt rehabilitation programmes for patients. The direct quotes included within the presentation of the study cast valuable light upon attitudes to and issues surrounding this emerging role.

Clearly the growth of the support worker role across different professional backgrounds has increasingly become the subject of research with a predominance of studies coming from England. In terms of my research study this evidence served to reinforce the value of following up the developments within General Practice and the particular value of doing so in Scotland.

2.5 HCAs in nursing homes

Only three studies of support workers in nursing homes were identified, two from USA and one undertaken in Ireland. In 1999 Friedman and colleagues undertook a survey of support workers in nursing homes in the USA to investigate and compare job satisfaction in 5 homes that were using a programme of all inclusive care of the elderly (PACE) which incorporates an interdisciplinary collaborative approach to patient care with 5 homes that did not utilise this programme. There were 191 nursing assistants of which 136 participated (71.2% response rate) at the PACE sites and 397 at the other nursing home sites of which 213 participated in the study (53.7% response rate). These response rates differ but statistical analysis took this factor into account. Other influencing factors regarding completion may be that the questionnaires were in depth and took around one hour to complete and that the assistants were all paid a nominal sum of money to complete the forms.

Questionnaires responses were appropriately analysed and found to show statistically significant differences in responses. The support workers who were on the PACE programme were found to have higher job satisfaction than other support workers with a mean score of 3.53 in MSQs compared to 3.29 from other support workers (out of possible scores ranging from 0 to 5). This satisfaction was identified as linked to being able to have more control over suggestions made about patient care. There was no difference between the two groups in the perceived importance of job elements and *'respect for my suggestions by people who make decisions about patient care'* and *'receiving positive feedback'* were rated of highest importance (Friedman *et al.*, 1999). This study is interesting to consider in contrast to the following research by Jervis (2002).

Jervis (2002), an anthropologist, in a qualitative study in USA explored the relationship between registered nurses and support workers in a single nursing home.

Jervis indicates that ethnographic methods were used to explore the power relationships between the two groups of staff. Interviews across all levels of nursing and aide staff were audio taped, transcribed and analysed and observations were undertaken in this study but scant information is provided about the study format and the number of interviews is not stated and this lack of transparency serves to detract credibility from the study. Commendably ethical approval for this study was secured and the details of home were changed to protect anonymity also the study findings were noted to have been reviewed by 3 other academic colleagues. Despite the lack of detailed study design the thematic representation of staff relationships within the nursing home make powerful reading. The turnover rate of all employees within this nursing home was 77% of all employees but turnover rates for all nurses' aides in the USA range from 40% to 200% (Kiyak *et al.*, 1997). Thus this would appear to be a subject very worthy of investigation and is interesting to compare to General Practice in the UK where staff turnover appears low (Andrews and Vaughan 2007). The research findings include direct quotes from participants and convey a sense of deep divisions amongst staff and the very hierarchical nature of the workforce with task orientated approach to work and tasks being handed down to aides and being considered as beneath nurses to complete rather than there being any sense of team working present. The nurses' aides felt devalued and inferior. Thought provokingly the paper goes onto draw parallels between these relationships and those between nurses and doctors in the sense that nurses have strived for professional status alongside medical colleagues. Overall this paper does not give evidence of a coherent research design which would have made the findings very much more robust.

Coffey (2004) explored the perceptions of nurses and care attendants regarding training for care attendants in two long term care of older people settings in Ireland. A qualitative study was undertaken with nurses (n=40) and care attendants (n=40) who took part in completion of questionnaires containing open ended questions. Construction of the questionnaire was informed by the issues raised in a focus group with 8 of the care attendants.

The total number of participants represented 50% of the total nursing and attendant staff in both facilities. The data were subjected to content analysis and 3 main themes were identified '*attitudes to training of care attendants*', '*perceived links between training and role ambiguity*' and '*nurse involvement in training.*' A positive attitude towards training for care attendants was uncovered and a perceived link to training and the blurring of the boundary between the attendants and nurses roles. Nurses were positive about the provision of training for care attendants but were not motivated towards active involvement in this. Limitations of the study are acknowledged in that findings are not generalisable but do add insight into a very under researched area. Overall it appears that despite increasing reliance upon support worker roles in nursing homes there is a great paucity of research in this area. The research studies examined here from USA and Ireland, whilst not directly transferable to General Practice in Scotland, do serve to highlight the significance of training and staff relationships to support worker function.

2.6 HCA roles in acute care

In Hong Kong, Chang *et al.*, (1998) in a quasi-experimental designed study compared observed activities of 8 HCAs and nurses in 4 hospital wards (2 HCAs in each ward) before and after the introduction of HCAs. A control group of 4 ward areas without HCAs and with similar patient numbers, gender, diagnoses and staffing levels were included in the study. It could be argued that the quasi experimental design weakens the evidence as it is not a true experiment with random assignment of the participants, but in the ward setting it would possibly have been impractical to establish the full experimental control of a randomised controlled trial. It could be argued that the use of non participant observation to collect data could have increased the risk of bias due to the possible 'Hawthorne effect' upon those being observed and 'halo effect' upon observers (Nisbett and Wilson 1977; Polit and Beck 2009).

Instruments developed by Hovenga (1990) were used by Chang *et al.*, when considering activity levels in the wards, patient dependency (a contributing factor to activity levels) was calculated and activities were categorised into patient care (performed in the patients presence and sub divided into basic and technical care), indirect activities (contributing to patient care but performed away from patient) and non-productive activities (personal activities- tea, meal breaks etc) accordingly. The study found a reduction in both direct and indirect care provided by nurses, with HCAs taking on more fundamental than technical and indirect care. The study concluded that HCAs had the potential to help overcome difficulties associated with shortages of nurses but that the increased work of nurses in delegation and supervision of HCAs also should be considered. This study in Hong Kong may not directly translate into the UK setting as professional roles, hospital organisation and other factors such as cultural differences will apply.

There has been research focused upon support roles in critical care and intensive care areas within the UK. Wainwright (2002) examined questionnaires completed by 24 intensive care nurses regarding the perceived function of HCAs in one unit and so due to the small number of participants and single location the findings are not generalisable. The questionnaire was constructed with some reference to previous questionnaire construction upon this topic, contained open ended questions and was appropriately piloted with 2 persons. Thematic analysis of responses revealed that there was consensus in recognition of the supportive role of HCAs but some concern was expressed about the scope to develop the HCA role into direct patient care within the complex intensive care environment and that completion of routine tasks without investment in development may lead to frustration and complacency over time (Wainwright 2002).

A large survey examining views on HCA roles in critical care was undertaken by the British Association of Critical Care Nurses (BACCN) in 2003. The questionnaire used had previously been constructed and used by the University of Salford in a study in Greater Manchester.

This questionnaire was adapted and sent out to all senior nurses in critical care units in the whole of the UK. However given that responses may have been delegated to more junior nurses and no recording of the grade of the staff actually completing the returned questionnaires was made, any difference in response across grade of nurses in the critical care team was not captured. The adapted questionnaire was not piloted any further and ethical approval was not obtained for the questionnaire and so extensive scrutiny, feedback and permissions regarding the questionnaire composition and circulation would not taken place, however these limitations are acknowledged within the study. Overall, 376 responses were received representing a response rate of 58% which is relatively high (Polit and Beck 2009) and indicates a good level of interest in the topic but it could be noted that this could perhaps have been even higher with attention to questionnaire piloting and ethical approval. The statistical package SPSS was used to collate and analyse data and qualitative data were analysed thematically. The research does legitimately illuminate the extent of critical care assistant (CCA) employment, their grades and titles, the range of tasks undertaken by CCAs and a view was expressed that the role of the assistant in critical care was not fully understood by everyone in the multidisciplinary team and should be examined further alongside examination of the impact upon the role of the registered nurse in critical care (BACCN 2003).

Later on in 2007, McGuire and colleagues reported on the implementation and evaluation of the critical care assistant (CCA) role and in a study of nine assistants who were employed over six critical care units. The evaluation had 3 stages over a six month period. Stage one included stakeholder completion of questionnaires about the appropriateness of education and training of the CCAs. The questionnaire was designed with support from local experts and was piloted and amended to reduce the likelihood of question ambiguity. Three critical care assistants (n=3) completed the questionnaire in stage one giving a low response rate of only 33% that may then not have been representative of the group. Other respondents in stage one were mentors (n=4), doctors (n=11) and senior nurses (n=6).

The second stage also involved a questionnaire given to patients and carers on discharge from the unit to the ward environment. Again the questionnaire was carefully designed with support but unfortunately out of the 120 questionnaires for distribution only 2 were returned from patients and 2 from carers. It does appear that the method of distribution which was by hand and timing of distribution at transfer out of the critical care unit may have had an adverse effect upon completion rates. The third stage of the study involved attendance at focus group interviews. Two focus groups were undertaken one with seven CCAs and the other with eight mentors and assessors. Thematic analysis of the interviews and questionnaires was undertaken and the findings indicated that the assistants felt confident and well prepared for their role. There was some evidence of the role easing workload pressures on qualified staff and the patients and carers evaluated the role positively.

As mentioned previously, there have been a considerable number of research reports following implementation of a national HCA training programme in the Republic of Ireland. Keeney *et al.*, (2005b) reported on a hospital focused part of the evaluation the national HCA training and development programme in Ireland. Survey methodology was used to gain information about nurses, midwives and patients perceptions of HCAs, however, this was only undertaken in one hospital randomly selected from fourteen hospitals.

A questionnaire was developed and piloted with a sample of clinical staff outside the study sample and following on from the pilot minor modifications to wording was made. Twenty five questionnaires in total were completed by staff from Theatre (n=9) and from Maternity (n=16) and women who received maternity care were interviewed (n=6). Analysis of responses was supported by use of the statistical package SPSS and group frequencies were calculated for each question and qualitative responses were the subject of content analysis. This study offers a restrictive sample, small and unrepresentative of all hospital areas however the authors do recognise limitations and point to positive views about HCA roles in all response groups, there was perception that HCAs made a valuable contribution to care and there was satisfaction with this contribution.

Spilsbury and Meyer (2004: 2005) in research using both qualitative and quantitative approaches in England explored HCAs work and the implications for registered nurse roles in an NHS hospital. The hospital was examined as a case study and survey, interviews, participant observation, focus groups and documentary analysis were undertaken. The study was built upon what the HCAs said they did in comparison to what was actually observed to happen in practice. Stage one involved individual interviews with HCAs (n=33). The second stage involved participant observation of 10 HCAs for a total of 220 hours. The third stage involved 4 focus groups with registered nurses convened by grade to gain their perspective on the HCAs interviews and observations. One focus group was undertaken with clinical lead nurses (n=22), a second with charge nurses (n=14), the third with senior staff nurses (n=19 and a fourth with junior staff nurses (n=14). SPSS was used to examine demographic and biographic data enabling a description of the HCA workforce in the hospital and the qualitative interview transcripts and observation field notes were analysed 'according to the broad principles and techniques of grounded theory' (Spilsbury and Meyer 2004, 413). The findings identified that registered nurses were taking on extra duties from medical staff and also conceding some of their role to the HCAs. The study uncovered deviations in practice from policy expectations and in the clinical environment the HCAs role was actively negotiated between registered nurses and HCAs. The study although undertaken in just one hospital by building analysis around the three distinct stages it does provide some in depth insight into factors influencing HCA activities. The authors called for registered nurses to consider and plan supervision and monitoring of HCAs.

An action research study by Atwal and colleagues (2006) in London explored the perceptions of nurses, HCAs, doctors and therapists of rehabilitation and the role of nurses and HCAs in one older adult hospital ward. Semi-structured individual interviews (n=24) and thematic content analysis were undertaken. Two researchers compared and discussed their coding and analysis was fed back to participants for comments on accuracy thus increasing the trustworthiness of the findings (Gerrish and Lacey 2010).

The study revealed three themes, '*understanding rehabilitation*', '*role perception and education*' and '*training and competencies*'. The study indicated that therapists relied on nurses and particularly HCAs for therapy carry-over. Only 3 people (1 doctor, 1 nurse and 1 OT) emphasised that rehabilitation was a process that involved the patient. The study identified views that HCAs should be more involved in decision making and discharge planning and findings indicated that their potential contribution was being overlooked.

Herbertson *et al.*, (2007) examined the role of clinical support workers in a teaching hospital in England and their ability to reduce the workload intensity of junior doctors whilst maintaining quality patient care. Two audits were undertaken 8 months apart. The first audit was to determine areas where clinical support workers would make a big impact. In this 50 junior doctors out of a possible 160 completed audit forms when on call during a 32 day period giving a poor response rate of 31% and so bringing into question the degree to which the responses can be taken to be representative of the group of junior doctors (Polit and Beck 2009). The second audit was to determine if the support workers had influenced the intensity of the work done by junior doctors and during this second 32 day period of audit junior doctors (n=49) completed forms regarding their activities.

The researchers acknowledge the poor response rates but the two audits had similar levels of response and the HCSW influence upon the number of activities undertaken by the doctors was clear from the results. A 32 day period is a lengthy time for an individual to maintain an accurate and detailed audit and the amount of detail recorded on the forms would be interesting to review. A comparable audit of all the activities of the clinical support workers could have perhaps yielded more robust information on this topic. The study did conclude that support workers had vastly reduced the number of venepunctures and cannulations undertaken by doctors and patient care was deemed to be uncompromised.

In summary, studies identified from acute care settings examining varied aspects of HCA activity. The majority of the studies identified were undertaken in England with only one UK wide study. The relationship of the HCSWs with registered nurses and with junior doctors has been a focus in the studies examined in acute care. This served to reinforce my interest in examining further the working relationships between HCAs and PNs in General Practice in Scotland thus informing my second research question asking how PNs perceive and experience the HCA role on an ongoing basis.

2.7 HCA role in primary care nursing teams

McIntosh and colleagues (2000) explored ways in which grade and skill mix of nurses and HCAs are taken into consideration in the delegation of nursing care in community nursing. The qualitative ethnographic research study took place across two health board areas in Scotland and had a good sample size drawn from twenty one district nursing teams and seventy six HCAs and district nurses participated. The study findings demonstrated similarly to those of Murray *et al.*, in 1997 in CMHTs, a variation in the responsibilities delegated to HCAs and also identified that the role of the Senior Grade of District Nurse was of central importance to team function.

England and Lester (2007) undertook a qualitative study in Birmingham to explore the views of GPs, primary care teams and patients on the value and development of the new role of primary care mental health workers. Primary care mental health workers are defined as *'offering brief evidence-based interventions to patients, develop practice infrastructure and establish links with the wider mental health community'* (England and Lester 2007: 204). Seven workers were attached to General Practices and six of the seven practices agreed to research follow-up. Thirty-seven semi structured interviews were undertaken and took place with the 7 primary care mental health workers and 21 patients. There were 11 focus groups involving 38 members of the 6 participating primary care teams and primary mental health workers, focus group size ranged from 3 to 7 participants.

Findings indicated that the new role had been implemented variously and those that had taken into consideration the views of managers, teams and workers had been most successful.

The need for rapid access to health care professionals at crisis points was recognised and the befriending role of the workers was viewed very positively. The mental health workers did sometimes feel professionally isolated and there were some tensions around ownership of the role as the mental health workers worked between the primary care trusts and the General Practices themselves.

Studies specifically examining HCAs in primary care in general are not well represented in the literature. The two studies examined in this section indicate a variation in the development of responsibilities of the HCAs across different areas in primary care. Leading on from this consideration of the factors that aid and hinder the HCA role development in General Practice in Scotland appeared very relevant.

2.8. HCA role in General Practice

Specific examination the literature relating to HCAs in General Practice reveals that there has been controversy about the scope and quality of practice.

An early small pilot study in Camden and Islington of seven General Practices employing HCAs in England was described by Holmes (1998). Evaluation of HCA role was undertaken by collating opinions of HCAs and the practice team and by a patient survey. Details of ethical approval, data collection and analysis are not offered so full evaluation of the study is not possible. Six PNs involved in the evaluation responded positively to the HCA role. The description of the evaluation is very brief and not comprehensive and so the robustness of the study design and delivery is in question.

Findings indicated that there were concerns about training and supervision of HCAs in General Practice and responses from patients were also described as positive but detailed responses were not presented and therefore findings cannot be viewed to be credible.

In the Netherlands, spirometric testing in General Practice by GPs and practice assistants, following a training programme, evaluated very well compared to tests taken in specialist pulmonary function laboratories within hospitals (Schermer *et al.*, 2003). A comparison of the accuracy of spirometric test results across the two different settings was undertaken. The study was carried out over a 2 year period involving 388 subjects across 61 general practices and 4 laboratories. The number of tests undertaken was deemed large enough to be statistically significant and the support of a statistician was evidenced (Harris and Taylor 2008). Consistency of test results across settings allowed researchers to point to the suitability of General Practice in the provision good quality spirometry as an alternative to hospital laboratories. The study supported the good quality of pulmonary function tests undertaken by practice assistants working alongside GPs in General Practice in the Netherlands.

A randomised controlled trial by Hesselink *et al.*, (2004), also in the Netherlands, showed sustained improvement in inhaler technique in asthma and chronic obstructive pulmonary disease (COPD) patients after the intervention which consisted of individually based education was given to patients by practice assistants whilst the control group patients received the standard interventions available to COPD patients. The study was undertaken over a 2 year period involving a control group of 137 patients and intervention group of 139 patients (Hesselink *et al.*, 2004). The positive results indicated offering support for the exploration of more structured education programmes. A larger study may have proved statistically conclusive in more areas as the study showed no significant differences in quality of life, smoking cessation, compliance and coping and the support of a statistician would have been useful (Harris and Taylor 2008).

However the study does indicate that there were a large number of patients who either refused to take part in the study or later did not respond. Ensuring high enough numbers of participants fulfilling selected requisite characteristics for RCTs and sustaining input over time can be problematic (Burns and Grove 2009).

There was some reference to evidence that HCAs have significantly reducing waiting times in General Practice in England; Joels and Benison's (2006) report of a HCA Conference presentation indicated that a pilot study in Bristol demonstrated that the introduction of HCAs had resulted in a reduction on patient waiting times to see a nurse. Comment upon the robustness of the study is not possible as few details are offered

A scoping study, involving a focused and systematic literature review, in 2006 by Longbottom and colleagues set out to inform the development of a support package to facilitate the employment, training and career development, skill mix and standards in General Practice nursing including HCAs. The study was undertaken to inform the NHS Working in Partnership Programme (WiPP) project to support PNs and HCAs in General Practice in England. A template of 19 fields was created covering the scope of the intended General Practice and HCA support materials. A team of people were employed to undertake the scoping exercise and multiple online and hand searches of literature were undertaken. The scoping study identified that the provision of health care services were moving from secondary to primary care and that roles and responsibilities have been introduced and were expanding in line with practice and community needs. Whilst rapidly executed for a specific purpose, this review of the literature although not on a par with systematic reviews has merit in providing background information not least in that it includes multiple case examples of skill mix in a variety of General Practices.

A qualitative study conducted to investigate the effectiveness of five general practice assistants in Scotland was conducted by Phillip and Turnbull (2006). The five trained General Practice assistants and their clinical supervisors who were GPs or PNs were interviewed individually.

The interviews were audio taped and transcribed and thematically analysed. Themes emerging from the analysis were *educational effectiveness, knowledge gain, personal development, role development* and *service provision efficacy*. These findings appear trustworthy with independent checks on the decision trail and analysis.

Andrews and Vaughan (2007) carried out a telephone survey of reception staff in General Practice in order to estimate the number of HCAs working in General Practice in England. The sample of 922 practices in England was chosen to provide a representative geographical spread and range of practice sizes and formed 11.1% of the total number of practices in England. Within the 922 practices were 730 HCAs which allowed an estimate of the total number of HCAs in the General Practice workforce in the 8,451 practices which was around 6,700. The results indicated that 55% (n=507) of all of the sample General Practices employed one or more HCAs. The larger practices, with seven or more partners, were much more likely to employ a HCA than small practices and fewer than one in ten large practices had no phlebotomist or HCA. Some employed HCAs in large numbers the highest number identified in a single practice being nine. There has not been such comprehensive assessment of HCA numbers in General Practice in Scotland. My own baseline research also falls under this heading and has already been described in Chapter One (Burns 2006; Burns and Blair 2007). The review of the literature enabled identification that there was a gap in research surrounding the HCA role in General Practice generally and more particularly in Scotland and this led me to consider undertaking further research to explore the impact of HCAs in the longer term.

2.9 The relationship of the literature to my research questions

The 'gaps' in the literature identified following this literature review are now summarised. A lack of research relating to HCSWs in the community setting was identified by the systematic reviews.

Studies of HCA education highlighted the significance of education to the changing HCA role but there was an absence of studies examining the education of HCAs in the primary care setting and only one study from Scotland. Studies of multidisciplinary HCA roles predominated in England but there were no research studies undertaken in Scotland.

Examination of the research relating to assistant roles in Nursing Homes identified a 'gap' in research. Two studies were identified from the USA and one from Ireland and although findings are not directly transferable to a study of General Practice in Scotland they did point to the importance of training and good working relationships in supporting HCAs in practice. The studies of HCAs in acute care highlighted relationships with nurses and junior doctors and served to highlight that it would be worthwhile examining the HCA role in General Practice in relation to registered nurses.

There were only two studies from Primary Care identified. One study was a study from Scotland examining HCAs in community nursing and another from England examined the role of community mental health workers. Both studies highlighted variations in the development and responsibilities of the support workers. Review of the literature related to HCAs in General Practice in Scotland identified a lack of research in this area apart from my baseline study (Burns 2006; Burns and Blair 2007) and no research at all within Scotland examining the HCA role in General Practice over time.

The 'gaps' in the literature that have served to inform my study have been highlighted in Table 2.2 under the previously identified and examined themes and these are linked to the chosen research questions numbered 1,2 and 3.

Thus the research aim for my study was identified; to explore over a two year period the perceptions and experiences of HCAs and PNs within the General Practice setting following the introduction of the HCA role with a view to informing future practice, support and education.

The research questions that arose were:

1. What are the perceptions and experiences of HCAs working in General Practice over time?
2. How do PNs supervising HCAs perceive and experience the role of the HCA on an on-going basis?
3. What do HCAs consider aids and hinders their ability to carry out their role in General Practice?

Themes in the literature	Research Questions	Overview and 'Gaps'
Systematic reviews (n=2)	1, 2, 3	Lack of research relating to HCSWs in community setting
Education (n=12)	3	Studies highlight significance of HCA education to the changing HCA role. No studies in Primary Care
Multidisciplinary (n=8)	1, 3	HCSW role across different professions. Predominance of studies in England. No studies in Scotland
Nursing Homes (n=3)	2, 3	General gap in research. Studies highlight importance of training and good working relationships to effective support worker roles
Acute care (n=8)	2	Inter related nature of HCA and nurse and junior doctor roles Inter related roles worth examining in General Practice
Primary Care Nursing (n=2)	3	Variation in responsibilities and HCSW role development across different areas
General Practice (n=8)	1, 2, 3	Lack of longitudinal research Lack of research from Scotland

Table 2.2: Themes in the literature with identified 'gaps'

2.10 Summary

Overall up to 2007 the UK appears to have completed more studies regarding health care support worker roles than other countries. However there was an overall paucity of research evidence in this area. There was more research examining education and training than in other areas and also more research from acute hospital settings in comparison with the amount of research undertaken in the primary care setting. Even fewer studies involve HCAs in General Practice. There have been studies undertaken in primary care in the Netherlands and Ireland and a report of some research evidence from England and only one other study was identified involving a pilot study of 'GP assistants' in General Practice in Scotland (Philip and Turnbull 2006).

In view of the unique situation of HCAs within the General Practice team and the increasing emphasis upon primary health care provision then investigating the experiences of HCAs appeared very apt. The findings of the baseline research into the introduction of HCAs locally raised further questions about the experiences of HCAs (Burns and Blair 2006; 2007). How do HCAs and PNs perceive and experience the role of HCA over time? Has the HCA role developed on an on-going basis? What has helped or hindered the HCA role? Developing a greater understanding of the HCAs experiences within the General Practice team could offer valuable insight to inform future practice, support systems and education. In view of the unique situation of HCAs within the General Practice team and the increasing emphasis upon primary health care provision then investigating the experiences of HCAs appeared very timely.

Chapter 3 examines various research methodologies to provide a rationale for the choice of design and methodology to address the research questions cited above.

Chapter 3

Research Design and Methods

3.0 Introduction

This Chapter details the research design and methods of my study as well as discussing the choice of research methodology in relation to the research focus, aim and questions. Research is influenced by wider assumptions and these can be classified into the following four levels of understanding: ontology; epistemology; methodology; and methods (Holloway and Wheeler 2010). The wider beliefs and influences upon the various research positions are discussed in order to determine the research approach and methods which would be deemed fit for the purpose of answering the research questions. The chosen approach was longitudinal constructivist grounded theory and an overview of the study design is described in Section 3.1.3 of this Chapter.

3.1 Focus of the Study

The focus of my study was on HCAs working in General Practice to capture their perceptions of their role and experiences over time. The perceived influence of the HCAs in the General Practice setting from the PN's point of view was also considered to be an important dimension of this study. The HCAs role was relatively new in General Practices in Scotland following the publication of the Review of Nursing in General Practice (SE 2004) and HCAs was just beginning to become established within the General Practice teams. Hence it was pertinent to carry out research in this new and developing area.

3.1.1 Research Aim

The research aim was to explore over a two year period the perceptions and experiences of HCAs and PNs within the General Practice setting following the introduction of the HCA role with a view to informing future practice, support and education.

3.1.2 Research Questions

1. What are the perceptions and experiences of HCAs working in General Practice over time?
2. How do PNs supervising HCAs perceive and experience the role of the HCA on an on-going basis?
3. What do HCAs consider aids and hinders their ability to carry out their role in General Practice?

Table 3.0 shows the research questions related to the chosen methodology and methods for this study.

Research Questions	Methodology	Methods
1. What are the perceptions and experiences of HCAs working in General Practice over time?	Longitudinal study to capture HCA perceptions and experiences over time. Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of HCAs in 1 st and 2 nd year of study participation and postal follow up every 3 months Year 1 - interviews – postal follow up x 3 Year 2 – Interviews – postal follow up x 3
2. How do PNs supervising HCAs perceive and experience the role of the HCA on an on-going basis?	Longitudinal study to capture and analyse PNs perceptions and experiences of HCA role over time. Constructivist Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of PNs in 1st and 2nd year of study participation Year 1 - interviews – postal follow up x 3 Year 2 – Interviews – postal follow up x 3
3. What do HCAs consider aids and hinders their ability to carry out their role in General Practice?	Constructivist Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of HCAs Year 1 and Year 2 - interviews and postal follow up every 3 months

Table 3.0: Research questions in relation to chosen methodology and methods

3.1.3 Overview of study design

This two year longitudinal study recruited HCAs and PNs and data collection took place in two contrasting regions in Scotland from February 2008 to the end of 2010. The break down of the actual number of participants (n=27) from each region is given in Table 3.1.

	Rural Region	Urban Region
HCAs	n= 10	n= 4
PNs	n= 8	n= 5

Table 3.1: Number of participants recruited to study.

HCAs and PNs from both regions were recruited to the study during 2008 and there were some amendments to the original plans for data collection and these will be described and justified later in this Chapter.

Table 3.2 contains the schedule that was followed for data collection. Participants were interviewed individually initially and then again one year later and in between times they were followed up at 3 monthly intervals to ascertain if there any changes to report. If participants did report changes they were followed up by telephone interview, arranged with their permission. The 3 monthly follow-ups were valuable as they allowed tracking of changes to be maintained between interviews with minimal intrusion for busy working participants.

2008-9	Rural NHS region	Urban NHS region
HCA's		
Individual interviews	n=10	n=4
Postal follow-up ¹ at 3 monthly intervals	n=30	n=12
Practice Nurses		
Individual interviews	n=8	n=5
Postal follow-up ¹ at 3 monthly intervals	n=24	n=15
2009-10		
HCA's		
Individual interviews	n=10	n=4
Postal follow-up ¹ at 3 monthly intervals	n=30	n=12
Practice Nurses		
Individual interviews	n=8	n=5
Postal follow-up ¹ at 3 monthly intervals	n=24	n=15

Table 3.2: Data collection schedule followed in my study

Recruitment to the study commenced in February 2008 and a detailed checklist of the schedule for data collection is set out in Appendix II. Methodical administrative follow-up was continued to adhere to the 3 monthly contact schedule. There were some changes to the schedule with one practice nurse retiring but being replaced for the planned second interview by her colleague from within the same practice. Three HCAs also took maternity leave and two of these HCAs were subsequently not available for second interview. One other HCA continued to work limited part time hours as a HCA while starting her first year as a student nurse with Open University (Open University 2008). She continued to be part of this study.

¹ Postal follow up – could be followed up by telephone interviews where appropriate

3.2 Study design

All research is based upon a set of philosophical beliefs about the world and this view of the world has been referred to as a paradigm (Holloway and Wheeler 2010). A paradigm can be further described as a general perspective, an interpretive framework which is guided by a set of beliefs. The beliefs that make up a paradigm can be listed in four levels or categories: ontology; epistemology; methodology; and methods (Holloway and Wheeler 2010). These four levels of understanding are discussed in this Chapter in relation to my study and are represented in Table 3.2. It can be identified that a constructivist paradigm forms the basis for qualitative research and a positivist paradigm forms the basis for quantitative research (LoBiondo-Wood and Haber 2010). The two paradigms could be described as being at opposite ends of a continuum and various different research approaches within qualitative and quantitative research fall at various points along this continuum (LoBiondo-Wood and Haber 2010). My research study used a constructivist grounded theory approach and hence belongs firmly at one end of this continuum within the qualitative constructivist paradigm. I will now outline the ontological and epistemological choices for my study.

3.2.1 Ontology

Ontology is the philosophical study of existence and the nature of reality (Powers and Knapp 2006). It can be described as being concerned with how the world is made up and the nature of everything. Within the positivist paradigm only one reality is viewed as existing that is driven by and explained by natural laws and can be divided into processes and component parts. In contrast within a qualitative constructivist paradigm there is an assumption that reality is a composite and irreducible mix of realities that need to be studied holistically (Parahoo 2006). There is a belief in multiple realities, in that there are many different beliefs held by humans depending on factors such as culture and environment. Table 3.2 charts the constructivist paradigm in relation to the four levels of understanding.

3.2.2 Epistemology

The term 'epistemology' is derived from the Greek 'episteme' meaning knowledge and 'logos' meaning theory (Grbich 2007). Epistemology means what we know or what is the 'truth' and is to do with beliefs about how one might discover knowledge about the world. Epistemologies are the identified knowledge traditions that may underpin and inform research approaches (LoBiondo-Wood and Haber 2010).

Positivism derives from the hard sciences and there is belief in the existence of universal laws to explain human and social phenomena in the same way as there are laws in physics, chemistry and biology (Grbich 2007). Positivism views the world as having existence independent of our perception of it and that it is possible to have objective knowledge of this (Polit and Beck 2009).

In contrast the constructivist paradigm asserts that beliefs are determined by social groups or individuals (LoBiondo-Wood and Haber 2010). There is acceptance of the multiple and subjective nature of 'truths' (Holloway and Wheeler 2010). Constructivism views reality as socially constructed and existing within the mind (Parahoo 2006).

Constructivism is consistent with the viewpoint of cognitive psychology whereby individuals gradually build their own understandings of the world through experience (Charmaz 2006). As previously mentioned in constructivism knowledge is viewed as subjective and based on a shared view of members of different groups or cultures (Holloway and Wheeler 2010). In my study it is understood that there are multiple realities as different people have different experiences and beliefs.

The third level of understanding, methodologies, have been related to the question of how we view the world to gain knowledge from it (see Table 3.2) (Grbich 2007). Quantitative and qualitative research methodologies have very different viewpoints and are now examined in relation to my study.

3.2.3 Quantitative research methodology

Quantitative research uses numerical data manipulations and statistical procedures to describe phenomena (Polit and Beck 2009). It involves collecting hard factual data measuring phenomena. Until the latter part of the 20th century quantitative research was held to be the superior research paradigm (Parahoo 2006). Indeed, randomised controlled trials (RCTs) were viewed as the gold standard and the only method of significance producing hard statistical data that could not be contested (Parahoo 2006). Medical trials are usually RCTs, and involve a full experimental test of a new treatment, with random assignment to treatment and control groups (Polit and Beck 2009). These studies are usually very large and multi centred. Other quantitative research designs include experimental, quasi-experimental and non experimental designs (Polit and Beck 2009).

The focus of my research study questions was upon the experiences and the perceptions of the HCA role and it is argued that this does not readily lend itself to positivist or scientific enquiry although it would have been feasible to undertake some quantitative enquiry by measuring the frequency of certain experiences and perceptions or attempting to grade these. However, the perceptions and experiences of the HCAs were considered to be variable, personal and indeed unique and so could not very easily be measured.

3.2.4 Qualitative research methodology

Polit and Beck (2009) describe qualitative research as the investigation of phenomena in a holistic and in-depth way through the collection of narrative materials using a flexible research design. As my study focus was on the exploration of the experiences of HCAs and PNs and the ways in which they construct or interpret events and situations within the General Practice setting it was argued that a qualitative methodology was more appropriate. The researcher is actively involved and engaged with research participants and forms a construction of their view of situations and processes (Charmaz 2006).

This inter-subjectivity, the construction of views by interaction with others, is predominantly of interest in qualitative research but this type of approach has been criticised for focusing too much upon small or narrow areas rather than taking a broader approach (Grbich 2007). However, it could also be argued that smaller studies provide valuable rich and in-depth insight into phenomena giving local and contextual theory that can be of great significance (Bouffard 2001; Charmaz 2006).

Qualitative research has grown in popularity in recent decades and it has become more accepted as a very valuable way of illuminating topics in ways that cannot be achieved by quantitative research alone (Polit and Beck 2009). An apt example of this is in oncology, where early research trials of cancer treatments measured only side effects and survival rates but later the importance of patients' feelings, experiences and quality of life were also just as important to take into consideration (Corner 1997). In short it is important to know if patients surviving aggressive cancer treatments are left with sufficient quality of life to make them feel that their actual survival is worthwhile (Corner 1997). Now large clinical trials often have qualitative research aspects too (Burns and Grove 2009).

The two methodologies are often combined in research studies to provide multifaceted insight into a topic (Burns and Grove 2009). It is argued that both qualitative and quantitative research help us understand the world about us in different ways (Holloway and Wheeler 2010).

Within qualitative research it is recognised that reality is influenced by multiple factors in society, language, laws, policies, discipline borders and so research methods and interpretation is framed by social and cultural constructs (Grbich 2007). There is also a strengthened belief in individual interpretation and the need for reflexive subjectivity so that researchers have great awareness of themselves within the research process (Grbich 2007). Throughout my study I adhered to these principles.

As previously mentioned, Table 3.3 charts the constructivist paradigm in relation to the four levels of understanding. The fourth level methods are examined in detail examined later in this Chapter.

Four levels of Understanding	Questions	Constructivist Paradigm
<input type="checkbox"/> Ontology	<input type="checkbox"/> What exists?	<input type="checkbox"/> Human science is a mix of realities
<input type="checkbox"/> Epistemology	<input type="checkbox"/> What can we know about what exists?	<input type="checkbox"/> Truth determined by individual or cultural group Subjectivity valued
<input type="checkbox"/> Methodology	<input type="checkbox"/> How can we know about social reality?	<input type="checkbox"/> Dialogue, understanding Context important Reflexivity
<input type="checkbox"/> Methods	<input type="checkbox"/> What are the most useful ways to gather information about experiences?	<input type="checkbox"/> Active participation of researcher. Participant observation, Interviews, Focus groups

**Table 3.3: The four levels of understanding in relation to the Constructivist / Interpretivist paradigm
Adapted from Parahoo (2006); Grbich (2007)**

Within qualitative research methodology ethnography, phenomenology and grounded theory approaches are now considered in relation to answering my study questions.

3.2.5 Ethnography

Ethnography is a qualitative inquiry that involves the description and interpretation of behaviour within a culture (Parahoo 2006). Ethnography studies human behaviour within the context of cultural rules, routines and norms (Holloway and Wheeler 2010). It has its roots in social anthropology and examination of culture, that is the way of life of the group and the behaviour that is learned and socially constructed (Holloway and Wheeler 2010).

Ethnography entails fieldwork that records the life of a particular group and requires participation and observation from within their community or social world. It is considered that in doing so ethnographers learn from cultural groups and learn to take an 'insider's view', cultural interpretations, social patterns and behaviours are described and understood (Grbich 2007). Ethnography can be very time consuming and researchers should always be mindful of their role so as not to become too entrenched in participation within the culture where conflicting interests may arise (Polit and Beck 2009). Data collection in ethnography is mainly by observations, interviews and examination of documents (Holloway and Wheeler 2010).

In considering ethnography in relation to my study, direct observation may have yielded information about personal experiences and perceptions from the HCAs and the PNs viewpoints alongside other information about practice culture. However, the use of ethnography could also be considered as ethically contentious within the General Practice setting as it would involve direct observation of highly personal interaction with patients (Parahoo 2006). Gaining ethical approval and permission for extended access to General Practice areas to complete such a study may also have been problematic. As a part time PhD student I was not free to conduct lengthy observations in practices. Ethnography was therefore considered impractical and inappropriate for my study.

3.2.6 Phenomenology

The term "*phenomenology*" is derived from the Greek word *phainomenon* meaning "*appearance*" (Holloway and Wheeler 2010). Phenomenology is an approach to philosophy and a research approach (Moran 2000). Phenomenological studies aim to capture the essence of the 'lived experience' of participants, to capture the personal perspective of their life. The person is viewed as integrated with the environment and reality is viewed as subjective and experience unique to the individual (Burns and Grove 2009).

The philosophical belief is that a person is situated and shaped by his or her own world and is also constrained by this in their ability to establish meaning in language, culture, purpose, history and values (Burns and Grove 2009). Data collection in phenomenology is predominantly by in-depth interview (Grbich 2007).

Phenomenology has historically three major streams and the similarities and differences between these streams are the subject of philosophical debate (Holloway and Wheeler 2010). The three streams are: transcendental or descriptive phenomenology of Husserl (1859-1938); hermeneutic or interpretive phenomenology of Heidegger (1889-1976); existentialist phenomenology of Merleau-Ponty (1908-1961) and Satre (1905-1980) (Husserl 1962; Heidegger 1962; Holloway and Wheeler 2010).

Phenomenology may have been an appropriate choice of methodology for my study. An in-depth phenomenological study with HCAs could have answered the research questions arising in my study and may indeed have uncovered very interesting data regarding the perceptions and experiences of HCAs and PNs. However phenomenology is concerned with revealing phenomenon but in my study examining and explaining the social processes taking place was also a focus of interest and so phenomenology was not seen as the most suitable way forward to address my research questions.

3.3 Original Grounded Theory

Grounded theory (GT) was established by sociologists Barney Glaser and Anslem Strauss (1965; 1967). Glaser and Strauss came from different backgrounds in research, Glaser has a background in quantitative research and Strauss's background was in qualitative research. They worked collaboratively in a study of the dying in hospitals in the USA and developed the constant comparative method later called grounded theory (Glaser and Strauss 1965).

The systematic methodological strategies used were described in their book "*The Discovery of Grounded Theory*" (1967) in which they first described developing theories from research grounded in the data. Given the dominance of quantitative research at this time, the work by Glaser and Strauss (1967) was ground breaking in proposing that qualitative analysis could be systematic, logical and generate theory. Indeed they applied the pervading positivist assumptions of the day to qualitative research analysis. Symbolic interactionism has been identified as an appropriate philosophical underpinning of original GT and is fundamentally interested in the way in which people make sense of social interactions and the interpretations they attach to social symbols (Polit and Beck 2009). GT has become an accepted method of inquiry in research in social sciences and in nursing (Chenitz and Swanson 1986).

Glaser and Strauss (1967) advocated consideration of inductive and deductive interplay within a research situation whereby researchers examine an area of interest and collect data and relevant ideas or concepts develop from constant comparative analysis of data with concurrent review of the literature. Coding and categorisation of data is integral to GT and it is a way of generating new theory grounded in the field and also considered in the context of existing theory (Glaser 1992). GT allows the researcher to gain insight into social and psychological experience by examining the processes at work in a situation (Glaser and Strauss 1967; Benton 2000; Polit and Beck 2009).

GT has been subject to various interpretations, changes and remodelling since it emerged (Charmaz 2006). Strauss later worked with Corbin (1990) and published a book about more concrete procedures for theory building to assist novice researchers in GT. Clarke (2005) offers an alternative interpretation of GT and Charmaz (2006) has taken also taken a less rigid interpretation of GT and advocated adaptation of GT guidelines by qualitative researchers. Charmaz's constructivist grounded theory (CGT) interpretation was chosen for my study and this will be considered in more depth following a brief overview of other interpretations of GT.

3.3.1 Straussian Grounded Theory

Straussian grounded theory is the name given to a reinterpretation of the original methods put forward by Glaser and Strauss in 1967. Strauss and Corbin published "*The basics of qualitative research*" in 1990 which set out to provide more substantial procedural information to assist researchers in theory building; however they diverged from the original grounded theory method. Strauss and Corbin (1990) argued that rather than the basic research problem only being discovered in the data, it may come also from the literature or researchers professional and personal experience. Strauss and Corbin (1990) also advocated 3 types of coding, open, axial and selective coding and an intricate process of integrating and refining these to arrive at a core category. The Strauss and Corbin (1990) approach culminated in a full conceptual description of behaviour within a substantive area unlike the more focused earlier GT approach.

Glaser (1992) replied to this publication to reassert the benefits of original theory and to highlight the differences in approach. In Glaser's book condemning the work of Strauss and Corbin he claimed that they had departed from the purpose of GT which was to generate concepts and theories to explain and interpret variation in behaviour in a substantive area that is being studied (Glaser 1992).

Glaser believed that the procedures described by Strauss and Corbin did not constitute GT and he considered that this attempted to describe the full range of behaviours occurring in an area rather than explaining and interpreting variation in behaviour within the area of study (Glaser 1992). Glaser has certainly written prolific and vitriolic condemnations of Strauss and others who have reinterpreted GT (Glaser 1992: 2004). It is interesting here to note that in the preface to her book on constructivist grounded theory (CGT) Charmaz (2006) recounts how the ethnographer Erving Goffman was purported to be reticent about writing about his methods for fear that researchers would blame him for mistakes, whereas Charmaz regarded the challenge and debate as healthy and useful.

It is however evident from the literature that some of the debate within GT has been difficult, protracted and remains contentious (Strauss and Corbin 1990; Glaser 1992).

Bryant (2002) claimed that the differences that emerged between Glaser and Strauss were due partially to the tensions between the epistemological assumptions, that is Glaser and Strauss (1967) had attempted to apply positivism and scientism to qualitative research. Likewise, Bryant (2002) concurs with Glaser (1992) that Strauss and Corbin sought to systemise and codify GT massively in order to pursue “*good science*” in line with positivism.

3.3.2 Grounded Theory – situational analysis

More recently GT has been open to reinterpretation. Clarke (2005) identified situational analysis as building upon and extending the work of Strauss by offering 3 main cartographic processes; situational maps, social worlds/arenas maps and positional maps. The 3 kinds of maps provide “*fresh ways into social science data that is especially well suited to contemporary studies*” of any size (Clarke 2005: 22). Clarke intended situational analysis to be supplemental to classic GT in that the basic social process will have maps capturing the more information surrounding this. The data are mapped empirically in situational analysis to give wider insight. Thus the same arguments that Glaser (1992) puts forward about Strauss and Corbin (1990) could be applied to Clarke (2005), trying to capture a full picture of the situation means that the focus upon discovering the basics social process is lost. However it could be contended that visual maps do add another dimension assisting in the articulation of theory.

3.3.3 Constructivist Grounded Theory

Most recently Charmaz (2006) claims to have reinterpreted GT from a constructivist view point contesting the idea that theories are discovered but that they are constructed because everyone is part of the world that they study and so each researcher constructs GTs from past and present involvements with people, perspectives and practices.

Charmaz (2006) identified that an interpretive picture of the studied world results from GT research is not an exact picture. Charmaz (2006:148) has taken a more flexible view of the application of grounded theory indicating that:

“Neither positivist nor constructivist may intend that readers view their written work as Theory, shrouded in all its grand mystique, or acts of theorising. Instead they are just doing GT in whatever way they understand.”

Charmaz (2006:128) views the creation of theory as inextricably linked to interpretation:

“It entails the practical activity of engaging the world and of constructing abstract understandings about and within it.”

This differs from original and Straussian GT that assumes an external reality in data that can be discovered by an unbiased researcher (Glaser and Strauss 1967; Strauss and Corbin 1990). These theorists follow an objectivist approach believing that careful application of their methods produces theoretical understanding whereas the constructivist approach of Charmaz (2006) aims to uncover the complexities of particular worlds, views and actions. Diagram 3.4 provides an overview of the CGT research process.

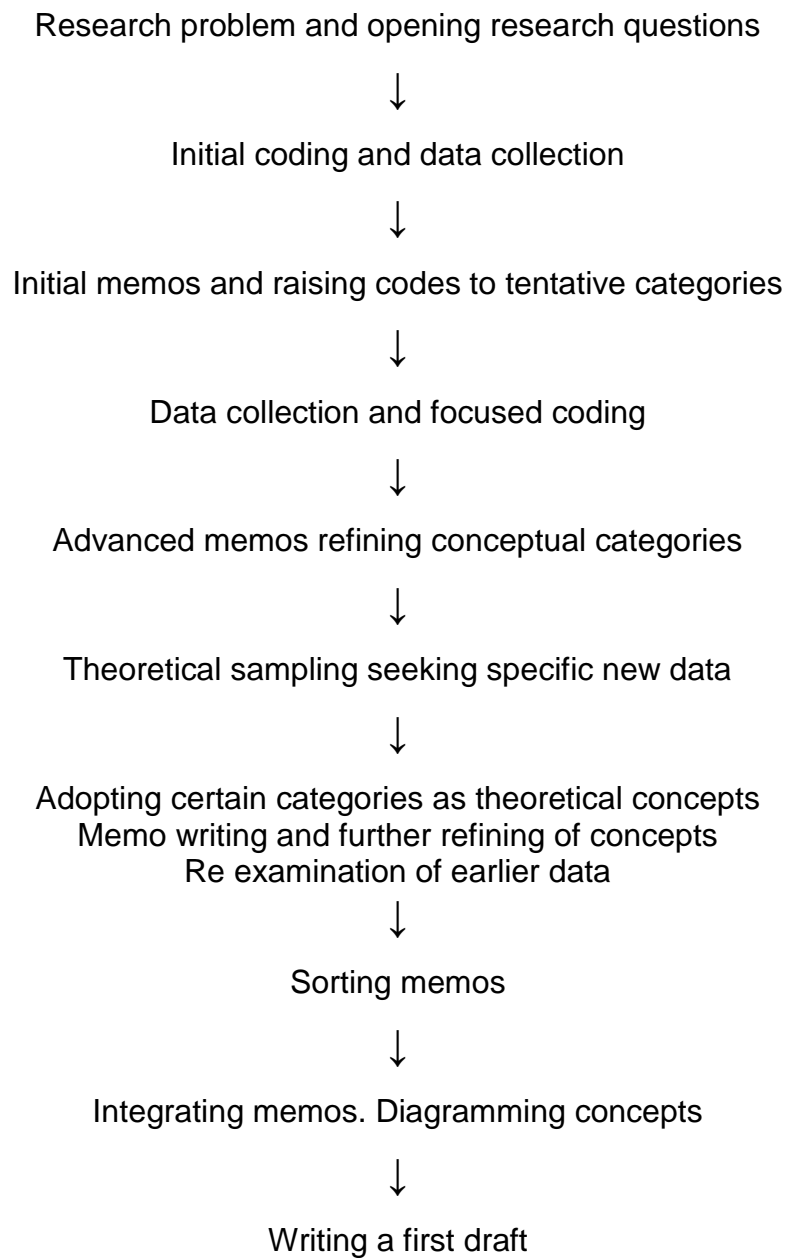


Diagram 3.4: The constructivist grounded theory process.
Adapted from Charmaz (2006:11).

Having considered the debate around GT methodology and the changes that have been advocated over time it had become evident that the work of Charmaz (2006) appeared very relevant to my study. I had already undertaken some work in this field (Burns 2006; Burns and Blair 2006; 2007) and so preconceived ideas about the area of study would be inevitable. I was also of the belief that in GT researchers are inextricably linked to phenomena under study and that although steps can be taken to highlight subjectivity it can never be completely removed. Reflexivity is very important to this process in the understanding of personal views and to the interpretation of findings. Reflexivity is covered in more depth later in this Chapter when data analysis is examined in depth.

CGT was considered most suitable for my study. It was considered that CGT had relevance to identifying and interpreting the perceptions and experiences of HCAs and PNs within general practice and associated factors within the social setting (Charmaz 2006). CGT methodology was deemed suitable for answering all my research questions. CGT identifies that the researcher is not removed or objective within the research process but part of the interpretation process and this very much corresponds with my own opinions (Charmaz 2006). Holloway and Wheeler (2010) acknowledge that researchers must make up their own minds about which approach to adopt when doing GT as long as they have knowledge and they point to the fact that some researchers adapt methods during the process of research. The work of Charmaz appears to be most relevant to today given that qualitative research has become much more widely accepted as valuable and relevant. This position today is in no small part due to acceptance of Glaser and Strauss's early work in GT. When considering research methods I could also see how the work of Charmaz (2006) has evolved and developed from of the work of Glaser and Strauss of whom she was a pupil, but is current and relevant to qualitative research today.

3.4 Longitudinal research

A longitudinal study can be described as a study designed to collect data at more than one point in time (Polit and Beck 2009). Longitudinal studies are useful in examining changes through time (Polit and Beck 2009). Longitudinal studies require prolonged commitment to the study by researcher and participants over time and the loss of participants is a recognised problem of such studies. Another the benefit of longitudinal research is the facilitation of an increased depth of response (Parahoo 2006). However, it has been postulated that under scrutiny over time participants may respond in a way that they believe to be congruent with the researcher's expectations; this is known as the *Hawthorne effect* (see Glossary) (Parahoo 2006).

The focus of my study was upon following up HCAs and PNs through time. Hence the research needed to be longitudinal in design and Diagram 3.1 details the composition of this design. Data collection was undertaken over a two year period for each participant and included two in-depth interviews a year apart and postal follow-up of participants every three months. The aim of my study was to explore the perceptions and experiences of HCAs and PNs over a period of two years within the General Practice setting following the introduction of the HCA role with a view to informing future practice, support and education. A longitudinal constructivist grounded theory study was used to achieve this aim and to answer the research questions. Table 3.5 summarises the qualitative methodologies within the interpretivism paradigm.

Paradigm/Philosophy to structure knowledge and understanding	Methodologies	Data Collection Methods
<p>Interpretivism/ Constructivism</p> <p>Seeks to understand. Knowledge seen as a possession of people</p>	<p>Phenomenology</p> <p>Seek to understand people’s individual subjective experiences and interpretations of the world.</p> <p>Ethnography</p> <p>Seeks to understand social meaning of events, activities, rituals in a culture.</p> <p>Grounded Theory</p> <p>Seeks to generate theory that is grounded in the real world. Data defines and directs development of theory.</p>	<p>Interviews</p> <p>Focus groups Observations Field work</p> <p>Field observations Interviews Textual analysis</p>

Table 3.5: Summary of Interpretivism Paradigm (Adapted from JBI 2011)

3.5 Location

Data collection took place in two contrasting NHS regions of Scotland. One was predominately rural while the other was predominately urban in nature. Two contrasting areas were chosen in order to gain a wider perspective from HCAs and PNs in General Practices in Scotland. The smaller practices within the rural area had led to some HCAs working in a dual role as HCA and receptionist whereas this dual pattern of employment did not predominate in larger practices in more populated areas.

Recruitment took place in both regions following full ethical approval and once the researcher had obtained an honorary contract in the NHS regions. Interviews took place in General Practices within the two regions.

3.6 Ethical considerations

The study was conducted in adherence to ethical principles preserving the interests and rights of participants. The ethical principles of beneficence and non-maleficence, the right to self determination and the right to justice and fair treatment, including privacy, are relevant to this and any research study involving humans.

3.6.1 Beneficence and non-maleficence

Beneficence and non-maleficence are fundamental principles to any research and impose a duty upon the researchers to ensure against harm to participants and to produce benefits to participants or groups in society as a whole (Polit and Beck 2009). These principles are also reflected in the Code of Conduct for Nurses and Midwives who have a duty to identify and minimise any risk to patients and clients and to protect confidentiality (NMC 2008).

3.6.2 Right to self determination

Ethical concerns may be raised where there is perceived to be an unequal relationship between researcher and participants. There must be very careful consideration given to the way participants are recruited to research studies. Certain groups in society may be viewed as more vulnerable than others (for example: poor; children; disabled; prisoners; mentally ill) and their rights have to be protected. Indeed it should be noted that the right to fair treatment is underpinned by legislation for example in the Disability Discrimination Act (HM Government 2005) and Equality Act (HM Government 2010). Here again the Code of Conduct for Nurses and Midwives also indicates the duty to respect individuality and need to obtain consent to any intervention (NMC 2008).

Within this study the participants may not be part of a vulnerable group but consideration had to be given to any pressures that participants may feel under to participate in this study and so access to participants needed to be carefully planned with the availability of access to information regarding the study from a person who is detached from the research.

Documentation and guidance about how participants would be accessed and recruited to this study were provided to the Central Office for Research Ethics Committees in the NHS (COREC). These include a flow chart of the process of recruitment and data collection (Appendix III). An invitation poster was displayed in General Practices with contact details of a person who has a background of working in General Practice but was not involved in the research study. The availability of a contact with knowledge of my study but who was independent of it was important in the provision of unbiased advice to possible participants. A letter of invitation to people considering taking part in the study was developed and included within a information leaflet detailing the study (Appendix IV). An expression of interest slip of paper was returned to me and I then requested the completion of a consent form (Appendix V).

Clarke (2006) warns of the potential for qualitative interviewing to be exploitative. This and other methods of data collection may be construed as damaging to participants if consideration and sensitivity is not displayed by the researcher. Interview guides and contact guides were required for ethical approval and are included in (Appendix VI). I was also required to give details of any experience and training that I had undertaken in these methods of data collection. Clark and McCann (2005) identified that researchers have greater ethical obligations if they share other relationships with participants for example if they are patients or students of the researcher.

3.6.3 Justice and the right to privacy

Study participants have the right to expect fair treatment and have their rights to privacy observed. The right to fair treatment means that researchers need to ensure that people who do not participate in a study or who decide to withdraw from a study are treated with respect and that attitudes to research participants remain non judgemental. The right of participants to privacy is also fundamental to research and it could be acknowledged that research with humans will involve some intrusion into their personal lives but researchers must ensure that intrusion is kept to a minimum and that data provided are kept confidential (Burns and Grove 2009).

This study has been reviewed by the Research Ethics Committee of the School of Nursing, Midwifery and Social Care at Napier University on 16/01/07. Following this I was asked to confirm how confidentiality and anonymity of participants would be achieved. I confirmed that data would be stored securely and that any personal details of participants would be stored separately from audiotapes and transcriptions. I also stipulated that when writing up the research project I would ensure that information used could not be traced back to individual participants. I was particularly aware of the need to be vigilant regarding the last issue when using participants from scattered rural locations which may have distinctive characteristics and therefore participants may be traceable if certain details are divulged. The university committee approved the research proposal following this confirmation and this review proved useful in assisting in the application to the NHS Committee when evidence of peer review was required.

3.6.4 NHS Ethics Committee Approval

Higginbottom (2005) points to the constantly changing and developing contemporary governance and ethical frameworks that provide robust processes to ensure good ethical practice that prevents harm to participants. Research undertaken within the NHS is subject to application for ethical approval online at the time of application this was via COREC that is the Central Office for Research and Ethics Committees. Ethical approval for my study has been obtained by completing and submitting a COREC application to the local NHS Research Ethics Committee and the local Research and Development Committee. I had to provide a supporting letter from the sponsor (Appendix VII).

I attended the ethics committee meeting where questions raised about the application were satisfactorily addressed. Application was then made to the NHS Ethics and Research and Development Committee and the NHS Research and Development Committee in the second region. Approval and permission to undertake the research was granted by both these committees although in the urban region this was subject to obtaining an honorary contract with the NHS region (Appendix VIII). I already had an honorary contract within the rural NHS region.

3.7 Recruitment

In order to meet the requirements of ethical approval pre-determined numbers of 30 HCA and 30 PN participants were identified. However it proved difficult to get access to HCAs and PNs in the practices due to their strict appointment regimes and the lack of direct telephone contact available during consultation time. The final number of participants recruited was determined primarily by the lack of any new codes emerging from later interviews and after discussions on progress and analysis with my supervisors.

Participants were recruited first in the rural region as an honorary contract was already in place and also there was greater ease of access to possible participants due to familiarity with individual General Practices and the geography of the area. All participants (n=18) from this rural region were recruited between February and July of 2008.

Data collection in the urban region did not commence until after April 2008 when an honorary contract was finally obtained. Recruitment took place via the practice nurse advisor who emailed details of the study to PNs and HCAs in General Practices. There were some expressions of interest in the study but recruitment was slow with responses to contacts by post and email being poor. A request was made to attend a PN meeting in November 2008 to present the study and make some personal contact with possible participants. However this was not successful and further information was emailed out by the practice nurse advisor and hard copies of information were posted.

The number of participants recruited in the urban region (n=9) was smaller and was achieved by snowball recruitment. However the PN advisor within the urban region indicated that there had not been a large recruitment of HCAs within General Practice within the region overall and there was employment of staff nurses to work in treatment rooms.

3.8 Methods of data collection

It has been indicated that research methods are important tools but that the personal communication skills and intuition of the researcher are vital to bringing them close to what they study (Charmaz and Mitchell 1996). The research problem should shape the methods chosen (Charmaz 2006). The 3 research questions were answered by the use of in-depth face to face interviews. Postal contact and telephone interviews were also included to provide on-going contact with participants. Glaser (2002) and Charmaz (2006) indicated "all is data" meaning that everything learnt in the research setting can serve as data.

The schedule for data collection has been set out in Section 3.1.3. and in Table 3.1. Methodical administrative follow-up was necessary to keep to the 3 monthly contact schedule. The creation and monthly adherence to the detailed schedule and checklist in Appendix II enabled the necessary follow-up to be identified and then recorded once achieved.

Likewise the administration and follow-up of returning information needed to be dealt with in a systematic way.

The sample of participants in my research are HCAs and PNs from two contrasting NHS regions in Scotland. Theoretical sampling was undertaken whereby data collection and analysis was undertaken concurrently and the number and sources of participants recruited was determined by the information gathered from previous participants. However, as previously stated recruitment was difficult. Saturation can be said to have been reached when no new data were produced (Charmaz 2006). However this is a contentious issue as it is difficult to claim saturation with confidence as one new interview could uncover differing data and lead to new coding. There were no new codes emerging from later interviews in my study but my claim to have achieved saturation of data is necessarily tentative.

3.8.1 In-depth interviews

Individual interviews are the predominant method of data collection in constructivist GT (Charmaz 2006; Polit and Beck 2009). However, there are different types of individual interview identified for example, formal and informal, structured and unstructured (Polit and Beck 2009). Wimpenny and Gass (2000) identify that interview types may vary in GT with interviews becoming more focused as GT studies progress and analysis of concepts are explored. Unstructured interviews have been identified as appropriate starting point in GT with the interviewer not intervening to direct the flow or depth of participant responses and so allowing respondents to raise the relevant issues (Chenitz and Swanson 1986). It has been recognised that unstructured interviews facilitate a holistic view of respondents (Gray 1994).

Completely unstructured interviews may be difficult to achieve and some form of structure may be necessary to prevent respondents from straying completely from the topic under consideration.

The degree of structure may vary and semi-structured interviews have also been identified as important to data collection in gaining insight into participants' interpretation of their own experience (Rubin and Rubin 2005; Charmaz 2006). Duffy *et al.*, (2004) identify the need to plan interviews ahead and recommend an interview checklist or guide. Taking note of this I planned a check list with the interview guide for my study and Appendix VI provides details of this.

Casey (2006) described how interviewer posture, positioning, eye contact and non verbal responses can be significant in encouraging respondents. The location of interviews may also be significant and whilst it should be in a place of choice of the interviewee, it should also be in an area that is quiet and free from interruptions (Gray 1994; Holloway and Wheeler 2010). The interviews in my study took place within General Practices at the request of the participants and this led at times to difficulties with interruptions. The interviews took place in between patient appointments, necessitating timeliness and focus. In accordance with the advice from Holloway and Wheeler (2010) recording of interview data was always done with the permission of the interviewee and participants reassured that it could be stopped or deleted on request.

Clarke (2006) explored the potential for qualitative interviews to be exploitative particularly those that are in-depth or longitudinal with prolonged researcher / participant exposure, reciprocity or intrusive interviewing may encourage disclosure that participants may later regret or find very distressing. Very appropriately, Clarke (2006) urged researchers to address problematic issues by openness and allowing scrutiny of the process by peers, supervisors and independent reviewers and also seeking participants views about the interview situation should also help ensure against poor practice.

In line with Charmaz (2006), I considered individual in-depth interviews with the HCAs and PNs to be an appropriate starting point of data collection as this would enable participants to freely express their own individual experiences whilst keeping to a loose structure. Charmaz (2006) advocates in-depth or intensive interviewing for eliciting participants own interpretation of their experience and an overview of the advantages of in-depth interviews are shown in Table 3.6.

In-depth interviews enable the interviewer to:	In-depth interviews enable the participants to:
<ul style="list-style-type: none"> •Go beneath the surface of described experiences; •Stop to explore a statement or topic; •Request more detail or explanation; •Ask about thoughts feelings and actions; •Keep participant on subject; •Come back to an earlier point; •Restate the participant' point to check for accuracy; •Slow or quicken the pace; •Shift the immediate topic; •Validate the participant's humanity, perspective, or action; •Use observational and social skills to further the discussion; •Respect the participant and express appreciation for participating. 	<ul style="list-style-type: none"> •Break silence and express views; •Tell their stories and to give them a coherent frame; •Reflect on earlier events; •Be experts; •Choose what to tell and how to tell it; •Share significant experiences and teach the interviewer how to interpret them; •Express thoughts and feelings disallowed in other relationships and settings; •Receive affirmation and understanding.

Table 3.6: In-depth interviews - adapted from Charmaz (2006: 26)

As my study and analysis progressed using the constant comparative method the second interviews became more focused in order to pursue the direction of analysis. Charmaz (2006) warned about forcing data into preconceived categories and indicated that interviewing style can completely shape the content of a study. *“Subsequently a naïve researcher may inadvertently force interview data into preconceived categories”* (Charmaz 2006: 32). Poor questioning technique can mean that important issues to the participants may not be explored and the researcher may impose ideas upon them. This was addressed by practising interview questioning and audiotaping with a colleague who has a background in General Practice in order to assist in the prevention of poor recording and questioning technique. My supervisors also read the drafted interview transcripts and provided feedback and guidance in line with good practice.

All of the interviews were recorded with permission of participants and transcribing them all myself helped me to reflect upon the nature of my questioning and the possible influence I had upon participants.

There were some changes made to the data collection methods in my study. Instead of individual interviews, focus groups were originally planned in both NHS regions for the PN participants (Krueger 1994; 1998). The focus groups were to be undertaken twice in each region, one year apart. However, the focus groups proved difficult to organise due to difficulty releasing PNs from practice duties.

The original decision to use focus groups as a method of collecting data from PNs was influenced in part by the close working links that existed between PNs in the rural region and the Higher Education Institution (HEI). PNs attended regular training and updating sessions locally at the University organised by the PNs themselves. This arrangement would have easily facilitated the setting up of focus groups along side the training sessions but sessions ceased prior to commencement of data collection. However, this arrangement has since ceased and the practicalities of organising focus groups for PNs proved problematic. The scattered geography of the area and the PNs ability to arrange time away from practice presented difficulties. It also became evident early in the data collection process that there existed significant differences between the levels of practice and activity of PNs supervising the HCAs. This could have impinged upon using focus groups for data collection. It became evident that the practice nurses who supervised the HCAs were practicing at differing levels and in view of this factor, in addition to the practical difficulties outlined above, it was considered that individual interviews may be a more acceptable and productive method of collecting data. The proposed change of method was then discussed the supervisory team and with PNs who had expressed an interest in taking part in the study and a check was made that this would be an acceptable alternative to focus group participation. Several PNs intimated that having an individual interview would actually be more convenient and that the activity would be less time consuming for them personally.

One PN indicated that she preferred to be interviewed individually because she may not have felt as comfortable speaking out in a focus group situation with people that she may not know very well.

3.8.2 Postal follow-up

Postal contact was made with participants at three monthly intervals during my study in order to follow the transitional journey of both the HCA and the PNs supervising them. This was to enable any issues that participants felt were of significance to be flagged up to me. Every three months, a short letter with a small number of questions written upon a single sheet of A4 paper were sent out asking participants to write down details of any changes or developments in their role. Appendix VI contains details of this follow-up contact. A stamped addressed envelope was included for return and participants asked to state if they minded being telephoned regarding further detail of their replies.

Participants were originally asked to respond to a three monthly email 'interview' in order to follow the transitional journey however the HCA responses to the emailed 3 monthly follow-up was initially very poor. Although Hamilton (2003) had used email and telephone interviews in a grounded theory study and reviewed very positively the 'to the point' rich data rendered by email contact with participants. I had experience of good email responses from hospital staff in a previous study (Blair *et al.*, 2007). However it was identified that one HCA participant did not have an email address and thought that this would exclude her from the study. Other HCAs reported a lack of time to access a computer at work for emails. Response rates to follow-up improved for both HCAs and PNs via the hard copy of the follow-up.

There is a lack of research evidence comparing email and other methods of data collection (Coombes 2001; Ahern 2005). Lefever *et al.*, (2007) conducted a large research study using online questionnaires with secondary school students in Iceland and identified concerns about fraudulent respondents and technical difficulties but highlight the benefits of timesaving and cost efficiency. They raised an important issue regarding email “Is the email address the personal property of the individual or the institution that issues it?” They found that opinions varied (Lefever *et al.*, 2007). It could be stated that there may be little transferability of findings from Icelandic schools to health care within the UK but the findings of Lefever *et al.*, (2007) added interesting background to my study plans.

More recently Guise *et al.*, (2010) have combined the use of paper and web questionnaires and Williams *et al.*, (2011) have successfully investigated men’s involvement in antenatal screening using personal email in a small (n=8) longitudinal qualitative pilot study. However, it is argued that these findings are predicated on having access to a work or personal computer which in my study was problematic for some HCA participants.

3.8.3 Telephone interviews

Telephone interviews offered an opportunity to continue to collect data from the geographically scattered participants of my study. It was considered that telephone contact may be more acceptable than more face to face contact as telephone contacts are generally less time consuming (Smith 2005). The shorter length of time taken for telephone interviews compared to face to face interviews has been linked to the increased likelihood of the interview being broken off, disturbances being harder to overcome and increased difficulties in establishing and maintaining rapport (Smith 2005).

As mentioned above the opportunity to clarify issues arising in postal follow-up was important but it was also important to check acceptability and convenience of the telephone contact with participants.

It was anticipated that a rapport would be established with study participants over time and this proved to be the case. The use of personal mobile phones has escalated considerably over the last decade and communication by telephone has generally become much more commonplace. Musselwhite *et al.*, (2007) presented a detailed discussion paper examining evidence to support the use of telephone interviews as a method of data collection in clinical nursing research.

They pointed to the cost benefits of using telephone interviews and also identified that telephone interviews minimise the disadvantages associated with personal interviews in that participants and interviewers may be potentially less affected by each others presence and this may help to reduce the possibility of bias (Musselwhite *et al.*, 2007). Relevant potential challenges identified by Musselwhite *et al.*, (2007) are maintaining participant involvement and maintaining clear communication. In practice telephone interviews were undertaken only on three occasions. On one occasion for participant convenience a face to face interview was conducted within the General Practice setting.

3.8.4 Changes to data collection methods

For the reasons discussed above the original plan to undertake focus groups with PNs was changed to individual interviews and email contact was changed to postal contact. The changes made to initial data collection plans are summarised in Table 3.7.

Original plan of data collection	Revised data collection plan 2008:
<ul style="list-style-type: none"> • HCAs • In-depth face to face semi structured interviews with HCAs to examine their experiences of working in General Practice. • 3 monthly follow up by email. • Telephone interviews as required. <ul style="list-style-type: none"> • PNs • Focus group interviews with PNs supervising HCAs. • 3monthly follow up by email •Telephone interviews as required. 	<ul style="list-style-type: none"> • HCAs • In-depth face to face semi structured interviews with HCAs to examine their experiences of working in General Practice. • 3 monthly follow up by post. • Telephone interviews as required. <ul style="list-style-type: none"> • PNs • In-depth face to face semi structured interviews with PNs supervising HCAs. • 3 monthly follow up by post. • Telephone interviews as required.

Table 3.7: Summary of data collection changes

3.9 The literature and grounded theory

It is useful to examine the place of the literature with regard to my CGT study. The place of an initial literature review has been debated.

It has been identified that in GT a literature review may or may not be undertaken prior to commencement of research but as data collection and analysis progresses the literature is referred to and prior findings related to the studies (Polit and Beck 2009). Indeed the completion of an initial literature review has been controversial (Strauss and Corbin 1990; Glaser 1992; McGhee *et al.*, 2007). Table 3.8 summarises the differing viewpoints regarding an initial literature review in GT.

Support for literature review prior to commencing GT studies	Factors against literature review prior to commencing GT studies
Identify gaps in research and impetus for study	In line with Glaser and Strauss (1967) Original GT guidance
Application form requirements for NHS Ethics Committee	To prevent researcher from making assumptions due to exposure to literature
Methodological investigation and appropriate choice	To keep the focus upon the emerging data not the literature
Justification for study	

Table.3.8: Pros and cons of the initial literature review in GT
Adapted from McGhee et al (2007)

However in relation to my study it is argued that the literature had already been reviewed for the baseline research project and the HCA foundation course and so further examination in order to identify gaps in the research and the impetus for further research was relevant and important. Thus it could be construed that I had some theoretical sensitivity (see Glossary) to data but this is not at all contended in CGT. Charmaz (2006) supports completion of an initial literature review and the weaving of the discussion of the literature throughout every research report. Charmaz (2006:163) also states that:

“although scholars may don a cloak of objectivity, research and writing are inherently ideological activities. The literature review and theoretical frameworks are ideological sites in which you claim, locate, evaluate, and defend your position”.

3.10 Trustworthiness

There has been some debate about how qualitative research should be assessed for quality and rigour and it is now generally accepted that the criteria required may differ from those of quantitative research where reliability and validity are examined (Morse 1999; Sparkes 2001; Gerrish and Lacey 2010). The issue of trustworthiness of data has been established as important and can be addressed by considering credibility, dependability, confirmability and transferability (Polit and Beck 2009). Credibility refers to the confidence in the truth of data and interpretation of them (Polit and Beck 2009). Credibility is supported by prolonged engagement with and persistent observation of the data thus enabling greater scope and depth of studies (Parahoo 2006).

The credibility of the researcher is another aspect and so experience, training, qualifications and background are important considerations here. My own personal development in relation to this study is recorded in Appendix IX. Qualitative research is deemed credible when there is a fit between participants' views and the researcher's presentation of them (Gerrish and Lacey 2010). Hence credibility is also established by checking with participants their agreement with findings.

The credibility of my study was addressed by taking findings back to participants and outsiders in the form of a created diary to be confirmed or refuted and to give comment upon. The use of diaries to check the credibility of a qualitative study was first used by Gray (1997) in her doctoral thesis and the use of diaries in my study is described fully at the end of Chapter 6. Dependability of qualitative research refers to '*data stability over time and over conditions*' (Polit and Beck 2009: 333). There may be more confidence in dependability if an inquiry audit involving examination of data and supporting documents has been undertaken (Koch 2006).

Confirmability refers to the neutrality or objective nature of the data and the likelihood of independent persons being able to agree about the accuracy and relevance of the data (Polit and Beck 2009).

The reflexive journal I kept served to illuminate a personal perspective of data collection and analysis and possible different avenues of enquiry. Documentation was systematically collected to support an audit trail of decisions about the data. Field notes, interview transcripts, data analysis notes, personal notes and drafts may all be relevant. Research supervision for my PhD studies has meant that work has not been undertaken in isolation but was open to review and questioning of decisions on an on-going basis by the supervisory team and by peers and other academic supervisors at the compulsory Annual Faculty Postgraduate Research Students Conference. An example of coding is contained in Appendix X.

Transferability refers to the extent to which findings from a study can be transferred to other groups or settings (Polit and Beck 2009). Sampling and design may influence transferability greatly but qualitative studies that provide rich thorough description of research settings and processes better enable judgements about similarities to other contexts.

3.11 Reflexivity

Reflexivity has been defined variously. Johns (2000:61) identified reflexivity as “*looking back and seeing self as a changed person*”. Finlay (2002:532) identified it as “*thoughtful conscious self awareness. Reflexive analysis in research encompasses continual evaluation of subjective responses, inter-subjective dynamics and the research process itself.*” Reflection is a familiar term in nursing and reflective practice should be an integral part of all nurse education and practice. However, reflexivity has been described as being as the other end of the continuum to reflection in that it is more complex involving continuing and dynamic self awareness and analysis (Finlay 2002).

Freshwater and Rolfe (2001) point to a need for a universal intellectual determination of reflexivity in order to enable it to be used as a guiding standard in research. Allen (2004) warned that unless the reflexivity is made more explicit and explored in depth it is open to be merely attached to studies superficially to give the appearance of academic rigour.

The role of reflexivity in qualitative research is also variably described. The reflexive stance of the researcher informs the relationship to participants and the conduct of the research (Charmaz 2006). It should be observed that the researcher must operate at different levels reflexively, in order to maintain self-awareness within both the process and the product of the research (Horsburgh 2003). Personal and epistemological factors are important and self awareness is needed but also an awareness of the relationship of self to the research environment (Dowling 2006).

Within original GT, Glaser (1978; 1998; 2001) appears to view reflexivity differently over time, personal experience of the researcher is initially recognised as playing a part in the comparative method but he later views it as an unnecessary distraction (Neill 2006).

Glaser (2001) identified reflexivity paralysis or overload as being counterproductive in that entering into too much descriptive detail can detract from the focus of data and he considered that any bias the researcher brings to the research will be checked by the constant comparative method. Neill (2006) concluded that reflexive accounts by the researcher can form part of the data to be analysed in GT. She identified that not only is reflexivity an important tool in GT by which researchers can identify the effect of self upon relationships but it should also be used to gain insight into the recruitment process (Neill 2006).

3.11.1 Reflexive journal

I maintained a reflexive journal for the duration of my research. This facilitated insight into the underlying assumptions and my own position that may influence the interpretation of the research. Regularly looking back at personal feelings and decisions enabled more informed research practice. A few examples are provided in Chapters 5, 6 and 7 to provide an in context illustration of this.

3.11.2 Field notes

I wrote field notes immediately at the end of each interview. Visiting the General Practice settings helped me to gain more insight into the daily activities of participants. I was able to observe and make comment on the environment, the appearance of the relationships observed and the general ambience of working environment. I was also able to note the tone and body language of participants. All of these notes assisted my understanding and insight fit with the verbal content of the interviews (Arber 2006).

3.11.3 Decision trail

A decision or audit trail is the record of the decisions made throughout the research process (Holloway and Wheeler 2010). A decision trail means that a second person can audit the analytical processes and decisions of the researcher. Auditing every activity in qualitative research would be very difficult but providing a rationale for the key decisions taken is important in ensuring confirmability (Parahoo 2006). An audit trail in my study is provided within my memos, field notes and reflexive journal. The use of memos is described later in this Chapter under data analysis.

3.12 Data analysis

In alignment with the CGT methodology adopted, the constant comparative method was used to analyse transcriptions of interviews and also postal follow-up responses. I personally transcribed all of the interviews which assisted greatly in becoming immersed in the data. I also made field notes after each interview about any related thoughts, circumstances, influences and ideas. Initial and then focused coding of the data was undertaken with concurrent examination of the relevant literature.

3.12.1 Coding

“Coding means categorising segments of data with a short name that simultaneously summarises and accounts for each piece of data” (Charmaz 2006:43). The process of coding involves researchers asking analytical questions of the data gathered; it aids understanding of the data gathered and enables decisions about the direction of further data gathering. Codes demonstrate how a researcher selects, separates and sorts data. Codes should relate very closely to the data, show actions, events, viewpoints, relationships and so codes emerge from close scrutiny of data and by defining the meaning found within it (Charmaz 2006). Hence, as the researcher defines and then refines codes a depth of understanding from the participants’ perspective is pursued.

Initial coding may be provisional, comparative and grounded in data and coding data as actions is recommended by Charmaz (2006). Glaser (1978) and Charmaz (2006) recommended coding using gerunds. The use of gerunds is important (see Glossary) in coding and memo writing as this fosters thinking about actions and processes rather than static descriptions (Glaser 1978; Charmaz 2006). Charmaz identifies that focusing coding on actions enables sequences to be viewed and connections to be made between these.

A code for coding is given by Charmaz (2006:49):

- *“Remain open*
- *Stay close to the data*
- *Keep codes simple and precise*
- *Construct short codes*
- *Preserve actions*
- *Compare data with data*
- *Move quickly through the data”.*

Word by word, line by line and incident by incident coding enables the researcher to move towards two criteria for the completion of GT analysis, that of fit and of relevance (Charmaz 2006). A study fits when codes are constructed and developed into categories that capture participants experiences and it has relevance when an analytical framework is created that interprets what is happening. In vivo codes that reflect participants own words or special terms can prove very useful but must be integrated into the theory.

Focused coding is the second major phase with codes becoming more directed, selective and conceptual than initial coding (Glaser 1978; Charmaz 2006). Significant and frequently used initial codes and data are re-examined and decisions made about the most analytically relevant for complete categorisation of data. As Charmaz (2006) stated, coding is an emergent process and unexpected ideas can come out of this re- examination of data.

The process of coding involved me asking analytical questions of the data gathered; this aided understanding and enabled decisions about the direction of further data gathering. These were documented in my reflexive diary to aid an audit trail. Codes were related very closely to the data, showing actions, events, viewpoints, relationships and codes emerged from close scrutiny of data and defined the meaning found within it (Charmaz 2006).

Analysis was pursued in order to gain deep understanding from the participants' perspective. In vivo codes were identified that reflected participants own words or special terms thus ensuring that analysis was closely related to data.

3.12.2 Categories and subcategories

Charmaz (2006) stated that categories may be major and have smaller subcategories and that the researcher should identify the categories that make data most meaningful and carry analysis forward.

Subcategories and categories developed as analysis progressed and codes were linked together to reflect the emerging ideas. Linking codes back together after initial fragmented coding helps to develop coherence in analysis (Charmaz 2006).

The following three categories were identified as capturing the significant processes from the analysis, '*getting going and proving worth*', '*building confidence and respect*' and '*shifting and shaping roles*'.

3.12.3 Memos

Writing memos according to Charmaz (2006) is an important step between data collection and writing drafts of research and it is vital in prompting early analysis of codes. She identifies that memo writing encourages thinking about the data and discovering ideas from it (Charmaz 2006). Memos are written in informal language to capture and probe ideas about codes.

I included memos in the annual review reports of my research in 2008 and 2009 and these created a good platform for discussion of analysis with the supervisory team. Memo writing helped to clarify my thinking and move analysis forward.

3.12.4 Using computer software

I attended training and used NVivo 8 software package initially to assist in the analysis of narrative data. Electronic analysis was lost when my computer failed but a hard copy was retained and so no data were lost completely. I then reverted to analysis using hard copies of interview transcripts and highlighter pens.

Computers can be used as tools to facilitate processes that were undertaken manually in the past but it is not true that computer programmes speed up data analysis (Holloway and Wheeler 2010). Once the use of a computer package has been learnt it can save time by making data more accessible and assist in organisation (Gerrish and Lacey 2010).

There has been criticism in the past of the use of computer packages in GT analysis. Charmaz (2000) warned that the use of computer analysis may have a distancing effect upon researchers. However, it could be argued that self awareness during the analysis process could help ensure against this pitfall. Computers have been accepted in qualitative research as they can assist in thorough analysis by the efficient management of data (Holloway and Wheeler 2010).

3.13 Summary

Within this Chapter the wider influences and assumptions behind my research have been examined. This Chapter has looked at interpretivist and positivist research approaches. An interpretivist approach was chosen and a rationale for the chosen approach, longitudinal constructivist grounded theory, has been put forward and a description has been given of the research journey. Table 3.0 is repeated here to summarise the link between the research questions, methodology and methods. In Chapters 4, 5 and 6 the research findings are given. Firstly, Chapter 4 describes the findings during the first phase of my study. The findings from interpretivist studies cannot be generalised but it is important that data is trustworthy. In order to meet the criteria of confirmability the diaries were constructed to demonstrate the codes and categories (Gray 1997) and HCAs and PNs were asked to agree or refute these by marking the diaries.

Research Questions	Methodology	Methods
1. What are the perceptions and experiences of HCAs working in General Practice over time?	Longitudinal study to capture HCA perceptions and experiences over time. Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of HCAs in 1 st and 2 nd year of study participation and postal follow up every 3 months Year 1 - interviews – postal follow up x 3 Year 2 – Interviews – postal follow up x 3
2. How do PNs supervising HCAs perceive and experience the role of the HCA on an on-going basis?	Longitudinal study to capture and analyse PNs perceptions and experiences of HCA role over time. Constructivist Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of PNs in 1 st and 2 nd year of study participation Year 1 - interviews – postal follow up x 3 Year 2 – Interviews – postal follow up x 3
3. What do HCAs consider aids and hinders their ability to carry out their role in General Practice?	Constructivist Grounded Theory Analysis of perceived social processes taking place around HCA role in General Practice	In-depth face to face interviews of HCAs Year 1 and Year 2 - interviews and postal follow up every 3 months

Table 3.0: Research questions in relation to chosen methodology and methods

Presentation of Findings

Chapter 4

Phase 1: Getting going and proving worth

4.0 Introduction

The data collected with HCAs and PNs were analysed using the GT constant comparative method (Charmaz 1996). Data were collected and analysed over a period of 2 years for each participant in order to capture changes and developments over time. As recruitment to my study took place over a year, the total period of data collection from recruiting the first participant to following up the last participant was actually nearly 3 years. The findings fall into three phases broadly related to the 3 years of data collection and are presented in the following three Chapters maintaining chronological accuracy. This Chapter relates to an initial period, Phase 1, over approximately the first year of data collection and analysis. Chapter 5 covers Phase 2, the approximate time period of between 1 to 2 years of data collection and analysis in my study. Chapter 6 relates to Phase 3, the approximate period of two years and more of data collection and analysis, when many of the remaining second interviews and postal follow-ups were completed.

Direct quotations from the HCAs and PNs have been used in order to reflect and illuminate analyses. An attempt was made to include quotes from all participants in this thesis although some participants did become more readily the source of in vivo codes than others and so are quoted more frequently. To preserve anonymity study participants have been identified by pseudonyms. Interview numbers one and two have also been used to identify data, 1 for the interview upon entry to the study and 2 for the interview in the second year of the study. The replies to the three monthly postal follow-up of participants are referred to as follow-up 1 and follow-up 2, 1 for the follow-ups between first and second interviews and 2 for those returned after the second interview. Table 4.0 contains the names that were allocated to the study participants and also indicates the extent of participation in data collection.

There were changes to the participants over the study duration and these are detailed here. One PN retired and her successor agreed to continue in the study. Two HCAs went on maternity leave. Only one PN moved on to a completely new post towards the end of the second year of her participation. One HCA remained working part time as a HCA but also commenced nurse education via the Open University.

Data Collection + Analysis					
Phase 1 → Phase 2 → Phase 3					
HCA's	Job	Interview 1	Follow-up Postal & Phone	Interview 2	Follow-up Postal & Phone
Amy	HCA/ Admin	✓	✓	✓	✓
Beryl	HCA/ Admin	✓	✓	✓	✓
Cara	HCA / Admin	✓	✓	✓	✓
Dawn	HCA/Admin	✓	✓	✓	✓
Emily	HCA / Admin	✓	✓	X	✓
Fiona	HCA	✓	✓	✓	✓
Gwen	HCA / Admin	✓	✓	✓	✓
Helen	HCA	✓	✓	X	✓
Isobel	HCA	✓	✓	✓	✓
Julie	HCA	✓	✓	✓	✓
Kim	HCA	✓	✓	✓	✓
Leona	HCA	✓	✓	✓	✓
Morven	HCA	✓	✓	✓	✓
Norma	HCA	✓	✓	✓	✓
PNs	Job	Interview 1	Follow-up Postal & Phone	Interview 2	Follow-up Postal & Phone
Audrey	Practice Nurse	✓	✓	✓	✓
Bethany	Practice Nurse	✓	✓	✓	✓
Celia	Practice Nurse	✓	✓	✓	✓
Dora	Practice Nurse	✓	✓	✓	✓
Eva	Practice Nurse	✓	✓	✓	✓
Felicity	Practice Nurse	✓	✓	✓	✓
Gail	Practice Nurse	✓	✓	✓	✓
Hailey	Practice Nurse	✓	✓	X	X
Ingrid	Practice Nurse	✓	✓	✓	✓
Joy	Practice Nurse	✓	✓	✓	✓
Kathleen	Practice Nurse	✓	✓	✓	✓
Leah	Practice Nurse	✓	✓	✓	✓
Myra	Practice Nurse	X	X	✓	X
Nora	Practice Nurse	X	X	✓	X
Orla	Practice Nurse	X	✓	✓	✓
Penny	Practice Nurse	X	✓	✓	✓

Table 4.0: Participants and their pseudonyms and contribution to data collection

4.1 Overview of findings

Data analysis took place using the GT constant comparative method described previously. The three phases of analysis are reflected in the final three categories and the related subcategories and codes. Diagram 4.1 presents an overview of the findings with the three major categories relating to each of the findings Chapters and to the three phases of data collection and analysis. These three categories encompassing all of the various subcategories and codes are shown in deeper blue on the inside of the diagram. In the centre of the diagram highlighted in pale blue are the subcategories relating to the categories. The subcategories are linked to the codes displayed on the outside of the diagram. Following Diagram 4.1 the first category '*Getting going and proving worth*' is discussed.

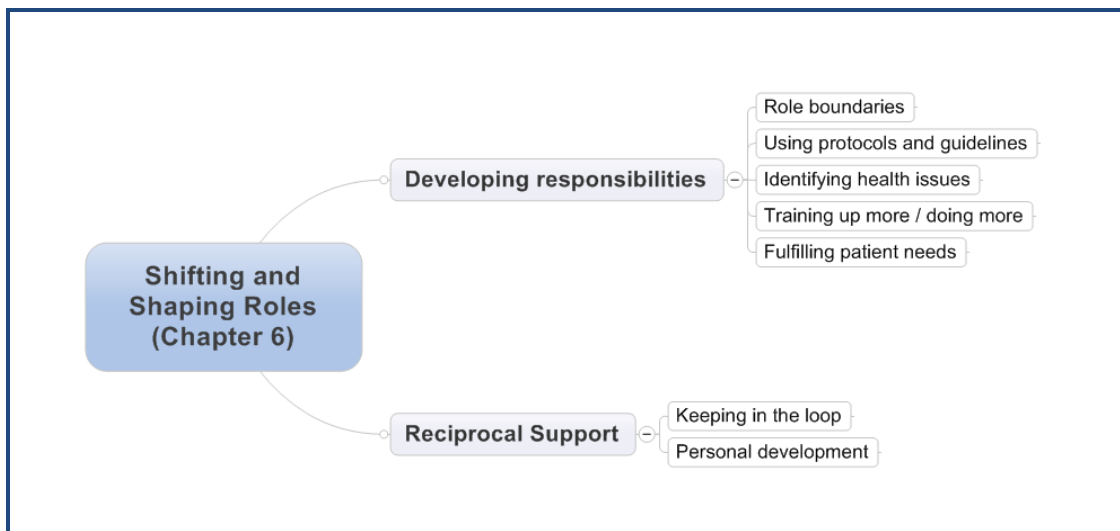
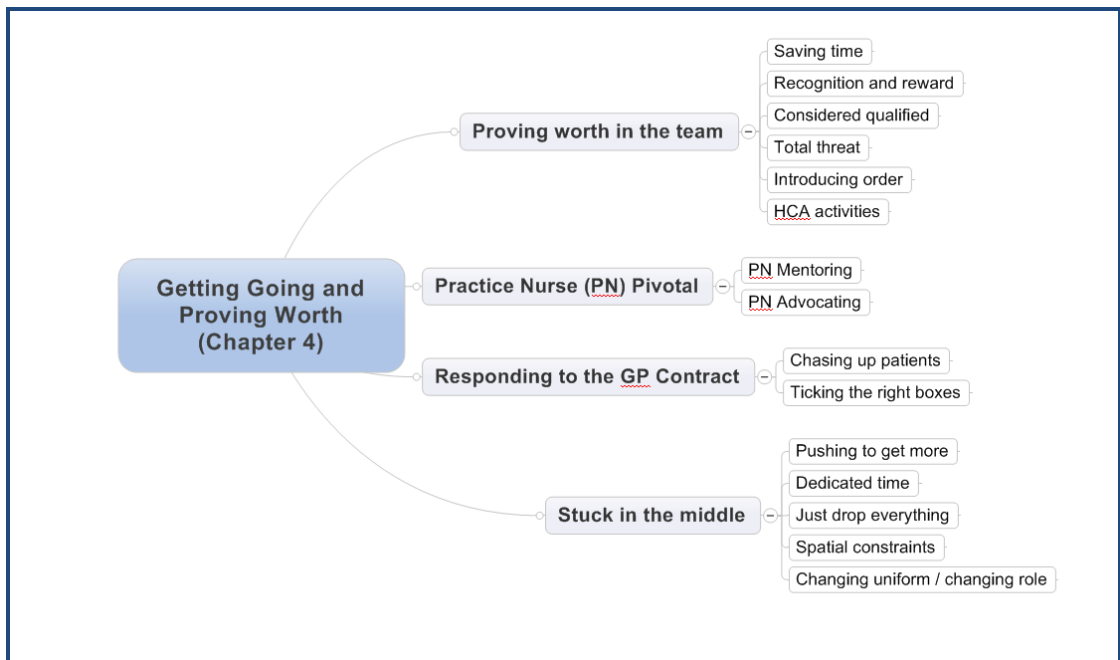


Diagram 4.1: Categories, Subcategories and Codes

4.2. Getting going and proving worth

A category *getting going and proving worth* emerged from the data during the first phase of data collection and analysis. This category has four subcategories called, *proving worth in the team*, *PN pivotal*, *responding to GP Contract* and the in vivo subcategory '*stuck in the middle*'. Within these four subcategories are fifteen codes and all the subcategories and codes are represented in Diagram 4.2. This category represents the HCAs experiences relating to the first year of my study called Phase 1. The HCAs role, being relatively new in General Practices in Scotland following the publication of the Review of Nursing in General Practice (SE 2004) and HCAs had only just started to become embedded within the practice teams. There was a real sense of the HCAs becoming more accepted into General Practice and carving out a niche for themselves over time. They responded to the needs of patients and other team members in a supportive way.

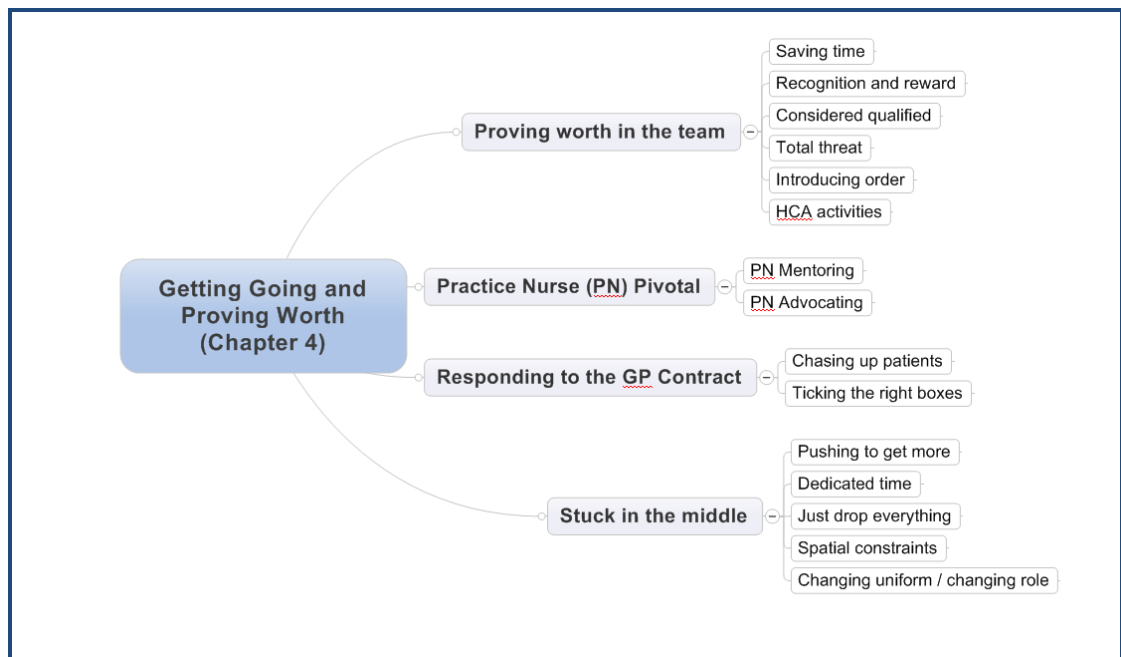


Diagram 4.2: Getting going and proving worth

Getting going in the HCA role often firstly involved taking bloods and measuring blood pressures and other duties were built in as time went by as one PN commented:

“When I first started work here in General Practice we didn’t have any HCAs and then we got two phlebotomists who progressed into being HCAs...they know the run of the place and it is really positive for all of us”

(Eva interview 1 p1).

Julie, a HCA, stated:

“To begin with I wasn’t sure but I now think the HCA role is important...And I think they see that too as a practice”

(Julie interview 1 p7)

Getting going and proving worth for the HCAs was closely related to team working and proving of value or worth with patients and within the primary care team. The HCAs were valued by the health care team for saving the time of and freeing up appointments with the nurses and doctors. They also frequently maintained equipment and took on stock replenishing and ordering. They were generally very well received and their contribution to the smooth running of the practices recognised by other team members and the subcategory proving worth within the team relates to this team contribution. The rare exception to this when HCAs were not well received by everyone is described in the code ‘*total threat*’ later in this Chapter.

Here the relationship of the other three subcategories to *getting going and proving worth* are described briefly. The subcategory *PN pivotal* relates to the PNs playing a pivotal role in the development of the HCAs. PNs were really important to HCAs getting started within the practices and the PNs remained supportive through time. One of the ways in which the HCAs proved their worth was in contributing to the fulfilment of the GP Contract and this is described more fully later in this Chapter in the subcategory named *responding to the GP Contract*. Many of the HCAs were appointed from within the General Practices, most had worked in an administrative role and some continued to work in an administrative role in addition to their HCA duties and so would already have been part of a General Practice team but they had then taken on a new and different position in the team.

Experiences of working in this dual role are captured within the subcategory 'stuck in the middle'.

4.2.1 Proving worth in the team

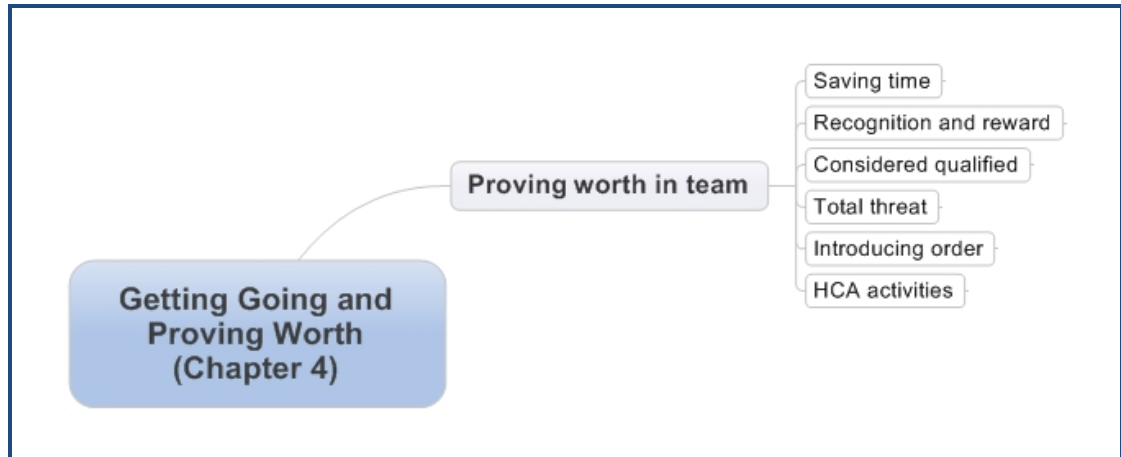


Diagram 4.3: Proving worth in the team

The subcategory of *proving worth in the team* is made up of six related codes, *saving time*, *recognition and reward*, *considered qualified*, *'total threat'*, *introducing order* and *HCA activities*. These are represented in the Diagram 4.3. This subcategory is described and then each of the codes related to it.

From the data there was a real sense of HCAs wanting to help and assist others and working cooperatively with others in the practice team. Members of this team include nurses, GPs and administrative staff and relationships with these close colleagues were important to the HCAs. As one HCA stated:

"I would say that a good relationship with everybody is very important...because at the end of the day it is a team and you are all out for patient care...you are making sure that patients get cared for"

(Norma interview 1 p9).

One PN commented:

"We have a good relationship, a small team here and she (HCA) was in the team already so there was no getting to know her if you like and she learnt very quickly you know. She was great and the patients knew her and they were accepting..."

(Felicity interview 1 p5).

Another PN commented thus about when she joined the practice:

“When I first came it was the high regard that the GPs had for (name of HCA) that impressed me. They were really pleased with her work and everything and that gives you insight into how things are”

(Myra interview 1 p3).

Team cooperation and being accepted by other team members was viewed as important by the HCAs. There was a sense of the HCAs working in order to support others in General Practice and of support being given to them by others in the practice team.

The support of GPs was important to HCAs and there was a difference in relationships across different practice settings. Some HCAs did not have much day to day contact with the GPs while others enjoyed a close working relationship. In several practices there was one designated GP for HCA related support issues. Support from administrative staff was also needed by the HCAs as there was reliance upon them to make appropriate appointments for them and in the dual role to support their changes in role.

One HCA, Julie, attached the highest importance to good team relationships:

“Important, yes definitely. I think that good team relationships are the main thing because if you have not got that then I think you have got nothing”

(Julie interview 1 p11).

PN Celia considered the importance of team agreement and acceptance of the HCA role in the practice from the beginning:

“We have a lot of regular team meetings and everybody is involved in putting forward ideas. I feel this is really important because I can see how if a HCA was employed without consultation with the nurses there could be problems. For our team the HCA has been a great asset”

(Celia follow-up year 1)

In keeping with CGT as indicated by Charmaz (2006) the literature has been woven throughout my research study to make comparisons and to indicate how my work fits with or extends relevant literature. This literature relates to the emerging themes and was sought as the themes developed.

Teamwork is viewed as being crucial to the delivery of good quality health care services (SG 2010). Within my study the HCAs and PNs viewed teamwork to be important in good service provision as the above quotes illustrate. Table 4.4 indicates the broad themes from the literature in relation to team working.

Authors	Study Country of origin	Themes in the literature relating to team work in health care
Thomas <i>et al.</i> , (2003) Makary <i>et al.</i> , (2006)	Large International survey - attitudes, culture and performance in intensive care USA survey of operating room staff	Different perspectives on team work between the different professions
Rafferty <i>et al.</i> , (2001) Wheelan <i>et al.</i> , (2003) Campbell <i>et al.</i> , (2001) Bower <i>et al.</i> , (2003) Proudfoot <i>et al.</i> , (2007)	England -postal survey 32 hospitals, 10,000+ staff USA survey 394 staff in 17 ITUs England observational study of 60 GP practices England observational study , 42 GP practices Australia – survey of general practices	Patient outcomes, quality of care, patient satisfaction can be related to teamwork
Borrill <i>et al.</i> , (2000: 2001)	England- NHS survey large crossing different sectors 2,000+	Teamwork aids decision making and leads to improved care
Baggs <i>et al.</i> , (1999) Hann <i>et al.</i> , (2007) Dackert (2010)	USA- 3 hospital ITUs staff self-report questionnaire England- survey 42 GP practices Sweden care of elderly-questionnaire to 329 NAs and registered nurses	Staff retention, job satisfaction, wellbeing of staff and patients related to teamwork
Baker <i>et al.</i> , (2006)	USA- education and training focused case study and review of literature	Commitment, communication, team training significant
Kaissi <i>et al.</i> , (2003; 2007) Clark (2009) Petrova <i>et al.</i> , (2010)	USA – assessment tool measuring attitudes in hospital ITU and Operating Rooms teams USA case study hospital ITU team England –re HCAs in GP practices interviews with 6 GPs and 13 PNs	Good communication and safe practice related to team working

Table 4.4: Themes in the literature related to teamwork.

Xyrichis and Ream (2008:238) undertook a concept analysis of teamwork reviewing the related literature and proposed a definition of team work in health care as:

“A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning and evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision making. This in turn generates value added patient, organizational and staff outcomes.”

The consequences of team work according to Xyrichis and Ream (2008) are summarised in Table 4.5. There is unsurprisingly a clear resonance here with the themes of job satisfaction and quality of care identified in Table 4.4 but this does provide further confirmation of the themes coming from the literature.

Teamwork Consequences
For health professionals
Job satisfaction
Recognition of individual contribution and motivation
Improved mental health
For patients
Improved quality of care
Value added patient outcomes
Satisfaction with service
For health care organisations
Satisfied and committed workforce
Cost control
Workforce retention and reduced turnover

Table 4.5: Summary of Teamwork Consequences – from concept analysis by Xyrichis and Ream (2008)

The findings of my study have some resonance with the above in that job satisfaction and recognition have been identified within the codes and categories. The findings of my study help to illuminate the team work issues facing HCAs within General Practice teams. Informed by Burns 2006 and Burns and Blair 2007, Petrova *et al.*, (2010) conducted a qualitative study exploring the benefits and challenges of employing HCAs in General Practices in England.

Thematic analysis of semi-structured interviews with GPs (n=6) and PNs (n=13) from across 16 General Practices in the West Midlands was completed. The findings indicate that HCAs were viewed as a valuable addition to the primary care team but patient safety was raised as a possible concern although no specific incidents of concern were identified. Petrova *et al.*, also reported that PNs were anxious about the impact of the HCA role upon their own professional roles and identity. These findings have similarities with and differences to my own study. HCAs were also valued within the general practice team in my study but concern was not expressed about patient safety. There was some initial concern expressed in my baseline study about PNs role and identity but this had quickly dissipated and was not evident in my study. In my study the PNs expressed confidence in the HCAs skills and abilities to recognise and act within role boundaries as described later in Chapter 6 in the code called *role boundaries*.

The report by Petrova *et al.*, (2010) forms only part of a larger as yet unpublished study in which 14 interviews were also undertaken with HCAs. The interviews with the HCAs should add a valuable additional dimension to the study of Petrova *et al.*, However, my study collecting and analysing data across two differing regions in Scotland and in following the experiences of the HCAs and PNs over two years offers a broader perspective with more focused consideration of the developing HCA role through time.

The literature relating to team work within General Practice was further explored. There have not been many studies and quantitative research predominates. Campbell and colleagues (2001) in a quantitative research study used questionnaires and practice outcome data to investigate the indicators of high quality care in English General Practices. There was a small study sample with only 10 General Practices taking part, with all staff within these practices requested to complete, amongst other questionnaires, the Anderson and West (1998) Team Climate Inventory (TCI). The TCI is a widely validated assessment tool usually administered as a self report questionnaire using a Likert rating scale and it has been shown that it can be used in primary care settings (Goh and Eccles 2009).

In Campbell *et al.*'s study (2001) overall 60% of staff (n=387) completed this inventory. This was a reasonable response rate from a questionnaire as response rates can often be low and when there is below a 50% response rate then statements about having a representative sample may be difficult to claim (Burns and Grove 2009). When the full numerical results were analysed using a computer software package it was found that where staff reported a better team climate, there were better scores for overall satisfaction with care, continuity of care and access to care in practices (Campbell *et al.*, 2001). In my study the sense of belonging to and contributing to a team was certainly important to both the HCAs and PNs and the quality of care provided for patients was a recognised goal.

In a later and larger study, Hann *et al.*, (2007) examined the association between culture, climate and quality of care in 42 General Practices in England. Hann *et al.*, took care to identify a representative sample of practices in England as the sample was identified from a previous stratified random sampling for another study (Bower *et al.*, 2003). Again the Team Climate Inventory (Anderson and West 1998) and other self-report measures were completed by staff (n=492) and the research also examined quality of care measures. There was an overall response rate of 66.6% but 4 practices had a response rate of less than 30% and so were excluded. The results characterised the majority of practices as 'clan' culture types (n=29) with others having a hierarchical culture (n=6) or a dominant market culture (n=3). The practices with a dominant 'clan' culture scored high on climate for participation and teamwork (Hann *et al.*, 2007). However, the results identified that there was no association between culture and quality of care and only limited evidence of associations between climate and quality of care (Hann *et al.*, 2007). Limitations of the study acknowledged by the authors are the relatively small sample size and the lack of a formal power analysis, making the detection of associations difficult (Hann *et al.*, 2007).

The term 'clan culture' appears an apt description of the close relationships between some staff within the General Practices. The close working and supportive relationships taking place within the General Practices I visited during my study were evident. Team working was referred to by the participants in my study and the desire to provide good patient care was also apparent.

In another larger study examining team climate in relation to care in general practice in Australia, Proudfoot and colleagues (2007) undertook research with GPs and other primary care staff participating (n=654) and also directly sought the participation of chronically ill patients (n=7505) within practices. All General Practices in Australia were invited to take part in the study and 97 practices replied and were involved in the study; these were of varying size and from both rural and urban locations. Although there was no attempt at randomisation or stratification of the sample to ensure overall representation of Australian General Practices, the characteristics of the practices that were involved were examined carefully and it was found that they usefully compared to the size and characteristics of all practices in Australia. The Team Climate Inventory and Overall Job Satisfaction Scale were adapted for use in General Practice in Australia and administered to the GPs and practice staff and patients completed the General Practice Assessment Survey (Proudfoot *et al.*, 2007). The results of this Australian study identified that better team climate predicted job satisfaction for GPs and other practice staff and better team climate was associated with better patient satisfaction with care (Proudfoot *et al.*, 2007). In my study team relationships were highlighted as well as job satisfaction and pride in work and care which are themes described in Chapter 5. The findings from my study provide a different in-depth qualitative view of HCAs contribution to team work within some General Practices in Scotland.

The literature indicates that teamwork is generally considered to have some bearing upon delivery of care in health care generally and also in General Practice.

In this light within my study the HCAs endeavours to prove their worth within the team suggests that this could be viewed as being worthwhile in respect of the positive consequences of teamwork as documented in Table 4.4 and 4.5. Next the codes within the subcategory named *proving worth in the team* are described.

4.2.2 Saving time

The code *saving time* refers to how the HCAs felt strongly that they were saving time by taking on work that PNs and GPs would previously have undertaken. It was also identified in the baseline research for my study that the HCAs did cut waiting times for appointments (Burns and Blair 2007). In my current study there was evidence of saving reception staff time by the HCAs taking on the administration of some clinics or recalling of patients and also by being flexible in seeing patients by switching their roles on an ad hoc basis when necessary for example dual role HCAs when working in administration may undertake ECGs for patients upon request of GPs. One HCA commented on the allocation of appointments for bloods thus:

“Then if it is only for that [bloods] then there is no point in taking up a GP appointment you know they can get that when the blood results come through”
(Beryl interview 1 p4).

Another commented on her work in relation to the PN:

“I bet it would be quite a lot of work for her if she was on her own. I can free some of her time up which is really good. It does make a difference.”
(Leona interview 1 p3).

Another commented insightfully about the movement of workload across HCA, PN and GP roles:

“...if we take more off the nurses and they take more off the doctors then it makes it easier for everybody and they are happy.”
(Helen interview 1 p8).

The HCA activities undertaken that saved time are described within this subcategory in the code of the same name.

4.2.3 Recognition and reward

During this first year of my study there was a sense that the HCAs needed to be recognised for the level of work that they were undertaking and the contribution they were making to the smooth running of the practices. Generally the HCAs were valued in the GP teams but occasionally they felt that the extent of their contribution was not always fully recognised by all GPs as one HCA commented:

“I think they do see how useful we are to them now but I don’t think that they really appreciate us”
(Amy interview 1 p5).

Remuneration was mentioned during interviews, the pay that HCAs received and the fact that some HCAs were unhappy with pay levels in relation to the increased responsibility and particularly if they were fulfilling two different roles:

“We don’t get paid any extra for doing it and it is a bug bear because it is quite a bit of responsibility”
(Cara interview 1 p7):

“I feel quite strongly about it that we are not getting any more pay for doing this role but of the two roles I can see which one needs the more skill...I know that it is more demanding as a health care assistant [than my role as a receptionist]”
(Amy interview 1 p4).

Interestingly this dissatisfaction with levels of pay did not seem to impinge greatly upon their job satisfaction and the desire to gain new skills and responsibilities. The HCAs did not agree with their pay levels but this did not stop them wanting to learn more and contribute more in their HCA roles. The contact with patients and making a difference in their lives appeared much more important to the HCAs. These findings can be related to the seminal work of Herzberg, Mausner and Snyderman (1959) who carried out research into job attitudes and factors that affected the motivation people have to work. This will be explored further under the heading of job satisfaction in Chapter 5.

There has been criticism expressed by the nursing press about GPs gaining huge financial benefits under the new GP Contract while practice staff and nurses in particular have not had any financial benefits despite taking on an increasing number of patient consultations (Timmins 2005; Tweddell 2008). There are no figures available that isolate the number of HCAs consultations in General Practice instead their consultations are routinely counted together with PN figures in national statistics (ISD Scotland 2010). However, PN workload rose from 21% of consultations in 1995 to 35% in 2007 (NHS Information Centre 2009). From the findings in the first year of my study it could be argued that HCA activity has made a significant contribution to any increase in consultations in General Practice in recent years but until statistical evidence is gathered separately for this staff group then the exact contribution of HCAs cannot be exactly quantified.

Examination of recent literature relating to the recognition and reward of HCAs identified as relevant the findings of the first large scale study of HCAs in the NHS in hospital settings in England by Kessler and colleagues (2010). There is agreement on the issues surrounding recognition and reward between my study and that of Kessler *et al.*, (2010). This large wide ranging study aimed to provide stronger evidence for the assumptions about HCAs within policy goals by asking how the NHS personnel viewed HCAs as a strategic resource, the research also explored who HCAs were and how their role was shaped and what impact it had upon stakeholders (Kessler *et al.*, 2010). There were three phases to the multi method research, firstly interviews were conducted with senior figures in strategic health authorities (n=9); secondly 273 semi-structured individual interviews were conducted with HCAs, nurses and managers across 4 different regions, 275 hours of observation in clinical practice and focus groups with 94 former patients; thirdly surveys of HCAs (n=746), nurses (n=689) and former patients (n=1651). Clearly a large number of hours of observation were undertaken and different researchers must have been involved and so issues of inter observer reliability may have arisen and this could adversely affect the reliability of the study (Gerrish and Lacey 2010).

The questionnaires used were reviewed by a variety of staff groups and piloted across target groups and revised according to feedback. This is good practice and should have helped to reduce the possibility of misunderstanding or ambiguity in the questions.

The findings indicated that HCAs were extending their role into traditional nursing activities and were often paid at a lower band than they should be which raised issues of cheap labour (Kessler *et al.*, 2010). The study also found that the HCAs were satisfied with their jobs although they lacked a collective voice within the NHS (Kessler *et al.*, 2010). It was apparent that some HCAs used their capabilities motivated by an interest in the role and its intrinsic rewards but there was underpayment of HCAs in relation to the use of these capabilities (Kessler *et al.*, 2010). One HCA in Kessler's study indicated that she continued to undertake duties at Band 3 (DoH 2005) although she had gone back to a Band 2 post (Kessler *et al.*, 2010). It is interesting to compare this with my study where HCAs also had variable roles and pay. It is worth noting that General Practices are not bound to adhere to the Knowledge and Skills Framework (DoH 2005) bandings that apply to the wider NHS and so pay in General Practice can be very variable indeed and may not reflect the skills and competencies of HCAs.

4.2.4 Considered qualified

The code named *considered qualified* refers to patients seeing HCAs in uniform and no matter how often they were told and were given written information about the unqualified nature of the HCA role they still considered them as registered nurses. This has been something that had been referred to in previous research in General Practice (Joels and Benison 2006; Burns and Blair 2007). Kessler *et al.*, (2010) in their large study examining the role of the HCA in hospitals in England also found that patients had difficulty in distinguishing HCAs from registered nurses.

One HCA referred to the way patients viewed the HCAs as registered nurses when attended appointments and they would try to get advice regarding other health issues:

*“Patients thought we were qualified nurses at the beginning...
I have had patients roll up their trousers to show me their problems”
(Amy interview 1 p1).*

The HCAs were aware of the pitfalls of being drawn by patients to give advice in areas that they did not have expertise. They would advise patients to make an appointment to see the PN or GP. It appeared that sometimes patients would use the HCA in order to get access to the GP without having to make a separate appointment.

The uniform of the HCA seems to be important in influencing patients to consider them to be registered nurses. Uniform in relation to assisting dual role HCAs to get into role is explored later in this Chapter in the code named *changing uniform/changing role*.

4.2.5 ‘Total threat’

‘*Total threat*’ is an in vivo code used by PN Celia when she talked about difficulties with a colleague in the past. This reflects the fact that HCAs were perceived as a threat by a few PNs:

*“This PN just found it a **total threat** and she just couldn’t understand why the HCA was coming in and being allowed to do things that were traditionally the role of the nurse”
(Celia Interview 1 p5).*

In the baseline study detailed in Chapter 1 some PNs felt a little threatened initially when plans for preparation of HCAs in general practice were presented within one region; they reacted negatively at first and some clearly felt that their own roles were being diminished (Burns 2006). Hence, when planning to take training for HCAs forward within the rural region it was important from the beginning to give the PNs the supervisory role with the HCAs so that they maintained a sense of control and responsibility (Burns 2006).

This proved to be a successful strategy and the PNs were consulted regarding the planning and delivery of training and retained responsibility for overseeing HCA practice with no difficulties.

For most PNs this threat was just a transitory experience as one PN stated:

“I wasn’t so sure to begin with. I thought ‘oh my goodness’ and you feel threatened...but now it is brilliant”
(Gail interview 1 p3).

A HCA observed:

“The nurses were against it to start off with, very much against it. And I think now they realise just how much it works to their advantage”
(Helen interview 1 p5).

However, 2 out of the 14 HCAs interviewed had significant problems and stated that they were bullied by the PNs within their practices. The 2 HCAs were actually intimidated by the PNs and in both cases the PNs eventually left their posts. It must be noted that this finding was only a one sided view of the issue as it was not possible to speak to the PNs involved, but the HCAs information was corroborated by colleagues from their General Practices.

The *‘total threat’* code is related to the HCAs having to prove themselves within their teams so that they were seen as valuable colleagues rather than a threat to the integrity of the PN role. The two HCAs discussed above were clearly supported by their practice teams when they felt under threat. Although their experience with individual PNs was contrary to general findings in my study, I felt it important to include these quotes as examples of negative cases and because of the impact these experiences had on the individuals:

“The bullying two years ago, it did really, really knock my confidence for six but I basically say I was not a threat. There is no way a health care assistant can be a threat to a practice nurse. No way, not in my book anyway because they do a very good job and they have got a lot more knowledge obviously and there is just no way...she just made my life a misery...and it went on and on”
(Norma interview 1 p7).

The negative and unapproachable relationship that another HCA experienced is described below:

“I think that the nurse that was like that I think she was being really selfish because she would have been at a point in her life when she was learning and she would have needed somebody to help her along...And for anybody to enter this and they have got somebody like that then I can understand how hard it would be for them because I nearly gave up”
(Julie interview 1 p 10).

These two HCAs interviewed clearly had a very negative isolated and serious experience. They felt that they were bullied and this was serious enough to warrant formal disciplinary intervention to examine this in one case. However, the HCAs stated that the negative experiences were in the past and did appear to have been dealt with appropriately within the practices and resolved.

Bullying has been identified as a problem within the NHS (RCN 2006b; Healthcare Commission 2008) and within health care in particular in the UK (Mistry and Latoo 2009; Randle 2003). It has also been identified as a problem internationally (Johnson 2009).

Burnes and Pope (2007) undertook research with a wide variety of staff in two primary care trusts in the NHS in England to examine negative behaviours in the workplace. A predominantly quantitative questionnaire was sent to random samples of staff in the two primary care trusts, over 10% of staff received questionnaires and a contact group of 16 persons who had sought help due to negative behaviour were included (220 persons). A pilot study was undertaken to test the questionnaire which should have helped to cut down on misunderstandings and partial completions (Gerrish and Lacey 2010). Ninety nine responses were received (n=99), this is a low response rate as frequently occurs with mailed questionnaires (Burns and Grove 2009). This could also be due to the sensitive nature of the questionnaire (Edwards *et al.*, 2002).

Experience or witnessing of negative behaviour was reported by (n=57) and the findings identified higher levels of workplace incivility than outright bullying and importantly identified that the incivility had very similar levels and patterns of effect as behaviour classed as bullying.

Burnes and Pope's (2007) study identified that all negative behaviour causes damage to individuals and to organisations and there is a need to focus upon preventing all negative behaviours. They advocated a focus upon leadership, policy and practice to address negative behaviour. It does appear that the issues arising within the practices within my study were dealt with under appropriate leadership within the General Practices. The close working relationships between staff in smaller teams in General Practice could mean that the negative experiences were intensified but they were also identified and dealt with effectively and good team relationships were restored.

4.2.6 Introducing order

The HCAs often took the initiative in tidying up clinical areas and of ordering and checking supplies. This also extended to checking emergency equipment and medications. Vaccines would be ordered, vaccine fridges checked and restocked. Nebulisers and other equipment loaned to patients were cleaned, checked and logged. The HCAs perceived the General Practices to be cleaner and better organised and maintained than before they came into post:

"We are in charge of the doctors emergency bag and everything that goes in it and we check for dates and everything...And the nebulisers we are in charge of the nebulisers...making sure that everything is clean and working properly....yes checking all the dates of the vaccines in the fridge and making sure that all the new stuff goes to the back...and ordering the new stocks. We check the fridge temperature morning and night...things should have been getting done before but they weren't"

(Cara interview 1 p19).

They also helped streamline clinics for visiting consultants by calling patients in a week prior to clinic attendance and carrying out necessary blood tests in advance:

“Mr (name) he actually said that he is very grateful for the fact that we actually do it [take bloods] but because he has got the right up to date blood results when he has got the patient and because he is not having to do bloods he can see more patients in his clinic”
(Dawn interview 1 p16).

The following PN certainly recognised the organisational skills of the HCA:

“Well for the diabetic clinics it is great because she does all the screening and she [HCA] sees them the week before. She phones all the patients and arranges for them to come in and when they all come in they are fasted and they have got their urine bottles and everything. She prepares them all for what they have to do and she does all their screening tests their urine, bloods, height, weight and then arranges for them to come back to me the week after when all their blood results are back”
(Myra interview 1 p1).

Myra continued:

“I don’t know how, if she wasn’t here how we would manage now. She does so much and a lot of her job is admin as well she does all the phoning...and they all turn up”
(Myra interview 1 p3).

From the data, it is apparent that HCAs made a clear contribution to the smooth running of the practices.

4.2.7 HCA Activities

The HCAs were keen to talk about the activities that they had been carrying out and those that they had developed and incorporated into their practice. The skills that HCAs had taken on in Phase 1 included phlebotomy, blood pressures, weights and heights, urinalysis, ECGs, new patient interviews, chaperoning, preparation of clinical areas and in some cases patient recalls for hypertension and diabetes. Beryl a HCA described her activities thus:

“I do mostly phlebotomy but I am also involved in blood pressure, we have a 24 hour blood pressure monitoring machine, ECGs, new patient medicals and some contract work that the doctors have for different areas”
(Beryl interview1p3).

Part time HCA Cara stated:
“I do thirty bloods or more every week and the ordering. I make sure all the supplies are the proper date too”
 (Cara interview 1p1).

Emily described how the activities grew:

“Initially it was just bloods and then we went on to blood pressures and it just kind of took off from there really and now anything that I am capable of gets passed on”
 (Emily interview 1 p1).

The HCAs also speculated about where they considered the HCA role may be developed next and what they saw as the extent of this development for themselves. There was variation within the individual General Practices with regard to activities. Some HCAs were taking on more than others but general patterns of activities were similar. Table 4.6 lists the general range of activities undertaken by the HCAs in Phase 1 of my study.

HCA Activities in Phase 1
Phlebotomy
Blood pressures
ECGs
Height and weight
Tidying and restocking consulting rooms and checking equipment
Urinalysis
Chaperoning
New patient interviews
Patient recall hypertension and diabetes
24 hour blood pressure monitoring

Table 4.6: Representation of the range of HCA activities in Phase 1

The growth in HCA roles is revisited in Phase 2, Chapter 5 and in more depth in Phase 3, Chapter 6 and illustrates how in my study through time the development of the HCA role progressed.

4.3 PN Pivotal to the development of the HCA role

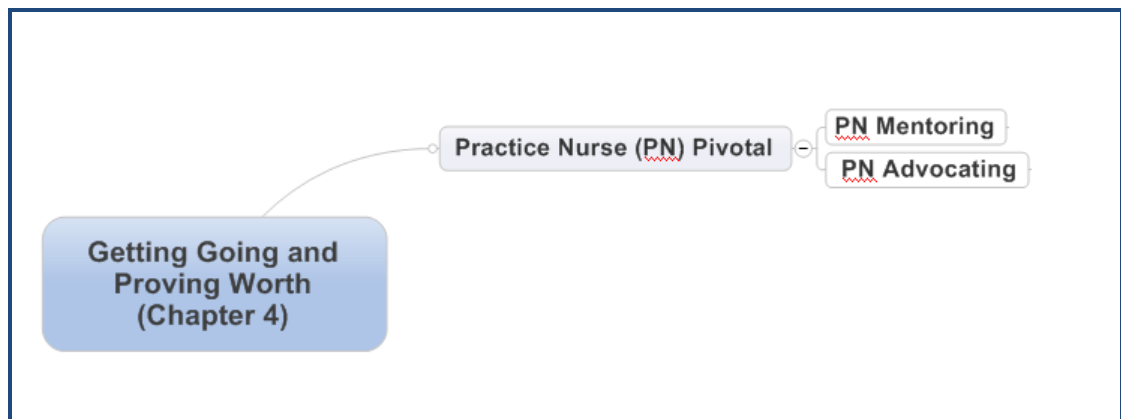


Diagram 4.7: PN pivotal

The PN pivotal subcategory covers the key role of the PNs in relation to the HCAs and there are two codes within the subcategory as shown in Diagram 4.7. These codes are named PN mentoring and PN advocating. From the findings it was clear that the PNs' status and influence within the General Practice setting was pivotal to the development of the HCA role.

The PNs had taken on the lead supervisory role for the HCAs in all but one practice where other arrangements were made for a GP to act in for a period of time due to the absence of nursing staff. The PNs were responsible for supervising, delegating work to the HCAs and also for assisting in the education and training of the HCAs. The HCAs identified the importance of a supportive and approachable PN with the drive to assist in developing the HCA role. This was especially important initially when the HCAs were learning and developing more new skills. The PN was viewed by the HCAs as pivotal to the HCA experience. Due to the continuing supervisory role of the PN, some of the illustrating quotes within this subcategory and related codes come from all three phases of my study.

An example of the PN pivotal code is:

“(Name of PN) has been a big help. She has pushed ...she can read in a magazine it says that health care assistants are doing such and such... and she will come back into the practice and put it to the management team and before I know it I am doing it as well. You know she pushes forward to get everything it is more or less ‘well we will get a protocol sorted out and you can do that too.’ Without her really I think it would have been left to lie just doing bloods and blood pressures after I had been doing the health care assistants course”
(Isobel interview 1 p4).

One PN said this about being the only one who supervised the HCA:

“She comes to me...I think everyone else would point her towards me if she has ever got any questions and I do keep an eye on her”
(Felicity interview 2 p1).

Felicity continued later in the interview to say:

“I think the GPs see it as ‘well she is yours; you get on with it and sort it out between you.’ Which I am fine with and there has been nobody else involved”
(Felicity interview 2 p3).

The codes PN mentoring and PN advocating is described next.

4.3.1 PN Mentoring

The term mentor has been used commonly within the nursing profession since 1980s and there are various definitions and characteristics attributed to mentors; advisor, supervisor, counsellor, assessor (Andrews and Wallis 1999; Gray and Smith 2000; NMC 2006b). The role of the mentor in relation to HCAs has not been evidenced greatly within the literature (Rennie 2007) so my study adds to this knowledge base. The NMC Code of Conduct clearly identifies that nurses have a duty to provide support to others in developing their competence (NMC 2008). The code also is unequivocal about delegating effectively:

- “You must establish that anyone you delegate to is able to carry out your instructions
- You must confirm that the outcome of any delegated task meets required standards
- You must make sure that everyone you are responsible for is supervised and supported”

It would appear that some degree of mentoring of the HCAs and others is inherent within any nurses' practice.

The supportive and nurturing role of the practice nurse was important to HCA development in the General Practice setting. It was clear from the data that the HCAs received a great deal of support and encouragement from the practice nurses and that their relationship with the PNs was often very positive within the General Practice team. This is evidenced in the following:

"The practice nurses have really helped us, they have been really good"

(Amy interview 1 p3):

"She has actually been brilliant any time I need her and she doesn't make you feel stupid if you ask a question"

(Dawn interview 1 p3).

Mentorship of the HCAs by PNs was something that was integral to the foundation course for HCAs in the rural region (Burns 2006). Other HCAs attended preparatory training in England and PN mentorship was also an integral part of this. However, it has emerged from my study that the PNs almost exclusively provided mentorship to HCAs through their induction period and when the HCAs had undertaken any additional training courses. Thus the mentoring relationship continued. The mentorship of the HCAs had already been identified by Burns (2006) as something that could be particularly time consuming and in my study it was often difficult for HCAs and PNs to get time to work together during busy working days where patient appointments were allocated in advance and tight time schedules had to be adhered to. Teaching clinical skills to the HCAs within the practice was undertaken by PNs and this has also been recognised in the aforementioned study by Petrova *et al.*, (2010). The PNs were skilled in assisting the HCAs who recognised this:

"I think to begin with the blood pressures, I was not very sure about it but my practice nurse...she was great. She said 'don't doubt' ...but she trusted me and you know it gives you confidence"

(Cara interview 1 p13).

Another HCA was very apprehensive about starting to take blood and needed to be guided in the right direction by the PN:

“The very first blood that I did... (name of PN) had just said to me...’right you are doing the next blood’ because I just kept saying ‘I will watch you, I will watch you’...She said ‘you can do this no bother”

(Dawn interview 1 p11).

4.3.2 PN Advocating

Advocacy is a legal term meaning to plead on behalf of another but it is important concept within healthcare and within nursing in particular (Jugessur and Iles 2009). Advocacy can also be defined broadly as:

“Stating a case to influence decisions, getting better services, being treated equally, being included, being protected from abuse, redressing the balance of power and becoming aware of and exercising right”

(Jugessur and Iles 2009:188).

The PNs role in relation to supporting the HCAs extended beyond that of purely mentoring. They spoke up for the HCAs to the GPs and practice managers often within the practice setting.

There was concern expressed by PNs about how satisfying the job would be for the HCAs as the following quote from Leah a PN indicates:

“I said to the practice manager ‘you need to make her job interesting you know. Don’t let her think that she is starting here to be a phlebotomist because that will just be soul destroying...we need to identify what her role is going to be to give her some job satisfaction and make sure that she can follow patients through”

(Leah interview 1 p2).

This concern was a consistent issue and links with the category of job satisfaction in Chapter 5 in which the HCAs mention being able to follow patients through and the variety of activities as important to job satisfaction.

Several PNs also intervened in order to try to secure improved payment for the HCAs:

“I got involved and said to the GPs ‘Come on you want to pay her more than that if she is going to be doing these duties it is quite a responsibility. She has done extra training and she has been doing loads of practising.’ And so they did pay her more, and I thought that was only fair. But they weren’t going to until they were pushed”

(Felicity interview 2 p3).

The PNs appeared to take the lead in valuing the job that the HCAs were doing and took a keen interest in securing their due recognition within the practice setting. The opportunity for a HCA to enter nurse education was actively pursued by one PN within a practice who played a very active role in persuading leads within the NHS to consider giving support to a HCA within General Practice.

Advocacy on behalf of patients is a core value within nursing (NMC 2008). However, in my study the PNs were active in pursuing the interests of the HCAs and they did plead on their behalf within the practices. The essence of the close supportive working relationships developing between PNs and HCAs in General Practice was captured here in the first year of my study.

4.4 Responding to the GP Contract

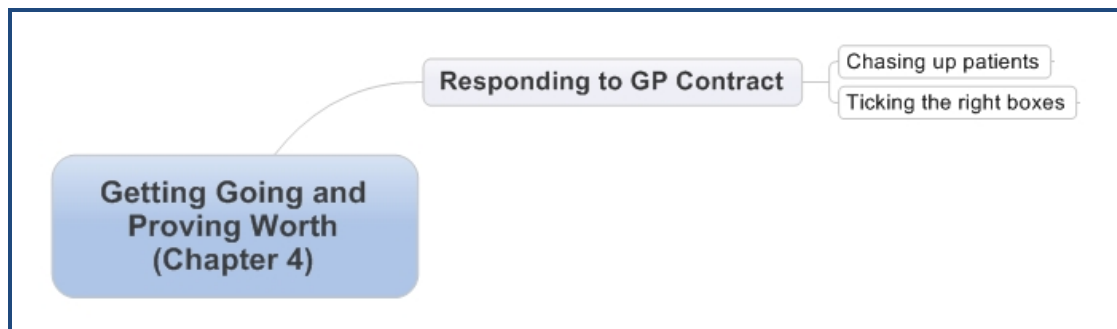


Diagram 4.8: Responding to the GP Contract

Responding to the GP Contract is the third subcategory within getting going and proving worth and is represented in Diagram 4.8. Two in vivo codes emerged within this subcategory ‘*chasing patients up*’ and ‘*ticking the right boxes*’. This subcategory although identified in Phase 1 of my study continued to be significant in Phases 2 and 3. Hence within the description of this code there are direct quotes from both the first and second interviews.

Responding to the GP Contract is a fundamental part of the PNs and most HCAs role and a means by which the HCAs proved their worth and assisted with the practice workload. The accumulation of points by gathering information from and undertaking interventions with patients in order to gain monetary reward for the practice is of great importance and over time the HCAs became increasingly involved in Contract activities. However, not all HCAs and PNs viewed the Contract as being central to the HCA role and a few PNs considered that the Contract was more related to their own role than that of the HCA.

Responding to the GP Contract was identified as central to the HCA role despite some lack of recognition of this by a few of the HCAs. The GP contract in the UK is the contract for payment that GPs have with the government.

The Contract exists because of the arrangement that came about in 1948 when general practitioners did not agree to be employees of the new National Health Service and so remained independent providing general medical services under contract (Cook 1999). In recent years the Contract has become more specific in nature (DoH 2003). The following quotes from Cara a HCA and Penny a PN illustrate this:

"I think there is quite a lot coming in the new contract that we will get handed"

(Cara interview 1 p6):

"Our particular health care assistant has a lot to do with the admin side and in particular collating information in certain disease areas...she focuses on diabetes in particular. And she will do a lot of pre diabetic clinics and she is entering contract information when she sees these patients"

(Penny interview 2 p2).

The HCAs recognised that *responding to the GP Contract* was fundamental and that different projects were allocated to the HCAs and PNs according to the targets included in the contract and that this was related to practice income. This resulted in changing projects and priorities for them as Amy the HCA commented:

"We did health checks on people in the practice aged 45 to 64 that we have just finished. We had really good feed back on that, but now unfortunately because of the contract, it has now stopped"

(Amy interview 1 p1).

The new general medical service Contract came into effect on 1st April 2004 and has provided a framework for the improvement of standards of patient care (BMA 2003; 2011; DoH 2003). General Practices aim to meet targets within the quality and outcomes framework (QOF). Different practices can choose to aim for different targets within four domains: clinical; organisational; patient experience; and additional services and points are attached to various criteria within these four domains (DoH 2003; Tinson and Holland 2004; BMA 2011a). Overall the UK General Practices scored much higher points on the QOF than was expected and the new contract was then more expensive than had been anticipated (Timmins 2005).

Using an ethnographic research design, Huby *et al.*, (2008) examined the reality of changes following the implementation of the new general medical services Contract within 4 General Practices: 2 in England and 2 in Scotland. Huby *et al.*,’s study aimed to explore the complexities of practice organisation and practice members’ perceptions of the organisation related to nGMS. Practice documents were examined, formal and informal meetings were attended by the researchers and semi structured interviews were undertaken with practice staff within all 4 General Practices. The exact number of interviews undertaken is not indicated but it is stated that there was representation from all key staff groups within the 4 practices.

The study found that the number of nurses, HCAs and admin staff increased in all 4 practices and that the practices became more hierarchical with decision making becoming concentrated in fewer people at the top and monitoring and control of colleagues’ behaviour took place in order to maximise performance and remuneration (Huby *et al.*, 2008). IT systems that were developed to implement the QOF were found to be very effective mechanisms by which to control the daily work of practice members in order to gain maximum QOF points (Huby *et al.*, 2008). The findings of Huby and colleagues (2008) have some resonance with my study: the subcategory *responding to the GP’ Contract* and the following 2 codes emerging within it are reflected within their study. The findings from my study serve to illuminate further the direct influence of working to fulfil the new GP Contract upon PNs and HCAs experiences. The day to day activities of the HCAs appear to be influenced by the requirements of the Contract.

4.4.1. ‘Chasing patients up’

This in vivo code refers to the HCAs undertaking administrative work to identify and then call patients in to attend appointments with them so that interventions can be undertaken to fulfil obligations relating to the GP Contract:

*“We do lots of searches and call patients in for the GP points. Things like fasting cholesterols and things we **chase the patients up**”*

(Gwen a HCA, interview 1 p2).

The patients were chased up in order to help maintain their health but also to obtain points for the Contract and this was sometimes linked to specific training. One PN commented thus about direct target numbers:

“We have all been to training for the alcohol brief intervention and (name of HCA) has been to training as well...we have got about four hundred to get through. So yes it is very much QOF led, very much QOF led”

(Ingrid interview 2 p2).

Another PN also recognised the value of the HCA in getting patients to attend so that health interventions could be undertaken and data could be collected for the Contract:

“Definitely the HCA work is related to the GP contract definitely, all the bloods that get done and all the blood pressures, the injections, you know the immunisations, flu and pandemic flu and definitely weights, urine, albumen urea you know she is involved in phoning people up you know to get them in and the samples and stuff”

(Leah interview 2 p2).

Chasing the patients up could be said to have health benefits for the patients themselves in that they were followed up appropriately but it also helped to fulfil the requirements of the GP Contract, which is based on health driven targets set by Government (DoH 2003: BMA 2011a) .

4.4.2. ‘Ticking the right boxes’

This in vivo code refers to the gathering of patient information and entry on to the computer system. The term ‘*ticking the right boxes*’ was used by several PNs and HCAs to describe entering information into computers to comply with the Contract. The following two extracts from HCA interviews illustrate this code well:

“Ticking the right boxes, yes...in fact there is a meeting...that I am going to about it...I will soon know if I am not ticking the right boxes...most of it is a lot of contract stuff and work towards that”

(Kim interview 2 p4)

“I have to SPICE a lot of information that I collect from patients. I still get hypertensive patients that are having their review. And I have to take their height, weight and blood pressure and that is all part of it. They have got to be within their....if it goes red then you have to get it to change to green. So it has to be done once a year or once every nine months usually we try to do it”
(Isobel interview 2 p2).

The term SPICE here refers to collection of information on the GP computer systems for the **S**cottish **P**rogramme for **I**mproving **C**linical **E**ffectiveness in primary care. The datasets included in SPICE allow comparisons in the quality of care provided in General Practices across Scotland (NHS Scotland 2002).

4.5 ‘Stuck in the middle’

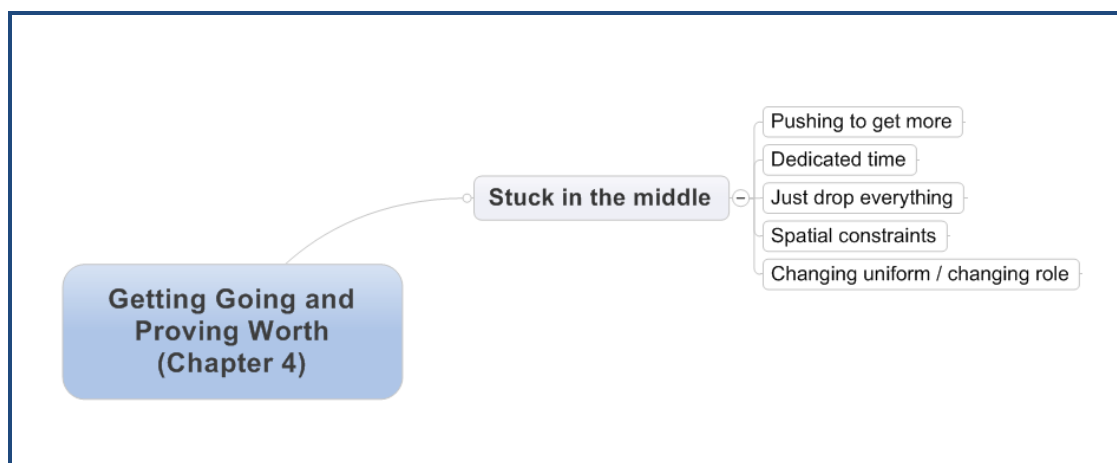


Diagram 4.9: ‘Stuck in the middle’

The subcategory ‘*stuck in the middle*’ relates to the perceptions of HCAs who have a dual role in General Practice, that is, working in a joint role as a HCA and in an administrative role such as receptionist. This subcategory and related codes are represented in Diagram 4.9. ‘*Stuck in the middle*’ described the perceptions of those who had a dual role and the following codes were identified in relation to dual role HCAs: ‘*dedicated time*’; ‘*just drop everything*’; ‘*changing uniform*’; ‘*spatial constraints*’. This in vivo subcategory describes the perceptions that the dual role responsibilities created for the HCAs.

Belonging to two different groups of staff in the General Practice and trying to be flexible at work created a sense of being '*stuck in the middle*'. For example HCAs who had a dual role found themselves on the duty rotas for the nursing and administrative staff and at times of holidays or absence this could create tensions with conflicting demands from different staff groups:

*"We are **stuck in the middle** for the likes of rota cover"*
(Amy interview 1 p2).

Another HCA commented further:

"Yes you feel as if you are torn between two places especially if you are busy at one end and then you get called away"
(Cara interview 1 p16).

The experience of being '*stuck in the middle*' was not always negative because it could mean that the person could often bring expertise from one role to the other and so assist colleagues. Some HCAs enjoyed doing administration that was connected to their clinical duties for example calling in patients or entering blood results.

4.5.1 Pushing to get more

This code refers to the attitude of HCAs to taking on new skills. Some HCAs were very keen to learn new skills. This role development was seen as something that they had to talk about with PNs and GPs and actively pursue. Some were very interested in taking on more because it made work more interesting and several of those in dual roles wanted to work more of their hours as a HCA. The following statements reflect this eagerness to take on more HCA duties:

"I know it sounds silly but I am quite happy to take on anything"
(Amy interview 1 p6):

"We are desperate to get more because we like it. It is good. What sort of things I don't know but we are willing. They know we are willing you know and quite eager to do it"
(Cara interview 1 p6).

This desire to gain new skills can be linked to PN concerns about giving HCAs a well defined and interesting role rather than just repeating a very narrow set of tasks, as illustrated in the quote by PN Leah in Section 4.3.2. *PN advocating* and it can also be related to the category of job satisfaction in Chapter 5 where satisfaction is linked to a more varied role. One HCA had worked as a phlebotomist in another General Practice that was nearer to her home but left to take on the HCA role because of the more varied and interesting work available to her.

4.5.2 'Dedicated time'

'*Dedicated time*' is another in vivo code referring to the times dedicated to the two different parts of the dual role:

*"I do have **dedicated time** on Wednesday and Friday morning for my health care assistant work and I do get that"*
(Amy interview 1 p2).

It was also used to refer to protected time allocated to working time with the General Practice while being mentored. PNs and HCAs often did not get much dedicated time together but some how managed the supervision and teaching in practice. The PNs often gave of their time and support out with working hours:

"The GPs supplied the funding for the training and the time really we spent, when you are mentoring you need a certain amount of time to go over things you know for training...You just make the time...It did encroach on my own time"
(Ingrid interview 1 p6).

The dedicated time in both these instances was often open to change. Reception duties may be undertaken while working as a HCA and vice versa but the dual duty HCAs preferred them to be separated:

"Generally they [the HCA and administrative roles] are just kept completely separate which is quite good because there can be no stressing about where you are supposed to be, where your loyalties for that day are going to be. The idea of them separate suits me..."
(Dawn interview 1 p6).

Thus it would appear that the separation of the roles by allocating dedicated time to them helped to reduce the tension created by demands from two staff groups. The following code '*just drop everything*' refers to situations arising out with this '*dedicated time*'.

4.5.3 'Just drop everything'

'*Just drop everything*' is an in vivo code referring to situations that dual role HCAs were placed in when they were asked to step into assist in seeing patients when they were undertaking administrative duties:

*"If we are asked we **just drop everything** and come to help"*
(Amy interview 1 p5).

As the need arises they could be asked by GPs to go do ECGs or bloods for patients attending for a GP appointment:

"I work late some nights and a doctor will come through and say 'I need an ECG' at 8 o'clock at night when everybody else has left, we have skeleton staff anyway, but I still have to do it if I can"
(Gwen interview 1 p4).

For some HCAs this was problematic when they were working under pressure and it sometimes created resentment within administrative teams but for others this made their job more interesting and satisfying. The HCAs also felt that their quick response to requests for assistance was about supporting good and efficient patient care so they were happy to give assistance. Over time the HCAs managed the movement between roles more effectively by sensitive communication with other team members, this process is covered under the code '*keeping in the loop*' in Chapter 6.

4.5.4 Spatial constraints

The HCAs identified that GP premises often restricted the HCA role as there was often inadequate space for them to see patients. Certain practices had converted space or shared space but the issue of space to work was acknowledged as problematic. One HCA when asked if her hours of work were likely to be increased replied:

"In this practice not at the moment as we are very limited space wise, if we had bigger premises then yes I think I might do"
(Beryl interview 1 p18).

Another commented similarly:

“It would probably be easier but for space, I don’t think it is practical you know, there is no room space really but it would be easier if I could just do a full day [as HCA]”
(Helen interview 1 p3).

Spatial constraints were identified as particularly important in the earlier baseline research (Burns 2006; Burns and Blair 2006; 2007) and have continued to be an issue in this study. Having to move from room to room to accommodate patients and colleagues was reported:

“Some days I am in the Treatment Room in the middle of a blood clinic and somebody needs seen so I have to move. You know it would be nice to just be able to have your own room”
(Cara interview 1 p18).

However, it should be noted that over the course of my study some practices obtained or were in the process of planning to obtain alternative premises. Some of the spatial constraints were resolved by new or adapted accommodation. This fits with the trend throughout the UK, as a survey of General Practices by the BMA showed that 75% (n= 251) of responding General Practices were severely restricted due to lack of space (BMA 2006; Doherty 2006).

4.5.5 Changing uniform, changing role

The HCAs mentioned uniform as significant in helping them to assume their role. The uniform had certainly led patients to presume that they were qualified nurses despite being informed otherwise. However for the HCAs the act of putting on a uniform helped them to separate their roles:

“What I find is that when you put a uniform on it makes a difference and the role is separated and patients have come to understand that”
(Beryl interview 1 p2):

“...so when I have got my uniform on I know what day it is and where I am going to be for that day”
(Dawn interview 1 p6).

The act of changing into the HCA uniform was significant to the HCAs interviewed, as it assisted them mentally to get prepared for their role and their status is also recognised by patients and staff.

The importance of uniform to medical students' identity has been examined in the now seminal work of Becker *et al.*, (1961). Becker and colleagues' research examined the student culture in a medical school in the United States where data were collected using participant observation and by interviewing students throughout their medical training (Becker *et al.*, 1961). The aim of the study was to discover the wider influence of medical school about the delivery of a technical education (Becker *et al.*, 1961). The participant observation of daily school activities was extensive following groups of students for up to two months at a time. The students were informed that the researchers were not students and they were there to gather material for a book on medical education. This seminal research gave fascinating insight into the life of medical students and the many aspects of their developing group identity.

The study described how uniform was important at various stages in medical studies marking a rite of passage:

"During the first two years he wears only a white laboratory coat. In the third and fourth years he puts on white trousers, jacket and shirt worn by interns and residents, but he is still not a physician as they are"

(Becker *et al.*, 1961:4).

The change in apparel marked the change in status of the medical students when they first put on a hospital uniform to begin work in hospital:

"That he now becomes, in a sense, a functionary of the hospital is symbolised by the uniform he dons at the beginning of the third year: the white shirt, trousers and jacket he will wear through the remainder of his undergraduate and postgraduate medical training"

(Becker *et al.*, 1961:194).

There are strong similarities in this current study with the findings of Becker *et al.*, (1961) with regard to uniform, the significance in the change of status with uniform change and also in providing assistance with the assumption of role.

My study is the first study to identify this phenomenon in HCAs in General Practice.

The issue of uniform does seem to be a factor influencing patients' view of nurses and HCA as to whether they present a professional image or not. A survey of 499 patients and visitors at a health centre in America found that as adults get older they create a perception of nurse image based upon uniform colour and style whereas younger study participants in this American study did not so much perceive uniform types to equate to professionalism (Albert *et al.*, 2008). Participants in the study were shown photographs of the same registered nurse posed identically in eight different uniforms and were asked to rate the photographs by image traits using a previously developed and well utilised nurse image rating scale (NIS) (Mangum *et al.*, 1991; Mangum *et al.*, 1997; Albert *et al.*, 2008). Attention was given to the statistical significance of responses and the convenience sample included in the study was deemed to be representative. Preference for a white fitted uniform was identified by persons of 45 years or over. It should be noted that Albert *et al.*'s study was funded by a research grant from a company making uniforms and they could be viewed as having vested interests that could possibly have led to some bias in the study.

The results of the American study are interesting to consider in relation to the possible influence of uniform upon the perception of the HCAs by patients in General Practice in Scotland. Patients who see the HCA on a regular basis will generally be aged 45 years or over (NHS Information Centre 2009). In Scotland, the uniform of HCAs varies in design and colour across different practices as there is no conformity with the uniforms that are standard within the wider NHS.

Recently in a study commissioned by the health professions council (HPC) explored aspects of professional practice with podiatrists, occupational therapists and paramedics.

Thematic analysis of 24 focus groups with 112 participants made up of students and educators in the above professions revealed that appearance and in particular uniform was considered important for public perception and confidence in practitioners' professional ability (HPC 2011). Patients' views were not sought in this initial research but further examination of perceptions of professionalism is planned (HPC2011).

This code could be identified as being similar to the code '*considered qualified*' where uniform appears to play a part in leading patients to believe that the HCAs are qualified nurses but here the changing of uniform refers to the differential status of HCAs who also work in an administrative role part of the time. The uniform assists the person wearing it get into their role.

4.6 Summary of Phase 1

The category *getting going and proving worth* provides an overview of some of the issues faced in General Practices after the introduction of the HCA role in the Phase 1 of data collection and analysis. Good working relationships within the practice team and in particular with the PNs were very important to the HCAs. The PNs provided mentorship and advocacy to the HCAs and were generally at the centre of supporting the initial development of the HCA role. The dual role of being a receptionist or administrator and a HCA is common and brings with it particular challenges and some perceived benefits. Responding to new general medical services Contract has hugely influenced activities of the HCAs and others within practices. The next Chapter will move on to consider developments in the HCA role in Phase 2 of my study.

Presentation of Findings
Chapter 5
Phase 2: Building confidence and respect

5.0 Introduction

Following on from the first category of getting going and proving worth encompassing Phase 1 of my study, approximately the first year of data collection and analysis, the HCAs started to become more fully established within the practices. During Phase 2 of data collection and analysis the second major category which emerged was *building confidence and respect*. Phase 2 relates to the approximate time period from one to two years of data collection and analysis. This second phase of development in the HCA role in the General Practice was when the HCAs became much more of an accepted part of the General Practices, they became more confident and subsequently felt that they commanded more respect from work colleagues and from patients.

This Chapter contains data from both first and second interviews with the HCAs and PNs and follow-up with them between first and second interviews are included in the data analysed within this second phase. It must be noted that time frames for the three phases are approximate and that some HCAs in the study had been in post a little longer than others or had undertaken phlebotomy initially before going on to develop in their HCA role. The second interviews of HCAs and PNs were really interesting and informative and the longitudinal study design certainly allowed appreciation of the changes occurring but as the following extract from my reflexive journal indicates there were also some pitfalls to avoid.

29/5/09 Extract from reflexive journal

I have noticed a difference in undertaking the second interviews. The HCAs are more confident and talking more fluently about their experiences. The PNs also appear more relaxed about being interviewed. I suppose I am also more relaxed and confident in conducting interviews. I am also eager to find out more about their experiences. This is helping to make the collection of rich data easier than in the first interviews. I had wondered if the second interviews may be shorter but this is not the case. I am finding it really enjoyable going back to see participants again and finding out what has been happening. I am aware that feeling more comfortable with those I am interviewing may lead to a tendency for me to talk more. I need to be careful that I cover the agreed schedule and follow-up new leads whilst being careful to avoid asking leading questions. I must not influence the responses of the HCAs and PNs. There are perhaps advantages and disadvantages in feeling this comfortable with participants and I must remain self aware.

Charmaz (2006) warned about forcing data into preconceived categories and indicated that interviewing style can completely shape the content of a study. Poor questioning technique can mean that important issues to the participants may not be explored and it would be all too easy to impose ideas upon participants. However I feel that transcribing the recorded interviews myself has helped me to reflect upon the nature of my questioning and the possible influence I have upon participants.

5.1 Building confidence and respect

The category called *building confidence and respect* contains two subcategories *job satisfaction* and *valuing increased knowledge*. The two subcategories will be discussed and illustrated by 7 codes including 4 in vivo codes '*really great*', '*towards nursing*', '*getting together*', and '*good foundations*'. The subcategories and codes within the category *building confidence and respect* are represented in Diagram 5.0.



Diagram 5.0: Building confidence and respect

The development of confidence in the HCAs appeared to be related to their growing experience and skills. One HCA made the following comment about her growing confidence in her abilities:

“It has been quite emotional as well because sometimes you went home at night thinking ‘oh did I manage to do that?’ ‘Did I write that persons name and date of birth?’ I went home thinking ‘did I do that?’ ‘Did I do that?’ And eventually it is just habit and you just get into doing it and now I feel that I am quite confident and I leave at night not having restless sleeping time thinking about it”
(Isobel interview 2 p1).

Another HCA, Leona, commented on the changes since her first interview:

“Yes the job has changed in a good way. I am more confident. I know the job better”
(Leona interview 2p1).

There seemed to be more than just satisfaction in and enjoyment of the role of HCA within this category as it was also reflected in their increasing confidence and competence and well as in the respect that they were afforded by patients and other team members. The education and training that the HCAs had received also contributed to the confidence and competence.

Respect is a word that came up frequently in interviews and follow-ups the concept of building up the respect of patients and colleagues was important to the HCAs. They noticed how they were afforded more respect from patients when working as a HCA than they did when working in reception. They enjoyed this increased status that the HCA role afforded them. One HCA at the outset noted thus the comparative difference when taking on the HCA role:

“People are a whole lot nicer to you and you get a bit more respect than you used to get that is what I find anyway”
(Helen interview 1 p1).

At a review meeting another HCA commented:

“I think they recognise my role and view me in a different light to that of reception staff. All practice members seem to have an altered perception of me. Patients seem to not have noticed me in reception even though I was there for 10 years. It is strange how differently you can be regarded according to your role”
(HCA Review Day 2009)².

The PNs noticed the increasing confidence of the HCAs:

“They have just been doing more of what they were already doing but they are obviously more confident and competent in what they are doing”
(Eva interview 2 p2):

“Our confidence in her has increased because we are now aware that she is aware of her own competency and we trust her to call if there is a problem and she does”
(Ingrid interview 2 p2):

“Her confidence has grown a lot. I have seen a huge change in her confidence”
(Kathleen interview 2 p2).

The subcategory *valuing increased knowledge* relates to the building of confidence and respect. This subcategory includes codes that are related to training and development and acquisition of knowledge related to the HCA role. There was a real sense of a thirst for knowledge and understanding amongst the HCAs. For example they wanted to know more about the blood tests they were taking and about patients' conditions.

² HCA Review Day refers to the yearly meeting of HCAs set up in rural region

All of the HCAs interviewed had undergone some form of education away from the work place although the extent of attendance at courses and study days varied across the practices. Education was valued by the HCAs and they were often very proactive in seeking out educational opportunities and this was also supported by their PN. This subcategory will be discussed following discussion of job satisfaction.

5.2 Job satisfaction



Diagram 5.1: Job satisfaction

The subcategory *job satisfaction* includes three codes '*really great*', *pride in work/caring* and *patient preference*. This subcategory and related codes are represented in Diagram 5.1. The codes cover the various aspects contributing to satisfaction in the HCA role. For example the HCAs commented as follows:

"We get a whole lot of satisfaction out of doing this role and we are keen to progress"

(Amy interview 1 p6):

"Well I think it is the satisfaction from being able to get this job and being able to reassure people that 'well your blood pressure is alright' things like that"

(Beryl interview 1 p4).

They particularly valued having learning new skills and developing their role:

"Well it is a wee bit more exciting when you get more to do... and it keeps your head up. You feel like you have a variety of things throughout the day"

(Isobel interview 1 p4).

As previously noted seeing patients on an on-going basis was also important in providing job satisfaction to the HCAs:

“I probably find it more satisfying because of the fact that people like to come back to see me. I like it that way because I obviously think well I am obviously doing something right and you know it is nice”

(Emily interview 1 p6).

The work of Maslow can be applied here to satisfaction within employment. Maslow (1954; 1987) is perhaps the most widely cited human motivational theorist. He concluded that human behaviour is controlled by both external environmental factors and by internal unconscious forces and that some factors have precedence. He postulated that humans have a hierarchy of needs that they are driven to fulfil (Maslow 1954; 1987). Diagram 5.2 illustrates Maslow’s hierarchy of needs related to needs in the workplace in the boxes on the right hand side of the pyramid.

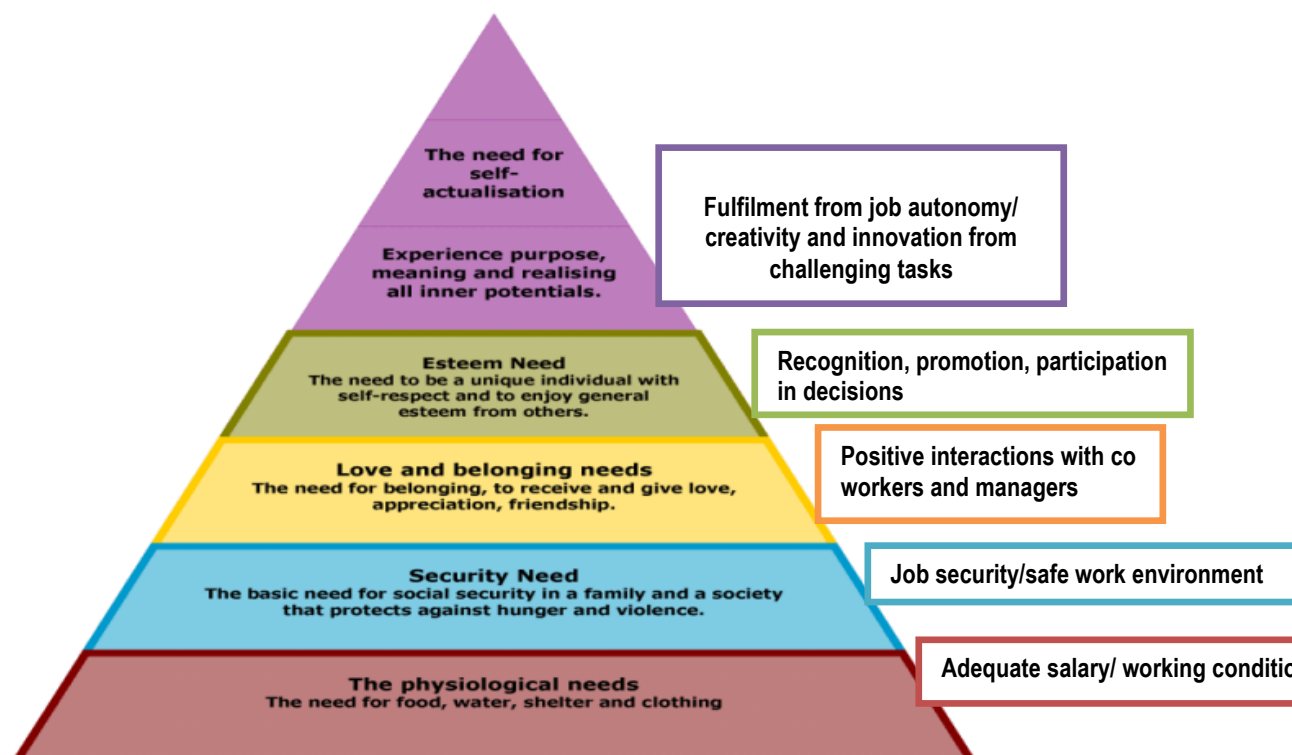


Diagram 5.2: Maslow’s Hierarchy of Needs in relation to the workplace (adapted from Maslow (1954; 1987) and Borkowski (2011))

According to Maslow (1954;1987) the most basic physiological needs are for water, food air and followed by the need for satisfying safety and security and so a home and job security are important here. The third level of need is to be loved, to belong and to be approved of by others. In relation to the workplace it can be seen that employees seek a sense of community and belonging and managers can help provide this sense of belonging and community (Borkowski 2011).

The next tier in the hierarchy is self-esteem and Maslow noted a lower (external) and higher (internal) version (Maslow 1954; 1987). He identified that external self esteem requires the respect of others, social and professional status and appreciation and recognition whereas internal self esteem requires self-respect, confidence and autonomy (Maslow 1954; 1987). It could be argued that employees want to be competent and grow in self-esteem when they receive recognition from others. The need to participate in continuing education and development and providing challenging and meaningful work is important in motivating people at work. Maslow (1954; 1987) indicated that lower level needs must be satisfied before they can be motivated to achieve at higher levels in the hierarchy. The highest level of need encapsulates an individuals desire to become all that they can be, this is not an end point but an on-going process of many choices involving growth and development (Maslow 1954;1987).

It has been argued that Maslow's theory is very simplistic in its view and does not take into account all the complexity of needs and interactions (Wahba and Bridwell 1976; Neher 1991). Work continued on an alternative needs theory and in 1972 Alderfer introduced the **ERG** theory with the categories of **E**xistence **R**elatedness and **G**rowth. Within the ERG theory there is not a requirement for lower level needs to be satisfied before seeking higher level needs and the order of needs may be different for different people and cultures. The principle of frustration - regression was put forward by Alderfer to explain when someone is prevented from obtaining a higher level need they may regress to a lower level need or vice versa to obtain satisfaction (Alderfer 1972).

This theory recognises some more of the complexity and multiplicity of human needs and the frustration-regression principle does illuminate workplace motivation and could allow steps to be taken to recognise and satisfy frustrated needs in employees. Below is a diagrammatic representation of Alderfer's ERG theory in Table 5.3.

Level of Need	Definition	Properties
Growth	Impel a person to make creative or productive effects upon oneself and the environment	Satisfied by person using their capabilities fully in problem solving; greater sense of wholeness as a human being
Relatedness	Involves relationships with significant other people	Satisfied by mutual sharing of thoughts, feelings: acceptance, confirmation, understanding, and influence are elements of relatedness process
Existence	Includes all various forms of psychological and material desires	When divided amongst people, one persons gain is another persons loss when resources are limited

Table 5.3: Alderfer's ERG Theory

Herzberg and colleagues' (1959) research and theory appear to be the most applicable to the processes occurring within my study and this is evidenced below. The subject of job satisfaction was explored by Herzberg *et al.*, (1959) in a study consisting of interviews with over 200 people working in manufacturing industries examining the motivation of people to work. Their findings contain parallels with my study that will be discussed further and are represented in Table 5.3. Herzberg *et al.*, (1959:117) refer to the philosophy of James E. Lincoln president of Lincoln Electric:

"The most insistent incentive is the development of self-respect and the respect of others... the worker must feel that he is part of a worth while project and that the project succeeded because his ability was needed in it. Money alone will not do the job,"

Herzberg and colleagues' interviewed accountants and engineers (n=203) regarding what caused satisfaction and dissatisfaction at work. Content analysis was used to examine the data collected and the 'motivation-hygiene theory' was developed to explain the results.

The theory indicated that the factors that caused satisfaction are different from those causing dissatisfaction and the two cannot be treated as just opposites (Herzberg *et al.*, 1959). The factors that were found to cause satisfaction were called motivators and the factors causing dissatisfaction were called hygiene factors (Herzberg *et al.*, 1959). Table 5.4 illustrates the hierarchy of the top six motivators and hygiene factors identified by their research.

Motivators	Hygiene factors
1. Achievement	1. Company policy
2. Recognition	2. Supervision
3. Work itself	3. Relationships with superiors
4. Responsibility	4. Work conditions
5. Advancement	5. Salary
6. Personal growth	6. Relationships with peers

Table 5.4: Hierarchy of factors causing satisfaction and dissatisfaction with work (Adapted from Herzberg et al 1959)

Herzberg *et al.*, argued that there are two distinct human needs, physiological need for payment to purchase shelter and food and psychological need for achievement and growth.

When considering the findings of my study in relation to the work of Herzberg et al (1959) it was clear that the top motivators and hygiene factors for the HCAs are well aligned. Table 5.5 has been created to illustrate how the top motivators and hygiene factors identified by Herzberg *et al.*, (1959) relate to the categories and codes with in my study thus correlating with the positive attitude to work encountered in the HCAs. The codes identified span across all the phases of my study.

Motivators	My study
Herzberg <i>et al.</i>,(1959)	Codes & categories illustrating HCA Motivators
Achievement	Pride in work/caring, HCA training
Recognition	Building confidence and respect, patient preference
Work itself	'Really great'
Responsibility	Identifying health issues
Advancement	Pushing to get more, 'towards nursing'
Personal growth	Valuing increased knowledge, personal development
Hygiene factors	Codes & categories illustrating HCA Hygiene factors
Company policy	Responding to GP contract
Supervision	PN pivotal, 'total threat'
Relationships With superiors	'Total threat' PN advocating
Work conditions	Spatial constraints
Salary	Recognition and reward
Relationships with peers	Proving worth in the team, 'getting together', 'keeping in the loop'

Table 5.5: Motivators and hygiene factors related to HCAs in General Practice (Adapted from Herzberg et al 1959)

The current literature (2009-2010) in healthcare regarding job satisfaction is substantial and conducted in several countries using a variety of methods. A brief summary of some research relating to job satisfaction is contained in Table 5.6. It can be seen that some of the themes within this table bear resemblance to those identified in my study although the extent of transferability of themes across cultures and countries is open to debate. The subcategory job satisfaction can also be linked to the literature regarding teamwork examined in Chapter 4 as this touched upon the issue of teamwork and job satisfaction and the relationship between the two concepts.

Country	Authors	Research Method used	Factors found to influence satisfaction at work
USA	Decker <i>et al.</i> , (2009)	Quantitative- Telephone survey	Supervisors behaviour, pay
	Kostiwa, Meeks (2009)	Quantitative and qualitative- Survey	Nursing homes Nursing Assistants (NAs) –empowerment, service quality
	Rakovski, Price-Glynn (2009)	Quantitative and qualitative- Interviews	From National Nursing Assistant Survey (NNAS) – Caring, learning new skills, challenging work, organisational support
	Osatuke <i>et al.</i> , (2009)	Quantitative- Evaluative questionnaires	Organisational development to increase civility and respect
	Bishop <i>et al.</i> , (2009)	Quantitative- Telephone interviews	(NNAS) - NAs job satisfaction increased when felt respected and valued by employers, good relationships with supervisors and time to do work
	Squillace <i>et al.</i> , (2009)	Quantitative- Survey	(NNAS) low wages, ill health and no insurance
Canada	Duggleby <i>et al.</i> , (2009)	Quantitative and qualitative - Questionnaires	Hope contribution to preventing burnout, supportive relationships, resources, encouragement by others
	Burke <i>et al.</i> , (2009)	Quantitative- Questionnaires	Gratitude, optimism, proactive behaviours
Israel	Goldman, Tabak (2010)	Quantitative – Questionnaires	Ethical climate, caring and service
Korea	Park, Kim (2009)	Quantitative- Self-report questionnaires	Consensual culture, teamwork, good relationships associated with higher job satisfaction in nurses
Belgium	De Gieter, De Cooman, Pepermans, Jegers (2010)	Quantitative- Online survey	Nurses-psychological rewards from lead nurse. Pay not influential
UK	Manthorpe <i>et al.</i> , (2010)	Qualitative- Scoping study describing evidence base	Social care support workers - scoping study- literature identified role clarity, training, pay, time with clients
Ireland	Freaney, Tiernan (2009)	Qualitative- Focus groups	Team working, fairness, reward, workload

Table 5.6: 2009-2010 Research literature job satisfaction-support worker/ nursing role: an international perspective

5.2.1 'Really great'

'Really great' is an in vivo code arising from data indicating the enjoyment the HCAs found in undertaking the role. There was often spontaneous affirmation of pleasure taken in the HCA role. Spontaneous statements regarding the enjoyment of the role were a feature of the HCA interviews when asked about their experiences of working as a HCA. Some examples of the responses given are below:

*"I am really enjoying it. It is **really great**"*

(Amy interview 2 p8):

"I really, thoroughly enjoy it"

(Beryl interview 2 p8):

"I am glad that I have done it"

(Dawn interview 2 p12):

"Very happy in my role and work"

(Julie follow-up year 1).

This positive attitude to work was apparent across all of the interviews and did not diminish over time. Patient contact was the major source of enjoyment cited by the HCAs. However there were a few individual problems identified by HCAs and PNs but these did not detract from the overall positive responses to the HCA role. It could be argued that to some extent study participants may be telling the researcher what they think she wants to hear. However, even with this factor taken into consideration the overall and continued appreciation of the HCA role by participants was obvious throughout data collection and analysis.

The large research study by Kessler *et al.*, (2010) for the National Institute of Health Research examining HCA roles in hospitals in England that, already mentioned in Chapter 4, also confirmed that the HCAs enjoyed their role and that the source of enjoyment was the contact that they had with patients. The questions asked by this first large scale study of the HCA role in the NHS were: do Trusts view HCAs as a strategic resource, who are HCAs and how is their role shaped and what is the impact of the HCA role? These major questions required extensive investigation.

This ambitious and complex study had three phases. The first phase involved 16 interviews with representatives from senior management and unions across 6 NHS Trusts from strategic health authorities in the South, Midlands and North of England. The second phase examined four cases one from each region plus one from London. There was a focus upon general medicine and surgery and the methods included interviews with HCAs, nurses and managers (n=273), observation of HCAs, ward housekeepers and nurses (275 hours), Focus groups with former patients (n=94) and action research in collaborative projects in 3 Trusts on aspects of the HCA role. The third phase included surveys conducted in all 4 Trusts of HCAs (n=746), nurses (n=689) and former patients (n=1651). Qualitative and quantitative data were collected and analysed as appropriate to the methodology and the report contains large comprehensive appendices including the documentation used at each phase of the study. The direct quotes from participant interviews do make captivating reading and cast light on an under researched topic. Kessler *et al.*, (2010) conclude that there was little to demonstrate that HCAs were used as a strategic resource. They ascertained that HCAs were typically mature women from local communities, with family commitments and with a breadth of experience from other work experience. Kessler *et al.*'s study found that HCAs enjoyed their work, patients reported positive care experiences with HCAs and nurses valued HCAs but also showed some ambiguity around certain role boundaries.

In my study the PNs generally had very positive attitudes to HCAs and ambiguity was not evident around role boundaries which will be explored in more depth in the code named *role boundaries* in Chapter 6.

5.2.2 Pride in work / caring

Pride in their work and a caring attitude towards others were recurring features of HCA responses. HCAs pointed to taking pride in doing a good job and spoke of satisfaction in providing care to patients. There was enjoyment of the challenge of the HCA role and a caring attitude towards patients was evident.

One HCA commented:

"I love the patient contact, it is really good. That is the best bit of the job speaking to them and I feel that I am helping and I know that it is not much but I know that I am helping"
(Cara interview 1 p3).

Another HCA showed care by making allowances to accommodate a few debilitated patients who struggled to walk down the corridor to her room by letting them in by another entrance which was nearer:

"Some of the elderly patients that I have ...the poor souls are exhausted coming down the corridor ...I let them in and have put some chairs outside my door for them and they said 'what a good idea'...so that they don't have to struggle so"
(Dawn interview 2 p7).

Another HCA was frustrated by the pressure of appointments impinging on the quality of her time with patients:

"The only thing that I don't like about it is when you feel that you are rushing people. I don't like that and I think that they feel it off you sometimes, especially first thing in the morning when you have a queue at that door"
(Morven interview 2 p7).

A sense of motivation and of pride in providing care is evident here:

"I get a lot of new patients through the door and if you can help with their healthy life style then it is good. When they come back and say 'well I have done this' and 'I have done that' then it is good because you know that they have listened...and you think 'well I have done something', which is good...They will say 'well I have stopped salt' or 'I have started walking'...I would miss it if I didn't have that. I would miss the patients anyway"
(Kim interview 1 p4).

One HCA when describing chaperoning of female patients commented thus:

"If you chat to the patients when they come back they think it is wonderful. It is a better service for the patient...it makes a big difference to them"
(Cara interview 1 p15).

Another described how she was concerned about some elderly patients and followed them up to check that they were alright:

"If it is an elderly person that has not attended I do give them a phone just to check that they are ok and that nothing has happened to them. They have usually forgotten and feel bad about that. But I just reassure them and tell them that as long as they are ok. But there are very few non-attenders, most of mine turn up"
(Julie interview 2 p5).

A sense of caring and ability to make a difference in patients' lives expressed by the HCAs within my study has been held up as important and relevant to health care today. In recent years there has been much written about providing dignity and compassionate care for older people (DoH 2006c; RCN 2008; NMC 2009a,b; Smith *et al.*, 2010).

The NMC states that the care of people should be the first concern of any nurse and that they should be treated as individuals, respecting their dignity (NMC 2008). HCAs whilst not registered nurses are also required to respect the dignity of patients. The RCN Dignity Survey (2008) was carried out to gain understanding of the nurses, HCAs and student nurses perspectives regarding the promotion of dignity in care. Electronic questionnaires were sent to 70,000 RCN members and 2,047 responses were obtained, a very small response rate of 2.9%, however the authors correctly recognised that the sample cannot be representative of the nursing workforce as a whole (RCN 2008). HCAs formed only 1.8% of those responding and so were not well represented in the survey and no distinct reference was made to their responses as a group within the survey.

The findings of the survey indicated the importance of physical surroundings, organisational culture, attitudes and behaviour and the way in which care duties are carried out (RCN 2008). Role modelling was identified as an important factor in the promotion of dignity in care. The benefits of team work and of a shared dignity promoting culture and philosophy were also highlighted (RCN 2008).

As previously mentioned, aspects of teamwork and the possible influence upon good health care have been highlighted in the earlier findings presented in Chapter 4. A sense of caring about patients and of very much wanting to deliver good care was expressed by the HCAs in my study. The HCAs in General Practice were really committed to providing the best care they could for patients. This aspect of care by HCAs in General Practice has not been identified in previous studies.

5.2.3 Patient preference

The HCAs reported that patients really appreciated their role and that they had made good relationships with patients and this was very important to the HCAs. Patients who came back to the practices regularly for blood tests and other procedures had expressed a preference to see the HCA who they were familiar with and they missed when they were on leave, sometimes choosing to wait until their return before coming back to be seen:

“Well there was one of them that went to the nurse for her bloods and said ‘aye and I will not be asking her again I will just come back to you.’ And I thought oh well that makes me feel really good”
(Julie interview 1 p9).

Another HCA spoke about her strong connections with patients over time:

“A lot of them I have known from when I was on the District, so you still get the ones coming in that you went into their homes or you went into their families or their mothers and fathers you know and they remember you from going into their parents”
(Morven interview 2 p2).

The PNs also recognised this *patient preference*, Kathleen, a PN, recognised how much patients were attached to the HCA:

“They love her. The patients here all really like her and want to see her. It is all very positive”
(Kathleen interview 2 p7).

Ingrid another PN commented:

“Patients are perfectly happy and sometimes when they come in here they will say ‘oh I usually get the tall girl’ and I will say sorry. ‘I am sorry you have got me today as she is off’ and they say ‘oh (Name of HCA) does it this way and I think oh goodness” (laughs)
(Ingrid interview 2 p5)

HCAs knowledge about patients and interest in their wellbeing were important features in the interviews and follow-ups. The HCAs also spoke of patients taking an interest in them and being very supportive and appreciative of their role. This was self-reported information not received directly patients but the PNs reinforced this and it does fit with the very positive responses by patients to HCAs in the baseline research where patients preferred to attend the same person who they knew well (Burns and Blair 2007).

The work of Kirk (2007) appears relevant here as he presented the concept of clinical intimacy in professional relationships with patients and described understanding, shared meaning and mutual trust as being central to the therapeutic relationship. Kirk indicated that clinical intimacy should be defined as distinct from empathy and called for more research to address this issue. It is apparent in my study that there is more than just empathy between HCA and patients and the term clinical intimacy is apt.

Many patients attending the HCAs in General Practice are of an older age group. Woolhead and colleagues (2004) conducted qualitative research using the constant comparative method of analysis with older adults in order to identify how older people view dignity in care. Fifteen focus groups and two individual interviews in 12 different settings included 72 participants from varying backgrounds. Three major categories emerged from the analysis, including dignity of identity, human rights and autonomy. The study identified that “*being human*” involved possessing an intrinsic dignity that is “*inalienable*” and does help illuminate some of the sensitivities of older people and their preferences for care providers who show them respect and take time with them as an individual.

The findings of my study concur with recent research undertaken by Kessler and colleagues (2010) who researched the nature and consequences of support workers in a hospital setting. Their extensive research project for the National Institute for Health Research identified that the:

“HCAs were able to develop a much closer relationship with patients than nurses, a closeness which patients put down to being able to relate much more easily to HCAs than nurses”
(Kessler *et al.*,2010:138).

The research by Kessler *et al.*, does go on to identify that patients did express a preference of patients to deal with nurses rather than HCAs on some issues and it suggested that the quality of care would be improved if patients were more clearly informed about the different roles of team members (Kessler *et al.*, 2010).

My study has also highlighted the strong connections between HCAs and patients in General Practice and the preference shown by patients to be seen by familiar HCAs.

5.3 Valuing increased knowledge

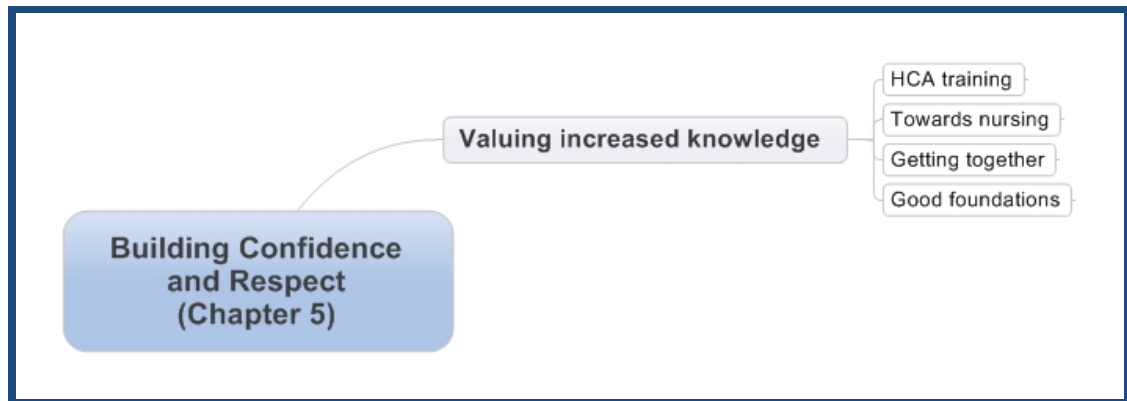


Diagram 5.7: Valuing increased knowledge

The subcategory named *valuing increased knowledge* and related codes are represented in Diagram 5.7. In my study the HCAs greatly valued the increased knowledge that had been gained in relation to their HCA role. Both the skills that they had learned in practice and the courses and qualifications that they had gained were important to them. They took advantage of any opportunities to learn and were aware of areas that they would like to learn more about in order to assist them in their role development. The following codes were identified within the subcategory *valuing increased knowledge*: *HCA training*; *'towards nursing'*; *'getting together'*; *'good foundations'*. One HCA commented:

"I could do with a tutorial on which bloods are what...you sort of pick it up but I rather know exactly what potassium and urea and all of that and the Us and Es for kidney function...I would like to know a bit more because its getting interesting and I want to know more"
(Cara interview 1 p7).

A PN valued time together with the HCA when she mentored her during SVQ training course:

"Our HCA has completed an SVQ in Health Care this month and being her mentor has enabled us to develop a closer working relationship and meant we have been able to discuss many issues to help her at work around patient care and standards"
(Myra follow-up year 1).

This search for more knowledge and understanding of the background to care provided was apparent in all the interviews and on-going communications with the HCAs and PNs.

My study has highlighted that the acquisition of this deeper understanding of aspects of care seemed to be related to the building of confidence and competence of the HCAs in General Practice.

The HCAs were taking on more activities in the practices in Phase 2 and they had increasing knowledge to support these activities. Diagram 5.8 provides a general indication of the building up of activities through Phase 1 and 2 of my study.

HCA Activities in Phase 1
Phlebotomy
Blood pressures
ECGs
Height and Weight
Tidying and restocking consulting rooms and checking equipment
Urinalysis
Chaperoning
New patient interviews
Patient recall- hypertension and diabetes
24 hour blood pressure monitoring
Additional HCA Activities in Phase 2
Health promotion
Alcohol risk
CV risk
Obtaining travel health information
Weight management

Table 5.8: Increasing HCA activities in phase 1 and 2 my study

5.3.1 HCA training

This code refers to experiences of training for HCAs and this was found to be variable. Initially, those in one region had undertaken the specific foundation course offered there (Burns 2006). In the other region HCAs had travelled to England to attend the specific training offered for HCAs in General Practice there and one had attended some single study sessions.

These are some of the comments on initial training:

“I think the HCA training course was really interesting. It was really good. It was more involved than what I thought it would be. It was a six month course and I went down to Bradford for three days. I enjoyed that”

(Kim interview 1 p1).

“I really did at the beginning find it hard travelling down every morning and sitting in the college you know for the day. I think we did learn more doing it that way rather than the nurse just saying ‘right you are doing it this way.’ We were given the background to the things as well”

(Dawn interview 1 p15):

“I am doing an SVQ level 3 in health care just now. I have been doing that over the months and just learning all the time, just as much as I am allowed to do”

(Leona interview 2 p1).

The HCAs valued any further training that they could access but there appears to be very little training that is tailored to the needs of HCAs in General Practice. HCA Gwen wrote the following about alcohol brief intervention training:

“Drug and alcohol workers have been giving training to GPs, PNs and myself on alcohol and have requested that we complete a questionnaire with patients and then I am responsible for contacting patients in a hazardous range in 3 months to review their situation and give advice also to arrange for liver function blood tests if necessary”

(Gwen follow-up year 1).

Some in house training was offered by the practice team:

“The GP did a teaching session with the practice nurse and myself, when I did a lot of ECGs they decided to do a bit of teaching to show us the basics, why you take them and what was working. It was good”

(Beryl interview 2 p4).

Other HCAs had attended some initial training upon coming into post but had not had this updated at all since then and wanted to attend more classes:

“The whole course it was really good but I think it would be good to have follow-up days for more follow-up information”

(Cara interview 1 p10).

Some HCAs were completing or had completed SVQ level 3 training with their PN acting as mentor. Other HCAs would have liked to undertake SVQ training but the opportunity was limited due to the lack of availability of local access to support, time and funding. Study days were attended by all of the HCAs over the two year period. Some had been sent to specifically targeted days while others had attended training along with the PNs at the specific times when surgeries were closed for this purpose. Some of the study days were funded by drug companies. Further developments in the HCA role had been appropriately supported by the attendance of HCAs at tissue viability courses, training for flu vaccination, a cardiovascular risk course.

The HCAs had all attended some form of training and development and there was a general sense within the practices of some attention being given to on an on-going basis to address the HCAs educational needs. The following quotes provide an indication of some of the subsequent activities:

“(Name of PN) and I are doing the cleanliness champions course together. I am working through the manual slowly and we are trying to get some time together”

(Julie interview 2 p9):

“At present I am doing a course on wound care organised by the Primary Care Training Centre in Bradford where I attended for one day and the course lasts 12 weeks”

(Kim follow-up year 1)

It was noted that to some extent that subsequent training may be linked to the needs of the GP Contract for example the alcohol brief intervention training and another example is cardiovascular risk training. Joy, a PN, wrote:

“Our HCA is doing a course at present regarding dealing with cardiovascular patients (CV risk) and she has asked me to be mentor for this”

(Joy follow-up year 1)

From the data gathered there is little doubt that the PNs often advocated for the HCAs with GPs in order to get access and financial assistance for courses. The PNs continued to be greatly involved in providing mentorship for specific education courses in particular initial preparation courses and SVQs.

A current agenda in health care in the UK is to develop different levels of HCAs or health care support worker (HCSW). The career framework for health care (Skills for Health 2010) identifies HCAs working at Band 2, 3 and 4 within the NHS and identifies three clinical support roles, HCSW, Senior HCSW, and Assistant Practitioner (SG 2009a). Specific guidance upon the level of training that should be offered at the three levels has also been published by Scottish Government (SG 2009b) and a toolkit providing guidance and education and role development for health care support workers has been launched (NHS Education for Scotland 2010). Assistant Practitioners roles have been developing in the UK since 2004, with some Trusts in England employing many Assistant Practitioners (Wakefield *et al.*, 2008). There is now some development taking place in Scotland but there have been no specific pilot sites set up in General Practice and as previously noted the pressure for General Practices to conform with pay and developments in the wider NHS is not there.

However work on HCA training had previously been undertaken in England, the NHS Working in Partnership Programme (WiPP 2006; 2007) had produced online guidance and courses to support the changes taking place in General Practice.

There was a specific toolkit for healthcare assistants on the WiPP website offering guidance about employment, roles and training (Vaughan 2007). WiPP have also supported the development and publication of guidance about delegation and the accountability of health care assistants in General Practice and emphasised the importance of appropriate education programmes (Hopkins *et al.*, 2007). Woodhead and Bates (2007) described the development of a distance learning course for HCAs in primary care in England. Moore (2006) and Hand and Rawles (2007) described the development of a training option for HCAs in Wales and call for standardised training programmes across the UK.

My study offers insight into the training and development of the HCA role in General Practice as the experiences of HCAs and PNs have been captured through time. It is apparent that the HCA experiences regarding HCA training are very closely related to and supported by the PNs. The training also helped to strengthen the HCAs confidence and sense of role identity in the practices.

5.3.2 'Towards nursing'

HCA attitudes to undertaking training to become a registered nurse were varied in my study. Not all HCAs were interested in becoming nurses but some were very interested and indicated that family commitments and financial constraints had prevented them from pursuing further study or entry to nurse training. One HCA commented thus early on:

*"It is making me now want to do more **towards nursing**. It has kind of given a taster for it, because I think a lot of people go into nursing, they get half way through and they think 'Oh this is not for me, I can't cope with this, I can't do that.' Whereas doing the health care assistant course and building your way to it that way gives you the experience to see if you actually like it before you decide what you want to do"*

(Isobel interview 1 p3).

Through a questionnaire distributed by Scott (2003) to delegates attending a UNISON conference it was identified that out of 300 HCAs who completed the questionnaire, 75% (n=225) stated that they would like to train as registered nurses.

Herzberg and colleagues (1959) identified advancement as an important motivator and for some HCAs progression into nurse education was a definite goal to be accessed via Open University, local college or university provision via completion of SVQ 3 and then a HNC in Health Care. Some more mature HCAs considered that they were too late in their career to undertake nurse education however they remained interested in general advancement in understanding and practice in order to enhance their role.

As previously mentioned in the initial literature review, Hibbert (2006) conducted a scoping study to gain insight into the progress of HCAs. Hibbert (2006) identified the following as influencing factors: Financial support; low secondment numbers; lack of recognition of existing knowledge; lack of confidence in academic ability and lack of workplace and education providers supportive powers were the influencing factors identified by (Hibbert 2006). Hibbert's research does shed some limited light upon the figures available regarding secondment and progression of HCAs and called for more robust and transparent systems designed to furnish HCAs with learning opportunities and recognition and accreditation for prior learning (Hibbert 2006).

The findings from my study only partially reflect those of Kessler *et al.*, (2010) with HCAs working in hospitals where they identified that there was a strong ambition to become registered nurses amongst the HCAs that they interviewed. The reasons for not progressing with this in Kessler *et al.*'s hospital based study were lack of confidence, feeling too old and domestic pressures. The enduring nature of the desire to become a registered nurse was noted and examined against length of service (Kessler *et al.*, 2010). It was only when HCAs had been in post for ten or more years that the ambition to become a nurse decreased significantly (Kessler *et al.*, 2010).

In contrast to Kessler *et al.*'s findings in my study some more mature HCAs, although much less than 10 years in post, were not interested in nurse training but were interested and motivated to take on more training related to their work in General Practice. They were very connected to their occupational identity as HCAs in the various General Practices. Reference back to the subcategory *PN pivotal* in Chapter 4 appears appropriate here as the strong supportive relationship with PNs who nurtured the HCAs to achieve their potential, who advocated for them and so enabled HCA progression to nurse training or other courses. This strong nurturing relationship is not reflected in Kessler *et al.*'s study in the hospital environment. My study therefore offers unique insight into the closely related experiences of HCAs and PNs.

5.3.3 'Getting together'

This code emerged when a number of HCAs referred to wanting to meet up and network with each other at study days and sessions. The chance to come together as a group is something that may not be afforded to HCAs very often and working in General Practice can be very isolating. They clearly felt that they gained useful information from one another at such events. Hence the *in vivo* code '*getting together*' under the subcategory of *valuing increased knowledge*.

The PNs also valued the opportunity to meet up with other PNs and it seemed that they were in fact afforded more opportunities do so in the course of their work. It also seemed that the PNs were perhaps more proactive in seeking out network opportunities with each other. It could be argued that possibly the need to network with one another is particularly important for the HCAs in General Practice because of the new and emerging nature of their role and identity. HCAs who work in a hospital setting may not be so isolated and have more regular contact with other HCAs within the work situation.

Their collective identity is something that the HCAs in the rural region have raised after completion of the initial introductory training course in the Higher

Education Institution (HEI) (Burns 2006) and they have requested to come together as a group once a year to socialise and discuss progress with one another. It does seem that their sense of collective identity may be something that could be nurtured from within the practices by encouraging contact with HCAs from other practices even by electronic means, by email or social networking. The following are examples of the 'getting together' code:

*"It is nice to go to courses and to **get together** and speak to other HCAs from other practices"*
(Amy interview 1 p3)

"I met one girl on the course on vital signs...she was a health care assistant in a General Practice and she wasn't doing the blood pressures or anything like that . But it was good to discuss you know what kind of things she was doing and what I was doing. This has been the only opportunity that I have had to speak to anybody else"
(Leona interview 1 p9)

"Well sometimes with the half day closing training [this is a nationally agreed arrangement whereby GP practices can close for a half day periodically to facilitate training activities] you catch up with other HCAs. We sometimes meet and say 'How is it going?' 'Are you going on this course?' 'If you are going then I will go?' And as I say the last one was that study day...it was nice I enjoyed that day...you can see where other people have gone with it [the HCA role]"
(Dawn interview 2 p9).

One PN, Leah, recognised the need for HCAs to get together:

"Our HCA could do with some peer support unfortunately there aren't many HCAs in general practice in the area. She is not included in the emails sent to the PNs by the PN facilitator in this area"
(Leah follow-up year 1).

The value placed upon relationships with peers and learning from each other could be correlated with one of Herzberg and colleagues (1959) hygiene factor entitled "relationships with peers".

5.3.4 'Good foundations'

The in vivo code '*good foundations*' refers to the recognition of valuable experience that the HCA role in General Practice offered prior to progression into nurse education.

*"There is no doubt about it had she not been given the **good foundation** of being a health care assistant and done that course and been in the job then I think she would have struggled or would not have had the vision to do nurse training"*
(PN Audrey interview 2 p1).

This PN recognised the importance of prior HCA work in providing a platform from which progression into nursing was achieved. The following part time HCA was a year into her nurse training acknowledged the significance of her HCA experience:

"If I hadn't done it [worked as a HCA in GP] I wouldn't have had so much experience because a lot of the things that I read in my nursing at the moment I can relate to and can say 'oh I have experienced that' and 'I have had some patients that had those conditions.' And I have got a wee bit of back ground on it and it does help a lot"
(Isobel interview 2 p1).

As previously documented in the initial literature review in Chapter 2, a small qualitative study (n=8) by Wood (2006) followed the socialisation of seconded health care assistants during preregistration nurse training and found this to be very different to other preregistration nursing students. Wood (2006) identified a unique socialisation process for the secondees with differing levels of guidance and expectations from mentors and other nursing staff. Gould, Carr and Kelly (2006), also referred to in Chapter 2, examined the experiences of seconded HCAs and undertook a qualitative exploratory approach to examine role transition, only 4 secondees (n=4) agreed to be interviewed in the study and interviews were also conducted with ward managers, preceptors and clinical practice facilitators. The study uncovered many anxieties about successful nurse education completion such as doubt in academic ability and fear of being judged harshly in practice because of being known previously as a HCA.

These studies do indicate that the experience of working as a HCA prior to nursing may be helpful but that the transition to life as a student nurse may also be complex because of the previous experience gained and the expectations of others.

5.4 Summary of Phase 2

The second category *building confidence and respect* relates to the HCAs developing skills and knowledge in Phase 2 of my study approximately between one and two years of participation in my study. It encompasses the experience of *job satisfaction* and also a greater sense of the HCAs valuing the *increased knowledge* gained from training courses and from learning in practice. The HCA role is becoming embedded into General Practice and the HCAs reported very positive feelings about their work and the support they received from patients and other staff. The findings within this Chapter can be related to theories of human need and organisational motivation and the work of Herzberg *et al.*, (1959) has been found to have particular relevance to the HCAs experiences. The next Chapter will examine experiences of the HCAs in Phase 3 of my study.

Presentation of findings
Chapter 6
Phase 3: Shifting and Shaping Roles

6.0 Introduction

This third Chapter of findings describes Phase 3 the progression of HCAs from their position of confidence and respect to one where their role changed shape and moved forward more. This Chapter describes experiences and perceptions of the HCAs from the approximate time period of more than 2 years of data collection and analysis. Within the third category described here called shifting and shaping roles, the changing role of the HCA in General Practice is addressed and this will be examined alongside the changing role of the PN.

6.1 Shifting and shaping roles

The codes and subcategories included in the category of '*shifting and shaping roles*' are arranged in Diagram 6.0 Shifting roles refers to the movement of responsibilities and duties from GP to PN to HCA. The shift in roles between PNs and HCAs and the importance of the development in roles and relationships were more fully apparent after completing the second round of interviews and follow-ups with the PNs and HCAs. The subcategory '*developing responsibilities*' includes codes related to the role development of the HCAs and PNs. The subcategory '*reciprocal support*' recognises the interdependency of the HCA and PN roles in General Practice.

Studies of General Practice have not to date uncovered details of the nature of the connection between HCA and PN relationship and roles that my study has identified (Charles-Jones *et al.*, 2003; Joels and Benison 2006; Petrova *et al.*, 2010).

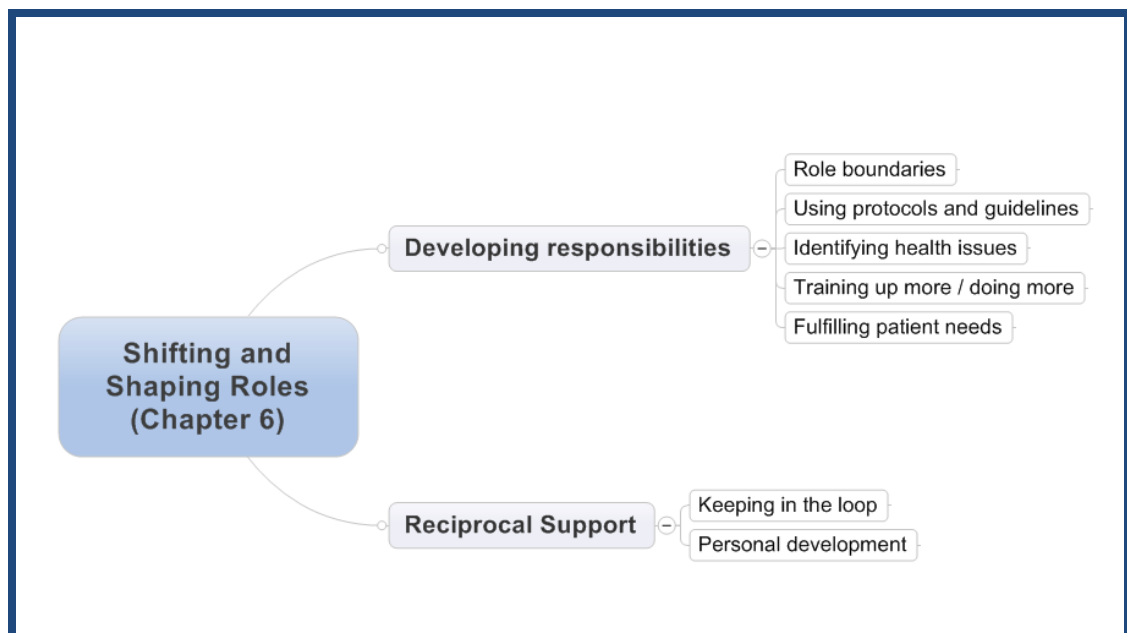


Diagram 6.0: Shifting and shaping roles

Ingrid, a PN, commented:

*“We have **shifted** what we can over to the health care assistant”*
(Ingrid interview 2 p2):

and

“It is absolutely fantastic for the practice nurses not to be bogged down with bloods and specimens and stuff. It is great to get that offloaded on to somebody else to free up our time. The GPs are offloading to us you know and we are sitting doing all the prescribing for all the dressings, catheters and colostomy bags...so the GPs have stopped prescribing these”
(Ingrid interview 2 p 6-7).

Another PN wrote:

‘HCA is working well within the health care team and can relieve PNs of a lot of routine work allowing greater focus upon chronic disease management’
(Celia follow-up year 2).

The shift in roles is described clearly by Ingrid who said that she and the other PN in the General Practice had undertaken nurse prescribing training over the last year and the GPs were now giving them responsibility for prescribing all catheters and dressings and other non oral medicinal products. Ingrid and her colleague were also prescribing for the patients they saw for chronic disease management.

Ingrid also thought that they would very soon be getting all the inhaler prescriptions to do too. They had been mentoring the HCA through training in wound management and an in-depth course related to risk assessment in cardiovascular disease. The following extract is from my reflexive journal following the second interview with Ingrid towards the end of my second round of interviews.

6/10/09 Extract from reflexive journal

Ingrid spoke about the change in roles and how the GPs were shifting work over to the practice nurses while they were shifting work to the health care assistant. This shift in workload was described graphically in this particular practice and there had been significant developments since my visit a year ago. It struck me that the term 'shifting roles' does describe well the process of change that had been occurring here. Indeed this shifting of roles appears to be fundamentally important and this was noted to some extent earlier in 2008. It appears that the individual General Practice environment is important to the development of the HCA role.

It has become evident that in some practices nurse practitioners and senior practice nurses are undertaking much of the role that was traditionally undertaken by the GP. They are holding surgeries, prescribing medications for patients and treating them on an on-going basis. In these practices where role boundaries have already moved substantially (i.e. between GP and PN) then it appears that the shift of duties and the greater role development of HCAs is more likely to be fostered. A more enabling rather than a controlling and restricting environment appears to exist in these practices where role development has been more extensive. The interconnected and interrelated aspect of the practitioners is really apparent here and in particular the connection between the HCAs and PNs is continually reinforced. It may also be of course that in some practices this impetus for role movement may be related more to pressure of work. Pressure on appointments and care provision may create and continue the impetus to move more duties over to the HCA and also there may be increasing pressure for more cost effective care and response to the GP Contract.

This general shift in workload was described graphically in this practice by Ingrid and there had been considerable developments since the first round of interviews. The movement in roles between PN and GP was examined in an earlier study in England. Charles-Jones *et al.*, (2003) conducted an ethnographic study and interviewed GP, PNs and practice managers in 9 practices. They used purposive sampling chosen according to practice size, location and socioeconomic factors to try to achieve a representative spread and in total 26 interviews were undertaken (n=26). The exact numbers of participants from each professional group is not apparent but an attempt was made to recruit from each group within the practices. The study identified that some nurses had then moved away from treatment room activity and were adopting a 'hybrid' identity between that of nurse and GP. The role of the HCA was not examined by Charles-Jones *et al.*, (2003) but it was much less common for HCAs to be employed within General Practices during this time. My study now serves to illuminate the PN and HCA role movement in General Practice.

The *PN pivotal* subcategory described in Chapter 4 Section 4.3 is connected to the shifting roles reflecting the importance of the PN and HCA relationship. The *PN pivotal* subcategory remained centrally important as the PN has a fundamental role in developing and overseeing the HCA role. However it has to be recognised that GPs and some practice managers may also be influential in role direction. The GPs who are in charge of the practices may have influence upon the development of the HCA role and their influence may be of overriding importance. This may be an area for further research.

The growth in HCA activities through time is shown in Diagram 6.1 giving some indication of the role movement.

HCA Activities in Phase 1
Phlebotomy
Blood pressures
ECGs
Height and weight
Tidying and restocking consulting rooms and checking equipment
Urinalysis
Chaperoning
New patient interviews
Patient recall- hypertension and diabetes
24 hour BP Monitoring
Additional HCA Activities in Phase 2
Health promotion
Alcohol risk
CV risk
Obtaining travel health information
Weight management
Additional HCA Activities Phase 3
Flu vaccinations
Vitamin B12 injections
Wound dressings & suture removal
Spirometry
Ear syringing (ear syringing was not routinely taken on by most HCAs)

Table 6.1: Developing activities of HCAs in my study

Ear syringing appears to be an exception and was undertaken by only one HCA. This was because of a lack of available insurance cover (MDU 2006).

One PN wrote:

“It’s very hard to delegate certain tasks such as ear syringing and drug monitoring. This is not because of the capability of the HCA but as a result of the medical defence union. They won’t cover HCAs for certain things” (Joy follow-up year 2).

For PN participants in my study, prior to HCA development some nurses had completed a nurse practitioner degree course and had extended their role considerably to take on more work previously undertaken by GPs. As aforementioned in some practices more role development and changing of boundaries had occurred than in others and this can be related various factors including pressure of workload and practice management. This is evidenced further in the next Section 6.2.

The following statement from the Nursing and Midwifery Council (2006b) recognises the broad changes in roles and the broad health care background to these:

“There are now significant changes in the way services are delivered to patients. In particular following the General Medical Services contract and the European Working Time Directive, nurses and midwives and community public health nurses are undertaking treatment and care that was once the domain of other healthcare professionals, notably doctors. Consequently this has led to non-registered staff members delivering some aspects of care previously undertaken by nurses”
(NMC 2006b:3).

Pearcey (2008) in a hospital based study examined shifting work loads in nursing by exploring role identity in interviews with 25 qualified nurses and used constant comparative methods to identify and analyse categories. Role extension was identified as significant with nurses taking on technical tasks previously undertaken by doctors and abdication of role to HCAs was also evident. The term abdication was used by Pearcey (2008) to indicate areas of work that had been given over to HCAs that qualified nurses were no longer able to maintain any involvement in. In some cases the main difference between the role of qualified nurse and HCA was the giving of medication (Pearcey 2008).

It may be that some elements of role extension have taken place in General Practice since the development of skill mix has been actively encouraged by government (SE 2004). However, role abdication has not been identified within my study.

Pearcey (2008) suggested clinical nurses must attempt to retain some influence and control over where their role takes them in order to preserve a sense of meaning and satisfaction in nursing. The findings of Pearcey (2008) have little resonance with the findings of my study as in general practice the PNs supervised the HCAs directly and there has certainly been very distinct areas of care for PNs to move into in more depth, for example chronic disease management and the PNs did appear to have a sense of control over the role movement and the close supervisory relationship with the HCAs was apparent. The following quotes indicate some of the perceptions of PNs about this role shift:

“Yes I feel very positive about the HCA role and you know you meet people who do not have this positive view and I think they are worried about becoming deskilled. I don’t think you need to worry as everybody’s role is changing and I think that it is a necessity in this practice and that we need the HCA”
(Penny interview 2 p3).

“When I first started I was the treatment room nurse and the practice nurse was teaching me. So they were teaching me and we didn’t have a HCA. We had a phlebotomist. So it has changed over the past eight years. The HCA that we have was a receptionist here for years and years. Her role has changed and the PNs have passed on more to her now from our roles”
(Joy interview 2 p2).

“I think that in twenty or thirty years they will look back...the HCAs have got the Florence Nightingale kind of posts just now, they do all the basic things that the nurses used to do. We have evolved so they are going to too. I can see it going pretty far”
(Kathleen interview 2 p3).

The PNs in my study fully embraced the shifting and shaping of roles and as previously alluded to in the code *‘pushing to get more’* Chapter 4, the HCAs have been very willing to learning more and enhance their role. The changes in the PN role are represented in Diagram 6.2. It is pertinent to view this PN development in relation to the HCA role.

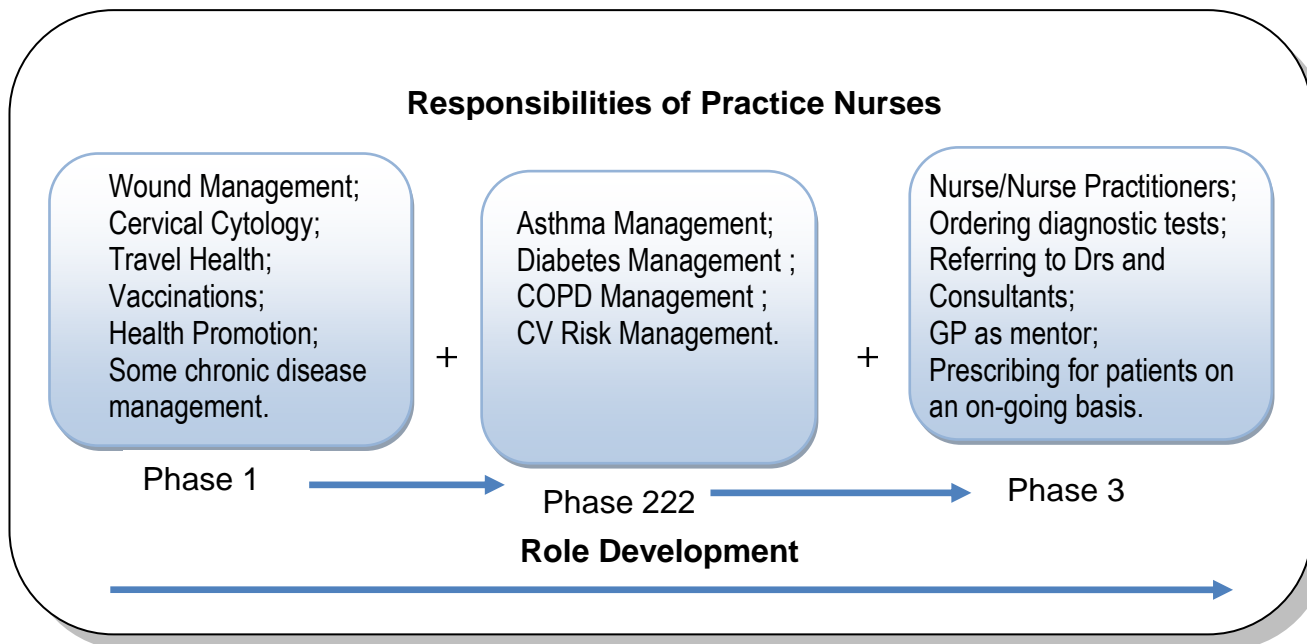


Diagram 6.2: Representation of shift in perceived PN responsibilities over time 2008-2010

The changes to the HCA role in my study are represented similarly in Diagram 6.3.

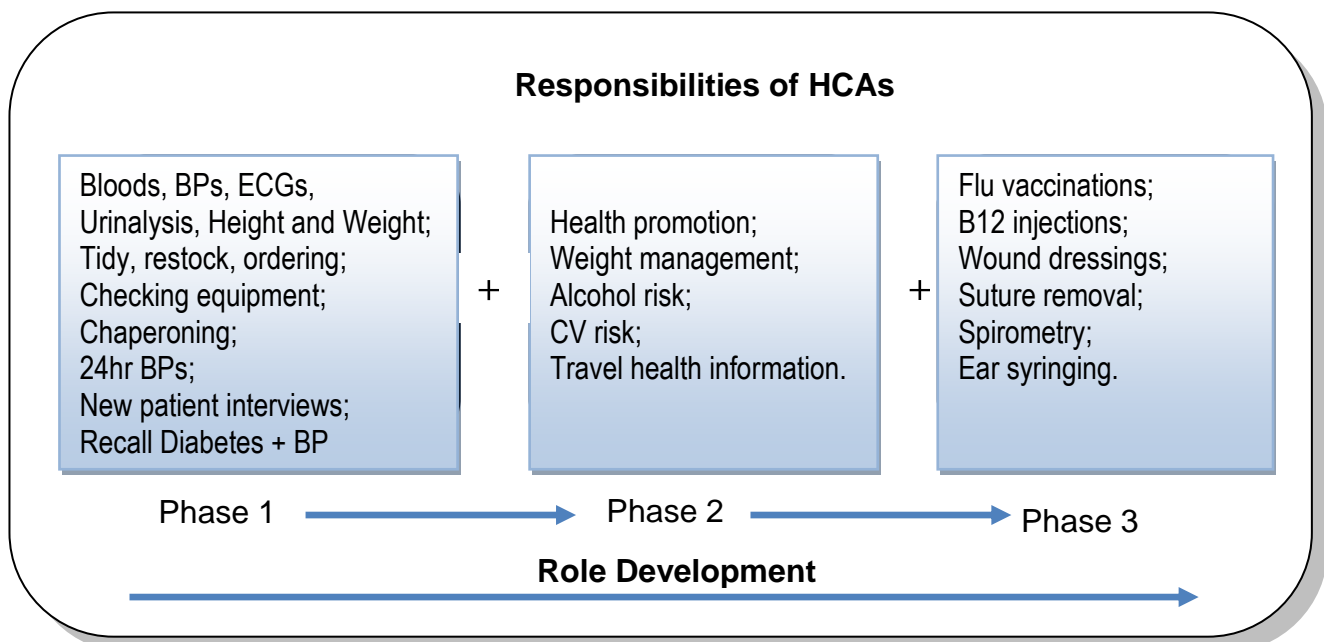


Diagram 6.3: Representation of shift in perceived HCA responsibilities over time 2008-2010

Influenza vaccination is an example of an activity that HCAs have become increasingly involved in overtime. The Medical Defence Union (MDU 2006) have been willing to insure this HCA activity but initially the Health Protection Agency (HPA 2005) did not support this. Now appropriate HCA training is available to support safe practice (McGrouther, Burns and Walters 2012) (Appendix IX). The developing HCA responsibilities are explored further in the next section covering the subcategory called *developing responsibilities*.

6.2 Developing responsibilities

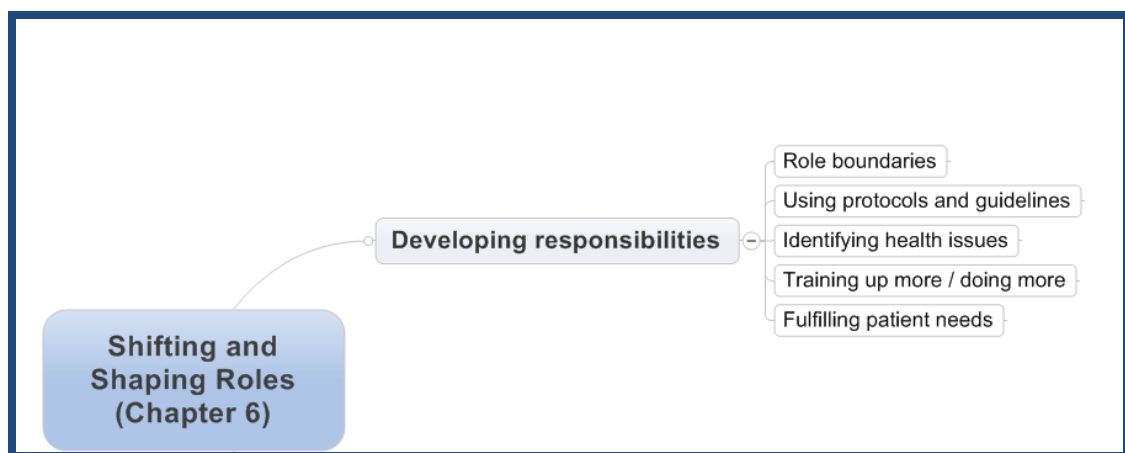


Diagram 6.4: Developing responsibilities

The subcategory *developing responsibilities* contains the following codes: *role boundaries*; *using protocols and guidelines*; *identifying health issues*; *training up more/ doing more* and *fulfilling patient needs*. This subcategory, represented in Diagram 6.4, identified the HCAs experience of taking on more responsibilities over time. Their role as a HCA in General Practice had developed and extended from initial appointment and more responsibility had been taken on progressively. The HCAs spoke of their satisfaction with more responsibility and more skills and that this enabled development of their role in new directions that were useful to patients and to the practice team. The development of their role is reflected in the follow-up replies over the year and this can be related back to the code *HCA activities* and the list of HCA activities from Phase 1 of this study in Chapter 4 and the activities were extended through time as illustrated in Diagram 6.1, 6.2 and 6.3.

It can also be identified that some of the activities of HCAs overlap with the PN activities of Phase 1 in Diagram 6.2 illustrating the role movement and development. It should be also noted that the HCA responsibilities were extended but were not totally removed from the PNs who undertook the supervisory role of the HCAs. The following comments by HCAs illustrate the on-going development of activities and responsibilities:

"I am now able to remove stitches and do dressings on my own"
(Norma follow-up year 2).

"I have been training for ear syringing and am doing this and I also have done the Counter Weight Management Programme and have started to see people in practice"
(Beryl follow-up year 2).

"I have been helping with Swine Flu vaccinations and Flu Clinics and have given the vaccinations under supervision of the practice nurses"
(Dawn follow-up year 2).

"I have now been given drug monitoring patients and recalls to deal with. This means I record blood results and if there are any problems I discuss this with the doctor and deal with it accordingly"
(Kim follow-up year 2).

The PNs also commented upon the development of HCAs:

"When she first started she took on venepuncture and as her confidence has grown she has taken on a wee bit more ...certainly last year saw the introduction of the influenza vaccines and things like that and she informs me that the wound management stuff the basics is coming up at the next course. So I think it is developing all the time and it is certainly keeping her motivated"
(Penny interview 2 p2).

"Well I have more patients that I can see for longer and I haven't got the things that I can do with my eyes shut any more. My role has got more challenging and so has (name of HCA)'s because the things that I can do with my eyes shut are all very new to her. She has taken them on really well"
(Kathleen interview 2 p2).

Two contrasting quotes below from PNs give an indication of how the developing responsibilities could be influenced by the General Practice environment and GP attitudes:

"May be it is different here I think than at some practices where it is the opposite. Here it is quite laid back. You are allowed to evolve here"
(Kathleen interview 2 p2).

“It is just the GPs do not feel comfortable in letting the HCA do more for what ever reason but when people retire then things will change, yes definitely. It is just traditional the way it is”
(Bethany interview 2 p2).

As previously stated not all practices embraced the development of HCA responsibilities to the same extent.

6.2.1 Role boundaries

The code named *role boundaries* is within the subcategory of *developing responsibilities*. Role boundaries were referred to by HCAs and the change in role boundaries between themselves and PNs was particularly important. Role boundaries were often actively negotiated and tied down through the creation and use of protocols and guidelines. The HCAs discussed how they recognised in practice the need to pass patients on to either the GP or the PN when faced with situations out with their range of skills and knowledge. One HCA wrote that she considered the following as significant in maintaining her role boundaries:

“The thing that I would mention to anyone is that it is important to know your limits and not to be pressured into doing something that you are not comfortable or confident with”
(Julie follow-up year 2)

The following comments from HCAs Leona, Morven and Norma illuminate their knowledge of their role boundaries and their relationships with others in the practice team:

“Sometimes if I am unsure I will always speak to (name of PN). Only if I am one hundred percent confident will I go ahead”
(Leona interview 2 p3):

“I would not do anything out with my depth. You know if I am not sure then I won’t do it’
(Norma interview 2 p6):

“Definitely you know your limitations and you know what you can do and you don’t step over the line and as I say if there are any problems, if there are any issues when people come in, I just go to the nurses or I go to the doctors”
(Morven interview 2 p6).

There does appear to be a clear understanding of the scope of practice of the HCAs and this PN commented thus on her trust in the HCA regarding adherence to role boundaries:

“I have never had to sit down with her and say ‘well you have to do this more’ or ‘you have to do that.’ She just does it. She has never once gone over the line. She phones me if there is anything she is not sure about”

(Kathleen interview 2 p4).

To set the term role boundaries in context, during my study NHS Education Scotland (2009) produced a guide to health care support worker (HCSW) education and role development and set out role parameters for HCSW, senior HCSW and assistant practitioners and the educational and progression requirements for each of these 3 roles. General Practices do not have to conform to the job descriptions, role profiles and the knowledge and skills framework pay scales set out for NHS employees as they contract into the larger NHS and at present they are not bound by the requirements.

There is scant reference to HCA role boundaries in general practice within the literature, with Petrova *et al.*, (2010) conducting the only other recent qualitative study in the UK mentioning this, highlighting the timeliness of my research in contributing to the illumination of role boundaries within General Practice.

There has however been some work undertaken on qualified nurses' role boundaries. Pearson (2003) in Australia commented on the changes in nurses' roles in recent years and indicated that role confusion and some conflict has arisen in due partly to demise of generalist nurse and doctor roles and the increase in technological interventions in health care. He called for nurses to take on generic roles and be less bound by rigid role boundaries.

Turner *et al.*, (2007) undertook an examination of the differences between policy and practice using critical discourse analysis after the introduction of Nurse Practitioners in rural Australia. Policy documents were examined in depth and compared with nurse experiences of working in the Nurse Practitioner positions.

However, only two Nurse Practitioners informed this comparison. The researchers recognised that this was a very small sample and also used information from a focus group of 15 registered nurses in advanced nursing positions and who were preparing for Nurse Practitioner roles. This comparison group is very small and inclusion of the focus group does not aid comparison as these practitioners were not yet appointed Nurse Practitioners. The study found that there was a gap between the policy ideal of autonomous nurse practitioner and the reality of the nurses who experienced some movement of role boundaries but were not autonomous. Role boundaries between nurses and GPs have been examined in General Practice in England and identified that nurses had developed their roles in areas of work previously undertaken by GPs, as noted in Section 6.1 (Charles-Jones 2003).

Sociologist Allen (2001) conducted an ethnographic study in one large general hospital in England over a 10 month period where nurses were being expanded to incorporate elements of junior doctors' roles and a new HCA role was being introduced. Allen used discourse analysis to examine the social processes around the division of labour. Fifty seven tape recorded semi structured interviews were conducted with ward nurses (n=29), doctors (n=8), auxiliaries (n=5), HCAs (n=3) and clinical managers (n=11). Other data sources included extended conversations with staff, organisational documents such as meeting papers and training materials.

Allen indicated that occupational 'atrocious stories' can function to support and maintain socially created occupational boundaries (Allen 2001). She focused upon how stories that nurses in the UK told about doctors served to support social group formation. Allen also examined the boundaries between nurses and HCAs. Allen (2001) found a good degree of consensus amongst nurses about medical-nursing boundaries but this was not so with regard to HCAs. Most 'atrocious' stories about HCAs were recounted by senior nurses who were more removed from clinical practice however ward staff told comparatively few 'atrocious stories' about HCAs. Nurse managers were keen to clearly differentiate between nurses and HCAs while ward based nurses emphasised the ward team rather than formal status.

Allen concluded that the difference in 'atrocious stories' about medical staff and HCAs may be explained by the way the stories assist in managing social friction. This friction was not present between nurses and HCAs on the wards and could be explained by the fact that nurses have greater control over HCAs than over medical staff.

Allen's study is very interesting to consider in relation to my study as, prior to commencing data collection, I was told only one anecdotal 'atrocious story' by a senior nurse removed from practice, about a HCA in General Practice. No further stories were forthcoming. Role boundaries were negotiated successfully between PNs and HCAs within my study and these were not identified as a source of conflict. Ten years on from Allen's study, my study has highlighted acceptance, understanding and management of role boundaries between PNs and HCAs in General Practice.

6.2.2 Using protocols and guidelines

In my study protocols and guidelines were mentioned as being important to the HCAs in supporting their role definition and boundaries. The protocols were viewed as providing security and protection and supported them in decision making regarding patient care:

"Yes when she first started we developed protocols and guidelines. We obviously had standard protocols and we obviously wanted to make them more simplified, in particular for things like blood pressures. We have drawn up specific protocols for the HCA. I suppose it is to do with their boundaries and when to hand patients over and so that they have some guidance. We have adapted policies within the practice"

(Penny interview 2 p3).

As new responsibilities were added into the HCA role then protocols and guidelines were developed to support these:

"We have a protocol for anything that comes to the clinic and if there is not one then we have to make one up ready to go ahead with it to keep everyone right. I think they are all on the computer now because we have been updating them all as well"

(Cara interview 2 p7).

Another HCA, Gwen, indicated how these assisted when a new HCA started in post:

“We have been looking at the protocols over the last few months ready for the new HCA to start. Everything is written down, what to do and where to get things and where to order things. Everything is in writing now”

(Gwen interview 2 p5).

Protocol based care relates to the provision of clear statements and standards for the delivery of care across different environments and professions (NHS 2002). There are different terms used relating to the processes of the managing care including: guidelines, protocols, procedures, care pathways, integrated care pathways, algorithms and clinical indicators (Rycroft-Malone 2004). First to embrace protocols and guidelines, the NHS Plan in 2000 indicated an increased emphasis upon improving the quality of care and evidence based practice within the NHS and this linked to the increased use of protocols and guidelines in health care in the UK (DoH 2001). The search for best practice has led to the extensive creation and use of protocols and guidelines within the NHS as the work of Health Improvement Scotland and the Scottish Intercollegiate Guidelines Network demonstrate, where best practice and standards of care are researched developed and published (NHS Health Improvement Scotland 2012; SIGN 2011).

Ilott *et al.*, (2006) undertook research into protocol-based care in which they undertook content analysis of policy documents and literature and individually interviewed in depth a purposive sample of 35 experts. The interviews were recorded and transcribed and coded using NVivo, a software tool. A systematic search and review of literature, policy documents and the interviews were undertaken to clarify the question ‘what is protocol based care?’ The findings identified that the terms protocols, pathways and guidelines were used interchangeably within policy and guidance documents.

Ilott *et al.*, (2006) produced a comprehensive definition of protocol based care:

“The term protocol-based care may be applied in two ways: firstly in generic settings where multi or uni-disciplinary staff standardize clinical care processes and secondly in specialist settings where authority for clinical care processes is delegated to those working in expanded roles. In both contexts, staff follow rules codified in documents such as protocols, care pathways and clinical guidelines, which aim to standardize health care delivery and outcomes. These documents do this in subtly different ways, by varying the specificity and scope in which they have an effect upon the processes of clinical care. Staff retain responsibility for using them appropriately and for obtaining informed patient consent.”

Ilott *et al.*, (2006), prior to the development of the above definition, had found protocol based care to be a generally ill-defined and understood concept and they called for managers to recognise the complexity of introducing this as a way of working.

However, in research comparing factors that influence the development of evidence based practice Gerrish *et al.*, (2008) surveyed junior and senior nurses in two clinical settings in England (n=1411) but achieved a low response rate of 42% (n=598). Data were collected in 2003 and so there was a significant time lapse between data collection and publication during which time responses may possibly have changed considerably as practice progressed. The study identified that senior nurses were developing skills in evidence based practice while junior nurses had not developed autonomy in implementing evidence-based practice. Gerrish *et al.*, (2008) called for robust evidence based guidelines to be available in the workplace in the NHS as these could provide much more accessible evidence relevant to practice than primary sources of research.

My study has illuminated the routine use of protocols and guidelines in General Practice and an awareness of safe and effective practice. It does appear that practice understanding of and acceptance of protocol based care has moved forward from the research of Gerrish *et al.*, (2008) and Ilott *et al.*, (2006) although perhaps the GP Contract requirements and routine use of computer systems in General Practice have also helped to drive this agenda forward.

Research undertaken by Rycroft-Malone *et al.*, (2008; 2009) evaluated the impact of protocol-based care on roles and service delivery. Rycroft-Malone *et al.*, (2008) used qualitative case study evaluation methodology across 5 sites, including acute and primary care settings. Observation, semi-structured interviews, tracking patient journeys and document review were the activities undertaken; there were 141 participants (n=141) including allied health professionals, doctors, support staff and patients. The study identified that mechanisms for standardisation of the use of protocol based care approaches were patchy. Protocols were commonly used as checklists for reference and some staff were negative about their use concerned that they could lead to restricted judgement and a 'tick box mentality' (Rycroft-Malone *et al.*, 2008). The use of protocols was linked to supporting role extension, for example nurse prescribing, streamlining care and to reducing doctors workload (Rycroft-Malone *et al.*, 2008). Protocol use was generally viewed as a 'nurses' thing' but some GPs and junior doctors were using available standardised care approaches. Rycroft-Malone *et al.*, (2008) indicated that the use of protocol based care had the potential to impact on nurses roles by increasing their autonomy and so provide a more streamlined service delivery. From my findings it was evident that the PNs and HCAs initiated and had ownership of the protocols and guidelines and this factor appears to have made a difference to their use in practice. The protocols and guidelines helped them to delineate practice.

In 2009 Rycroft-Malone and colleagues undertook a case study using an ethnographic research approach in two secondary care clinical areas, a diabetic and endocrine unit and a cardiac medical unit and reported exploring protocol based care and decision making. Participant observation, semi-structured interviews with staff with representation from different levels of nursing staff and medical staff (n= 64) and patients (n=17); feedback sessions to explore preliminary analysis and documentary reviews of the protocols based care in place in the units were undertaken. Data collection took place over a 50 day period with 4-6 hours per shift. The findings were that there were many different and interacting factors involved in nurses' decision making.

Some standardised care approaches were available but decision making was identified as a social activity and a variety of information sources informed decisions. This study used observation and participant observation in clinical practice and so it was particularly important to obtain informed consent from participants for this and due ethical and research and development approval was obtained. Rycroft-Malone and colleagues (2009) reported that standardised care approaches were rarely overtly referred to but where they were used staff reported using them in a flexible and particularised way. Nurses in the study described following a 'mental flowchart' (Rycroft-Malone *et al.*, 2009).

My study has some resonance with the findings of Rycroft- Malone (2008; 2009) as protocols and guidelines were also linked to the role extension. In my study however the HCAs extended their role and did speak of the protocols providing a check list for use in practice. When HCA roles were extended then protocol development and use was routinely integral to this process and the protocols were stored on the General Practice computer systems. The use of protocols did appear to be very much routine in my study within the General Practices and, as previously mentioned, this may be related to initiation and ownership of them by the PNs and HCAs from the outset.

6.2.3 Identifying health issues

The code *identifying health issues* refers to the HCAs role in uncovering health issues in the patients coming to see them. The HCAs valued the one to one contact with patients and following them up over time. The care and consideration for patients was clearly evident and as the HCAs built up knowledge about the patients in their care they became adept at identifying problems that the patients had and flagged these up to the PNs and GPs. The fact that they were able to do so demonstrates the increasing understanding and experience that they were developing within their work.

Early on in my study it became apparent that routine screening by the HCAs had identified patients with diabetes or with hypertension:

“We had a few diabetic patients that were picked up because of the clinics”

(Amy interview 1 p1).

“There was one diabetic patient, I did the urinalysis and thought oh goodness me I am going to have to get a doctor ...and he got started on insulin that night. That was how bad it was”

(Cara interview 1 p21).

Dawn, an experienced HCA, stopped a man walking out of the practice:

“I had one Warfarin patient....he mentioned that his foot was really badly swollen and he was very out of breath.....I basically said I would advise him to speak to the doctor... but he is the kind of person ‘oh I am always here’. And I knew he wouldn’t want to speak to the doctor, so I thought I would just go and mention it to the doctor...and he actually had cardiomyopathy and was in AF”

(Dawn interview 1 p4).

Julie reacted to the urgency of a significantly abnormal ECG:

“ECGs, I know that I am not trained to read them but it tells you what it is as you are doing it and you can see if it is a wee bit different. I had a man in one day and I went and knocked on the door for Doctor straight away and I mean he came straight through and whisked him away down the road [to hospital]. You can just see if it is different”

(Julie interview1 p3).

However, there were more frequent references to identifying health issues in phase 2 and 3 of my study. Morven, a HCA, recognised:

“It happens regularly you notice things especially with elderly people. You may get someone in who is looking after a partner with dementia and they come in with them and you can see the strain on their face. You recognise the stress that they are under and you think ‘oh dear’ and I then pass this on so that they can be assessed for more help with care”

(Morven interview 2 p5).

Kim commented:

“You can notice things about patients or they will ask you things or they will say ‘well you know I have not been feeling well.’ ...So you do pick up things as well and obviously doing urine tests and blood pressures when they are in...then you do pick up on things”

(Kim interview 2 p7).

The code is further illustrated in this quote where Morven was able to identify and get help for a patient with a major mental health problem:

“There was someone in just the other day, an older lady, but I knew something was really wrong...I was really concerned and so I went straight to the GP...But I knew right away that there was something really wrong with that woman. I could tell... it is amazing just what you can pick up on just with people speaking to you. They do open up to you.”

(Morven interview 2 p5).

Amy, another HCA recognised that the health of an elderly man was deteriorating and called upon colleagues to follow this up:

“We had a patient last week in for bloods and from his appearance and everything, he was really struggling. He was in to see me first so I did have a discussion with the GP and one of the nurses about this....one of the nurses went out to assess him at home and see how he was coping”

(Amy interview 2 p5).

This ability to identify the presence of health issues is significant and it illustrates that the HCAs are not just carrying out tasks in a mechanistic way. Rather they are applying skills and learning from previous experience to identify health issues. They then use their judgement and call in the PN or GP to follow this up.

The previously mentioned research study examining the HCA role in hospitals in England by Kessler and colleagues (2010:117) identified how ‘*HCAs could often uniquely elicit information and responses from a patient*’. The following quote from the study by Kessler illustrates resonance with the findings of my study:

“Manager London:” when I was a student nurse, the healthcare assistants were the ones that absolutely, you know, knew what was going on, were incredibly, usually stayed in one place for a long time, much longer than the qualified nurses so knew the running of the ward, knew what was expected, could, had that intuition, if you like of ‘Oh, you know, that patients not right’, sort of, that sort of expert in people skills”

(Kessler *et al.*, 2010:63).

Kessler *et al.*,’s research (2010) refers to the term ‘*radar*’ HCAs who had really good awareness of patients and problems. This seems a really apt description of the skills of the HCAs and the analogy can be transferred to the experiences in general practice within this study. PN Celia observed this about her HCA picking up on health issues:

“If they have got a cold or a cough or seems less well and if they are diabetic or someone who has a chronic disease and hasn’t been in then she [HCA] is likely to pick this up...they are coming in for bloods but never actually getting an assessment done because they are trying to avoid me in case I pick up any other issues. She is good at picking these up and saying ‘you haven’t actually been here for a while’ and she will say ‘well I will do your extra bloods because you are here today’... and then she makes an appointment for them to see me”
(Celia interview 2 p5).

The vigilant HCA helps by intervening and directing patients towards the appropriate care even when changes in health were not dramatic but may be a cause for concern.

The HCAs in my study identified that they were able to take decisions based upon prior knowledge and experience. Here the HCAs were expressing something beyond identification of health issues as they also began to act more decisively based upon their prior and developing knowledge. The level of experience and skill in taking decisions was evidenced in relation to patient problems within clinical practice:

“I have got experience of working in community behind me. There was a man that came in and I could smell urine on him and so I discussed it and said well we can get this and that done and get you referred. They do really appreciate it and you know that you are looking after people”
(Morven interview 2 p5).

To use the analogy of the ‘*radar*’ HCA (Kessler *et al.*, 2010), here the ‘*radar*’ seems to become more finely tuned with experience. In my study the HCAs based in General Practice have been able to develop more long term and individual background knowledge of patients and families over time than is possible in the short term nature of care in many secondary care settings included in Kessler *et al.*,’s study.

The enduring nature of the work with patients by the HCAs in General Practice may contribute to the finely tuned 'radar'.

6.2.4 Training up more- doing more

'*Training up more- doing more*' refers to the need to train more HCAs within the practices to fill the gaps in service provision when the HCAs were absent. The HCA role had grown and developed to such an extent that when the HCAs took annual leave or were off sick getting cover for their duties became increasingly problematic. Helen, a HCA, commented:

'I was on holiday for 2 weeks so there was no HCA for that time. Nurses and doctors missed not having a HCA available and the nurse's load was under strain. The practice has realised how important the HCA role is'
(Helen follow-up year 2).

PNs may have absorbed the HCA duties in the past during any periods of absence but this became increasingly difficult for them to maintain. It is evident that that staff working elsewhere within the practice were chosen for development in this case:

"We have got another part time health care assistant (name) our secretary because we have had staff shortages and we were again so busy. (Name) who actually has done phlebotomy for a while and she has actually started to see our new patients and she is happy doing a bit more so she has actually doing a bit of a health care assistant role as well.. This is great because it means that if somebody is on holiday there is cover"
(Audrey interview 2 p7).

Another PN, Joy, also identified that the phlebotomist had been extending her role more to help cover the needs of the practice:

"One of our phlebotomists has also been through training as a HCA so we have mentored her for that and now wound care training"
(Joy interview 2 p1)

This code does help to illuminate the importance of the HCA role within the practices. The HCAs were missed greatly if they were absent at all and the pressure of the workload led to more HCAs being appointed.

6.2.5 Fulfilling patient needs

The division of work between HCAs and PNs whilst improving the efficiency of clinics were noted to involve more patient visits to the practices. Patients may attend the HCA for bloods and other interventions one week and then return to see the PN at a later date. Audrey, a PN, noted that for some very debilitated respiratory patients this system did not best fulfil their needs as attending the practice entailed a great deal of effort and she indicated that they were trying to set up clinics differently:

“We have been working hard and trying to improve patient care and obviously streamline patient care in the practice...we are going to invite COPD patients in for a half hour slot. The first ten minutes would be under protocol, the health care assistant would carry out the spirometry and then the patient would come through to see either myself or the practice nurse or the GP and that way the patient does not have to be sent away and have to come back again”

(Audrey interview 2 p2).

This attempt not to fragment patient care is important as the split in workload due to skill mix has the potential to cause problems for patients. The patients could be required to attend for appointments more frequently and if for example they are really debilitated or live a long distance from the General Practice premises, then attending more often may be very onerous for them. It suggests that fulfilling patient needs relates to the shifting and interconnected nature of roles.

Although it could be observed that often the actions of a HCA assisted in fulfilling patient needs by stepping in to carry out an intervention such as an ECG to save patients having to wait or return at another time. Cara, a HCA, commented when she was called to do an ECG that was not previously booked:

“Well it helps stop everyone from running behind...It is better for the patient that is what it should be about”

(Cara interview 2 p2).

Another HCA had to call upon the support of an interpreter in order to fulfil patient needs. There was the need to get an interpreter on the telephone for some patients who do not speak English very well:

“They speak on the phone and we say who we are and who the patient is and we have to say to them what we want to ask and then they speak to the patient and they tell us what the patient has said so it does take quite a lot longer especially if you have a new patient and the amount of questions you need to ask them”
(Dawn interview 2 p12).

Orchard (2010) explored the literature regarding the nurse’s role in inter professional collaborative practice and concluded that all professionals should move away from service orientated delivery to patient centred collaborative approach. UK government policy regarding the NHS has advocated patient centred care (DoH 2006a). The ‘Better Health, Better Care’ report regarding plans for the NHS in Scotland outlined the necessity of putting the needs of patients at the centre of care provision (Scottish Government 2007). My findings indicate that awareness of the need for patient centred care was to the fore amongst the HCAs and PNs interviewed.

6.3 Reciprocal support

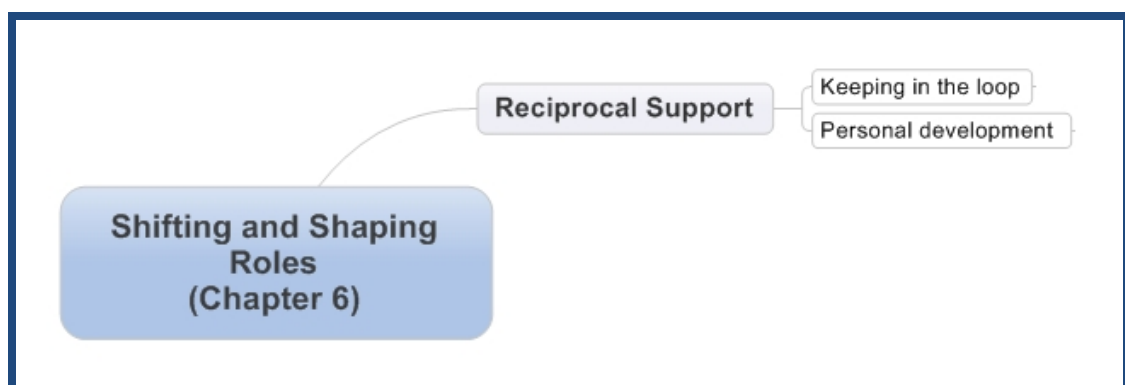


Diagram 6.5: Reciprocal support

The subcategory *reciprocal support* and related codes ‘*keeping in the loop*’ and *personal development* are represented in Diagram 6.5. *Reciprocal support* refers to the relationship between the PN and HCA that is one of mutual assistance and cooperation.

The initial hard work of the PNs in mentoring and teaching the HCAs paid dividends in the longer term as the HCAs proved an invaluable support to them. It emerged very much as a reciprocal arrangement. The PN comments below illustrate the nature of this support:

“I find that I am concentrating much more on chronic disease management. The HCA has actually taken on other things like BPs coming in for review or whatever. Yes so we are complementing one another you know and it is good”

(Gail interview 2 p1):

“Although I am a practice nurse I will visit the care homes and patients’ homes sometimes if I am chock a block and if she is going anyway to the care homes to do INRs then she will pick up a couple of blood pressures or blood tests that would be mine really. She will pick them up and vice versa. I can pick things up for her to save travelling”

(Felicity interview 2 p2).

Morven, a HCA, also recognised that the reciprocal nature of the support:

“Well (name of PN) and (name of other PN) they are both part time but we all work really well together...They will come to me if they are stuck and I will go to them because we have different things that we are good at. Especially I do the bloods and if they are stuck they will come to me even sometimes about dressings they will even just discuss, because I worked on community for so long”

(Morven interview 2 p1).

Julie, another experienced HCA, found herself supporting qualified nurse who were new to General Practice:

“We have been busy with the new nurses coming in to the practice who have worked in different settings. One was quite rusty at taking bloods so it was quite an eye opener for me to show her and I have shown them the ECG machine and have been giving them support too”

(Julie interview 2 p1).

It is interesting to consider the above experience in light of previous findings of HCAs learning to take blood in the code *PN mentoring* in Chapter 4. The practice and experience of the HCA had clearly moved on so that she was confident enough demonstrate her skills and give advice to the new PNs within the practice under the supervision of the Nurse Practitioner.

6.3.1 'Keeping in the loop'

The in vivo code '*keeping in the loop*' emerged during second interviews of HCAs. One HCA, Cara, commented about learning from experience to improve communication within the team when she was requested to move between the two parts of her role administration and HCA duties:

*"I think if we **keep** the practice manager more **in the loop** and I come and check and they say 'yes that's fine' but they might not have liked me just going away when it wasn't my day to be away sort of thing... if you play it right it works"*
(Cara interview 2 p1).

This comment appears important as Cara was indicating that she had learned how to adjust and to balance the two sides of her role better by keeping the practice manager informed of her actions.

Isobel, another HCA, found that when she reduced the number of hours that she worked as a HCA she then had difficulty in keeping up good communication with others in the General Practice team:

"Now I am down to working much less hours and I don't feel as much part of the team... I mean with the ordering and things it is difficult to keep in touch with all the other nursing team... and they will have ordered something that I would have normally ordered and just well it doesn't really work very well. But you just have to deal with it and try to keep in touch"
(Isobel interview 2 p5).

HCA Fiona found that one part of her role enabled good continuity of care and communication:

"It works fine. I mean the warfarin bloods I start from taking the bloods and follow it right through to the result being sent to the patient or to phoning the patient to give them the result so that is both of my jobs together"
(Fiona interview 2 p8).

The HCAs had become more aware of the need to maintain communication within the practice team. They had learned how to negotiate their way between the different aspects of their role and they were mindful of the value of streamlining communication with patients.

Communication was one of the themes identified in the literature related to its importance in effective team work in Chapter 4 in Table 4.3.

6.3.2 Personal development

The code *personal development* identifies how the personal development of the HCAs and the PNs were closely linked together in that they had both moved on to develop new skills and knowledge. The personal development and training of the PNs must be stressed as being considered important within the General Practices in relation to the shift in roles. The majority of PNs had undertaken significant further training and development while in their posts in General Practice and many had undertaken some training over the last year. The on-going nature of this development was evident with many PNs completing COPD and Diabetes Diplomas, Nurse Prescribing Courses, Specialist Practitioner Qualifications and more.

One PN, Penny, said:

“The demands in the role are more and also academically as well because the pressure is there for you to complete the various diplomas in the chronic disease management areas so that you are competent and obviously happy in doing the chronic disease clinics”

(Penny interview 2 p1).

The pressure to keep up to date with personal development is summed up below:

“I was at the nurse practitioners conference last month. It was great ...so good workshops so....I went on a Saturday but no it shouldn't be in your own time. You need to give it time. It is your personal development and you need to show that you have kept yourself up to date”

(Audrey interview 2 p6).

“The new PNs can learn to manage more complex things...so they need more training so that they can expand upon their own roles COPD, asthma management and diabetes, so that they can move up themselves as well, I don't see a limit particularly”

(Celia interview 2 p7).

“I am studying things that I am already doing. I just don’t have the certificate for it, for instance minor illness. I am doing a lot of minor illness just now at University and I have learned a lot about what I should have been doing before but you are just thrown in at the deep end. I think a lot of nurses feel that way”
(Kathleen interview 2 p3).

HCA Morven saw the connection between her own development and that of the PNs:

“They are both doing nurse prescribing and (name of PN) is doing a triage course with one of the Doctors so that she can do a clinic, the actual name of it is minor injury clinic. So she can do that but it is because of what I have been training to do too”
(Morven interview 2 p3).

6.4 Credibility of findings

As previously mentioned in Chapter 3 qualitative research is deemed credible when there is a fit between participants’ views and the researchers’ presentation of them (Gerrish and Lacey 2010). Participants should be made aware of research findings and consulted about whether these findings reflect their own experience and it is important in establishing the credibility of a study if participants endorse findings (Holloway and Wheeler 2010).

The use of diaries to check the credibility of a qualitative study was first used by Gray (1997) in her doctoral thesis. Gray (1997) used diaries with student nurses to provide member and outside validation for her study exploring the professional socialisation of student nurses.

In my study once data collection and analysis were complete I created a diary of a HCA in General Practice and a diary of a PN that reflected the findings of my study (Appendix XI). The diaries were divided into three sections reflecting the three phases of my study and statements were examples of categories and codes that had emerged. At the end of each sentence or group of sentences a square box was inserted. Guidelines were created to accompany the diaries and the reader asked to place a ✓ or a x in the boxes within the diaries.

The guideline stated: "If you can identify with the content of the diary by recognising yourself or a colleague in the diary you read then place a ✓ in the box. If you cannot recognise yourself or a colleague in what you read place a ✕ in the box." Respondents were encouraged to write any comments on the diary in addition.

The diaries were sent to all the study participants. Thirteen HCAs and eleven PNs responded from the fourteen HCAs and fourteen PNs approached. (Total n= 28). This was a healthy response rate of 85.7% from participants. Two non-participating PNs and two HCAs were also approached individually and they all responded. These additional responses enabled me to check findings beyond the study participants and verification was obtained. The responses are contained within Appendix XIII where the numbers in agreement are listed next to the categories and codes represented in the diaries. The HCAs and PNs were invited to write their own comments on the diaries and these are presented in Appendix XIV.

Overall, there was an agreement of 83.5% (n=11) from the HCA diary responses (excluding the optional section) and of 80.9% (n=9) from the PN diaries. From these responses to the diaries it is argued that this reflects the credibility of findings.

6.5 Summary of Phase 3

The third category *shifting and shaping roles* examines the nature of the developing role of the HCAs in General Practice in Phase 3 after approximately 2 years of my study. There are strong links evident between the HCA and PN role development. In Chapters 4, 5 and 6 I have endeavoured to capture the essence of the experiences and perceptions of HCAs and PNs through time as the HCA role has become embedded and has developed in General Practice. The findings will now be discussed further in Chapter 7 in relation to the research questions.

Chapter 7

Emerging Theory, Discussion and Conclusion

7.0 Introduction

This Chapter details the construction of my emergent theory within the interpretive tradition of Constructivist GT. The theory is linked to the findings and the underpinning processes are identified within all of the data. New literature has also been examined in order to provide greater knowledge of the processes grounded in the data. The emergent theory is discussed and recommendations and conclusion are made.

7.1 Interpretive theory development

The aim of grounded theory is to generate theory in order to illuminate and give insight into the topic being studied. The constructivist approach to grounded theory looks at how individuals view their situation theorizes about this and acknowledges that the theory is an interpretation. According to Charmaz (2006) the aim of Constructivist GT is to provide interpretive theory that does not seek causality but gives priority to patterns and connections. The Constructivist GT assumption is that data and analyses are social constructions that are a reflection of all that is entailed in their production (Charmaz 2000). My analysis of the data in my study has led to the development of an emergent theory of the evolving HCA identity in General Practice.

Charmaz (2006) describes an interpretive definition of theory as emphasizing understanding rather than the deterministic explanation of positivist theory aimed for in original grounded theory. Constructivist GT provides a contemporary version of original GT (Charmaz 2008). According to Charmaz (2006:126) "*interpretive theory calls for the imaginative understanding of the studied phenomenon*" and examines how and why participants construct meanings and actions in specific situations.

In the development of theory, Collins (2004) stated that it is what you remember; meaning that it is the important insight given into a topic that stands out vividly in a theory. In developing Constructivist GT this means stopping, considering data and analysis in depth and rethinking again. The constant comparative method in GT involves consideration of data from multiple vantage points, making comparisons, following up leads and building on ideas.

Theoretical sensitivity is the name given to the process whereby researchers develop theory following on from the creation of categories and by constant reference to the literature (Charmaz 2006). Researcher reflexivity leads to an attempt at awareness of preconceived ideas and provides insight into decision making processes. Charmaz (2006) asserts that constructing theory is not a mechanical process and that the researcher needs to consider and reconsider theory and be open to new and unexpected ideas and to ask questions, she calls this theoretical playfulness. In order to illustrate the theoretical playfulness and evolving theory I constructed diagrams at different stages in data analysis and theory development and some of these are included in Appendix XII.

As previously mentioned in Chapter 3 the use of gerunds (see Glossary) in coding advocated by Charmaz (2006) fosters thinking about actions and connections between actions and this maintains the focus upon processes in order to aid the development of theory. Analysing processes assists in constructing theory as it enables identification of major phases and the relationships between them (Charmaz 2006). My analysis of the perceptions and experiences of HCAs in General Practice over time has led to the development of three major categories *getting going and proving worth*; *building confidence and respect*; and *shifting and shaping roles*; tracing developments within the HCA role in General Practice over the three years of data collection in my study.

Charmaz (2006) does not give expansive details regarding theory development in her book on Constructivist GT. She does however describe analysis through the same terminology of Original GT created by Glaser and Strauss (Charmaz 2008). The establishment of core or major categories is an important stage in theory development (Glaser and Strauss 1967). The core or major categories named above were established within the three phases of my study. Theory development then is formed by making links with existing theories by comparing and contrasting and bringing theory together around these major categories (Charmaz 2006).

7.2 An emergent theory of the evolving HCA identity in General Practice

Glaser and Strauss (1967) describe different levels of theory development. A formal theory is one that offers a broad level of explanation applicable across different settings. A substantive theory is one that is applicable in a specific setting and cannot be generalised to others. Glaser and Strauss (1967) indicate that many substantive theories go on to be developed further and become formal theories as they are refined and applied to other settings over time. An emergent theory is one in an early stage of development. My emergent theory is:

'The HCA role in General Practice is incremental and is predicated on a search for belonging and occupational identity. It is developed and influenced according to the organisational dynamics and support for learning from within the specific small business environments of individual General Practices.'

Diagram 7.0 illustrates this incremental development of the HCA role identity in General Practice over the three time phases identified in my study. The important foundation beneath the three steps (relating to the 3 phases of my study) is identified as the prevailing organisational environment, the culture and support available within the individual General Practice. The first step on this foundation is the HCAs' search for belonging within their new role.

Following on from this initial step is step two, where occupational identity becomes more established as the HCAs became well known, accepted and comfortable in their new role. Step three relates to the occupational role growth that occurs overtime where the HCA role is further shaped and developed.

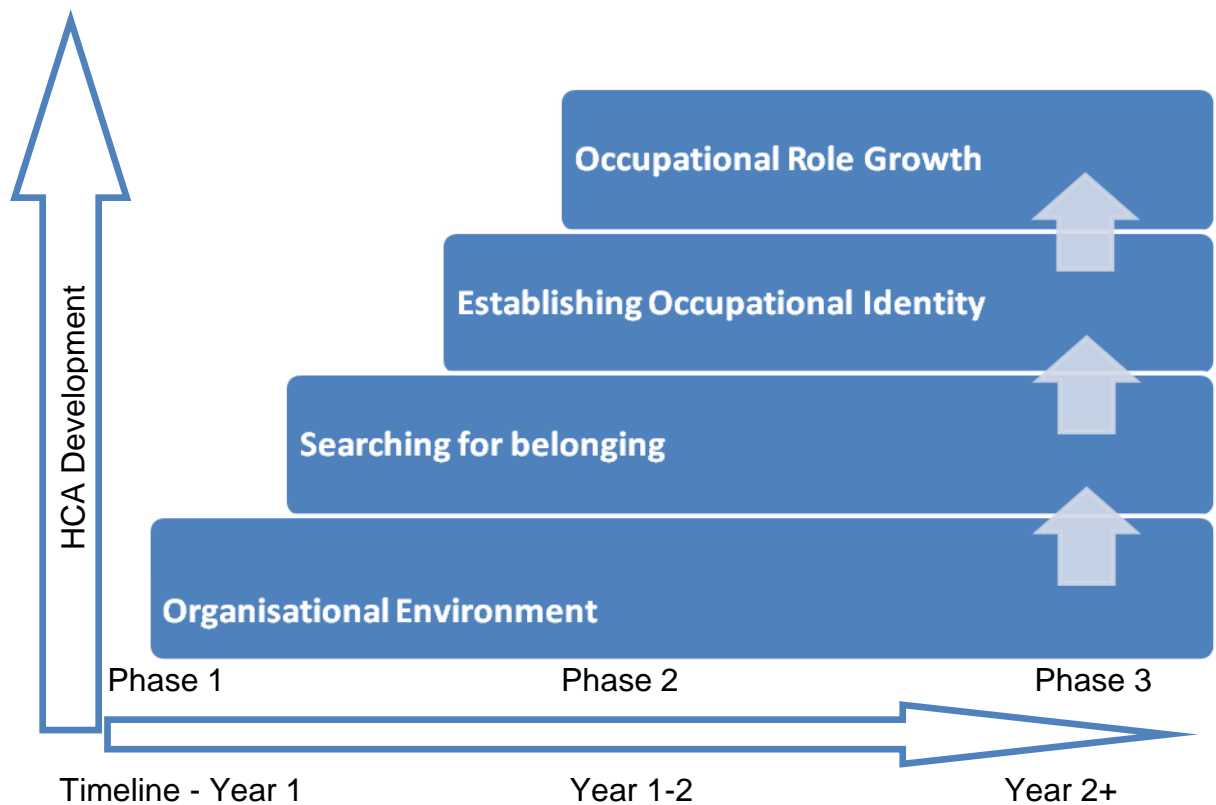


Diagram 7.0: Emergent Theory- Steps in the development of HCA role identity in General Practice

7.3 Theory development -Evolving role identity

Having very briefly summarised my emergent theory I will now give a detailed account of its development. From the first round of interviews with the HCAs it became apparent that they were becoming established in their role in General Practice and were proving to be helpful to other team members. It was also evident that there were developments taking place within their role. The HCA role was in a process of transition as had been anticipated during the baseline study (Burns and Blair 2007).

In 2007, the HCA role was relatively new to General Practice but almost all of the HCAs had worked within the General Practice setting, most commonly in an administrative role, prior to becoming a HCA. Some had also continued to work part time in an administrative role while undertaking HCA duties. Hence the processes taking place within the study were not related to the HCAs initial socialisation into the General Practice setting but were related to them taking on a new and different role within a setting within which they had already worked. The HCA role although new to General Practices in Scotland had been in place in England for some years. The process of introducing the HCA role in Scotland was not predefined but rather open to developments reflecting the changing demands from within the practices.

The importance of the organisational environment became evident and will be examined in detail next followed by consideration of the three steps shown in Diagram 7.0. These three steps called searching for belonging, establishing occupational identity and occupational role growth developed from the 3 major categories identified in data analysis in the three phases of my study. Diagram 7.1 shows my construction of the social processes occurring around the developing role identity of the HCAs in General Practice over time.

Evolving HCA identity in General Practice

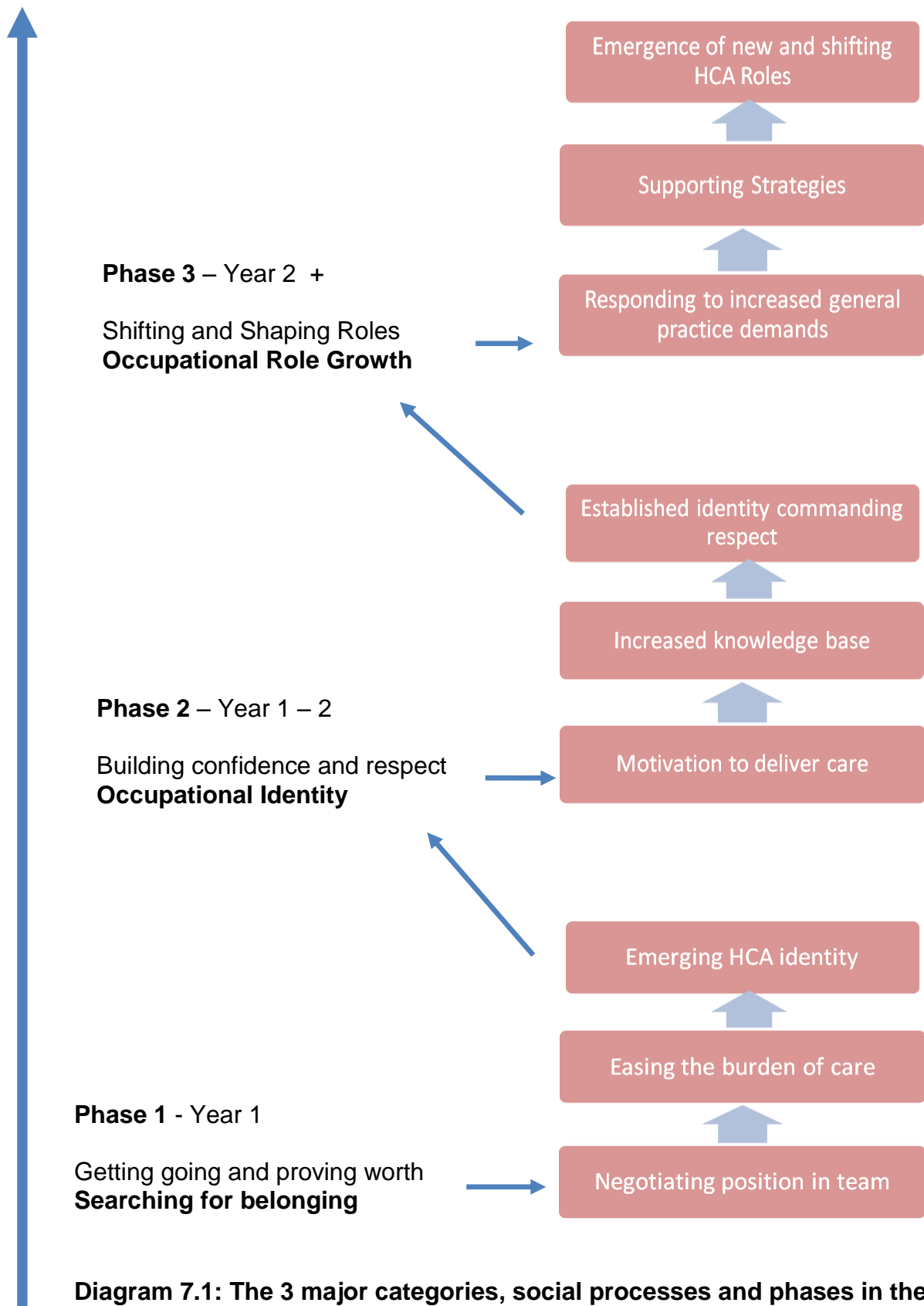


Diagram 7.1: The 3 major categories, social processes and phases in the evolving role identity of HCAs in General Practice

7.4 General Practice Environment

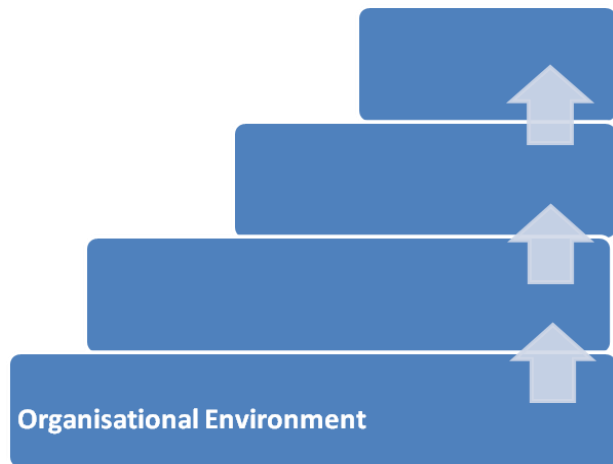


Diagram 7.2: The organisational environment of General Practice

The context in which this evolving HCA role identity in General Practice is taking place is important and unique. This is identified as the organisational environment in Diagram 7.2 illustrating the incremental nature of my emergent theory and its fundamental importance in developing the HCA role. In order to illustrate this, the theory diagram shows the organisational environment as the foundation on which the theory related to the three phases of my study are built. In order to reveal the process of development of the emergent theory, the other component parts of my emergent theory are added throughout this Chapter and related to the categories and social processes of the three phases of my study.

General Practices sit outside the main NHS with General Practitioners holding a Contract with the NHS for the provision of care taking place within their practices. It has become apparent that the 'climate' within individual practices are very significant in enabling HCA role development. The individual practice 'climate' varied but in my study the environments were identified as being very supportive to and accepting of the HCAs with only a few exceptions relating in part to actions and attitudes of individuals (see Chapter 4 in the code '*total threat*').

There has been research into the climate and culture within General Practices but not in relation to HCAs specifically. The work in England of Hann *et al.*, (2007), previously described in Chapter 4, examined culture, climate and quality of care in 42 General Practices and identified that the majority of these practices had a 'clan culture' demonstrating a climate of participation and teamwork.

Clan culture is one of four cultures characterised by Cameron and Freeman (1991) in the Competing Values Framework an instrument measuring organisational culture in health care (Scott *et al.*, 2003). The four cultures characterised in the framework are clan, hierarchical, market-orientated and adhocratic (Cameron and Freeman 1991). Clan culture is identified as placing importance on teamwork, collaboration and consensus with high group loyalty and sense of tradition and a strong concern for people (Cameron and Freeman 1991). This clan culture was evidenced in my study and was observed to be instrumental in fostering the development of the HCAs. The developing HCAs very much depended upon the support of practice team members and in order to thrive in their role.

Huby *et al.*, (2008), previously described in more detail in Chapter 4, undertook case studies of 4 General Practices in England and Scotland examining organisational change in relation to the GMS Contract and there was found to be a move towards a more hierarchical structure with decision making becoming more concentrated in fewer hands due to monitoring of delivery of the Contract. The study identified that the staff within the practices had failed to recognise the change in culture from a flattened structure with a good degree of choice and autonomy in ways of working. My study has certainly identified the impact of delivering the GMS Contract upon the daily activities within the practices but also identified that delivering the GMS contract has meant that there are shared goals within the practices that the whole team work towards achieving the points needed for the QOF with some GPs recognising the work of HCAs in relation to this.

The tensions between the economic needs of practices and the desired altruistic relationships between health care professionals and patients should be noted here and will be examined in detail later in this chapter under the heading Phase 3. Much of the HCAs work was noted to be configured around delivering the GMS Contract and the employment of HCAs is observed to be advantageous to this end. It was certainly evident that a shared team spirit and identity predominated in most General Practices. In the General Practices where it was not reported to be strong, the HCA role had not developed as much as there was predominance of a more controlling than an enabling and mutually supportive culture identified.

There are multiple factors within the general practice environment that have an impact upon the developing HCA role and I have drawn these together in Diagram 7.3. This is recreated from a drawing I completed in my reflexive journal whilst I was undertaking interviews.

23/2/10 Extract from reflexive journal

I have just undertaken a second interview today with one of the HCAs and it was good to see how much she has grown in confidence since I spoke to her a year ago. The interview has really made me think about all of the different factors that have influenced the HCA role within the practices over time. There are many factors and these are related to one another. The external demographic and policy factors such as the new GMS Contract and the increasing chronic disease workload influence and shape the General Practice structure and functions. HCAs have played a significant part in enabling more patients to be seen and they have contributed to the delivery of the GMS Contract. It is being reinforced to me that the internal relationships between practice staff are very important to HCA development and that supportive working environments have enabled HCAs development. Access to training and the growing self-confidence of the HCAs has influenced the ongoing development of their role. Drawing this diagram immediately following data collection has enabled me to capture in a focused way my understanding of the factors impacting upon the HCA role in General Practice that I have built up and consolidated during data collection and analysis.

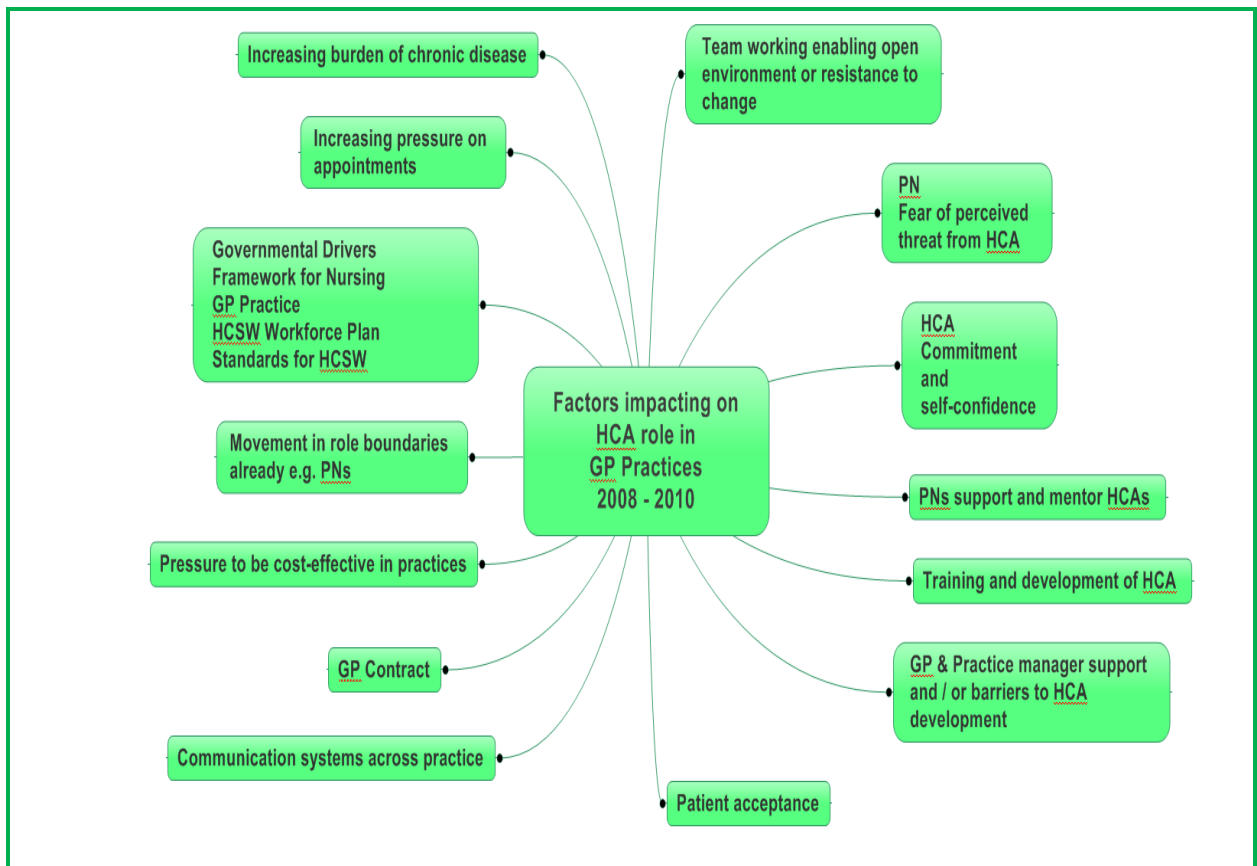


Diagram 7.3: Factors impacting on HCA role in General Practices
Excerpt from reflexive journal 23/2/10

Diagram 7.3 shows external factors such as delivery of NHS policy, the GMS Contract, increasing pressure upon patient appointments and the increasing burden of chronic disease management have impacted on the General Practice environment and the HCA role. Communication, teamwork, training and support were also noted to be important. As previously recognised in analysis in Chapter 4 the HCAs proved strongly allied with the PNs who mentored and supervised them into the HCA role and from whom they learned skills and subsequently took over some duties. The PNs certainly played a pivotal role in assisting HCAs to become accepted in to the practice teams in their role. In view of the above factors the literature relating to organisational theory and in particular learning theory have relevance to my study. Theories relating to the environment that are relevant to my emerging theory will now be examined.

7.4.1 Organisational and Learning theories

The learning organisation has been defined as '*...the intentional use of learning processes at the individual, group and system level to continuously transform the organisation in a direction that is increasingly satisfying to its stakeholders*' (Dixon 1994:4). Rushmer *et al.*, (2004a; b; c) describe how in the NHS and in primary care knowledge and experience exist but they are often not systematically employed effectively with staff failing to contemplate changes or developments in practice. Rushmer *et al.*, also indicate how NHS policy has in the past been aimed at avoiding bad practice rather than following and building upon good examples. However, new NHS policy aims to employ the principles of learning organisations whereby individually and groups of staff are given discretion to adapt practice and new ways of working, thus enabling ownership and job satisfaction (DoH 2010; NHS Scotland 2010).

Learning collectively has been linked to making changes in organisations that become owned by participants and also to sustainability and service improvement (Chin and McNichol 2000). Rushmer *et al.*, (2004; 2007) attached importance to organisational learning and have focused extensively upon General Practice. Rushmer *et al.*, (2007) outlined a diagnostic tool to assist General Practices to identify and measure collective learning and the extent to which practice culture supports learning, this is named the LPI or Learning Practice Inventory and is a self-assessment, fixed choice, survey feedback tool for use by all General Practice members.

The importance of organisational culture to learning can be related to a study by Billett and Somerville (2004) who point to the reciprocal and interdependent relationships between individuals' sense of self and identity at work and their learning. According to Billett and Somerville (2004) individuals actively construct meaning from encounters and so learning for change, working life and participation should take into account individuals' sense of self and identity as these are shaped by and shape action and intent.

The more recent work of Ahlgren and Tett (2010) has an affinity with that of Billett and Somerville (2004) regarding identity and learning and is relevant to my emergent theory. Ahlgren and Tett drew on analysis from a previous research project (Ahlgren *et al.*, 2007) in which they had carried out case studies in 14 small and medium sized business enterprises in Scotland and examined work-based learning in order to discuss how the relationship between organisational culture, identity and learning opportunities impact upon the workplace. They argue that the identity of the learner is shaped by interaction between individuals, the workplace culture and the activities in which workers engage. Ahlgren and Tett (2010) identify the potential for employers to influence workplace culture and learning either positively or negatively and conclude that it is in the employers own longer term interests in constantly changing workplaces to value the development of their employees capabilities so that everyone can benefit from new knowledge.

This links to my emergent theory with regard to the importance of a predominantly enabling and supportive culture in General Practice associated with progressive work practices as opposed to those practices where development was limited and controlled.

The HCAs in my study were learning a new role within the General Practice setting and the learning environment provided in the practices was found to be hugely significant. Learning in the workplace takes place when the individual employee's learning processes interact with the learning environment of the workplace. It has been stated that the learning process is optimised when individuals and groups within the workplace collaborate together to develop learning opportunities (Illeris 2004). Illeris identifies three main components in workplace learning: the technical-organisational learning environment, the social learning environment and the employees' work processes (Illeris 2004). A model for learning in working life has been developed by Illeris (2004).

Diagram 7.4 has been adapted from some of the work of Illeris (2004) who built on the work of Jorgensen and Warring (2001) to develop a holistic model showing the basic elements of workplace learning and their connections. In order to illustrate how these issues relate to the HCAs learning in General Practice I have created this adapted diagram. The HCAs individual learning at work in General Practice is important but it is influenced by the technical learning environment which is characterised by advances in health care, increasing demands, workload pressures. The social cultural learning environment also relates to and influences the General Practices community and the degree of support for learning including the availability of mentorship and learning by role modelling.

Employees' Learning Processes

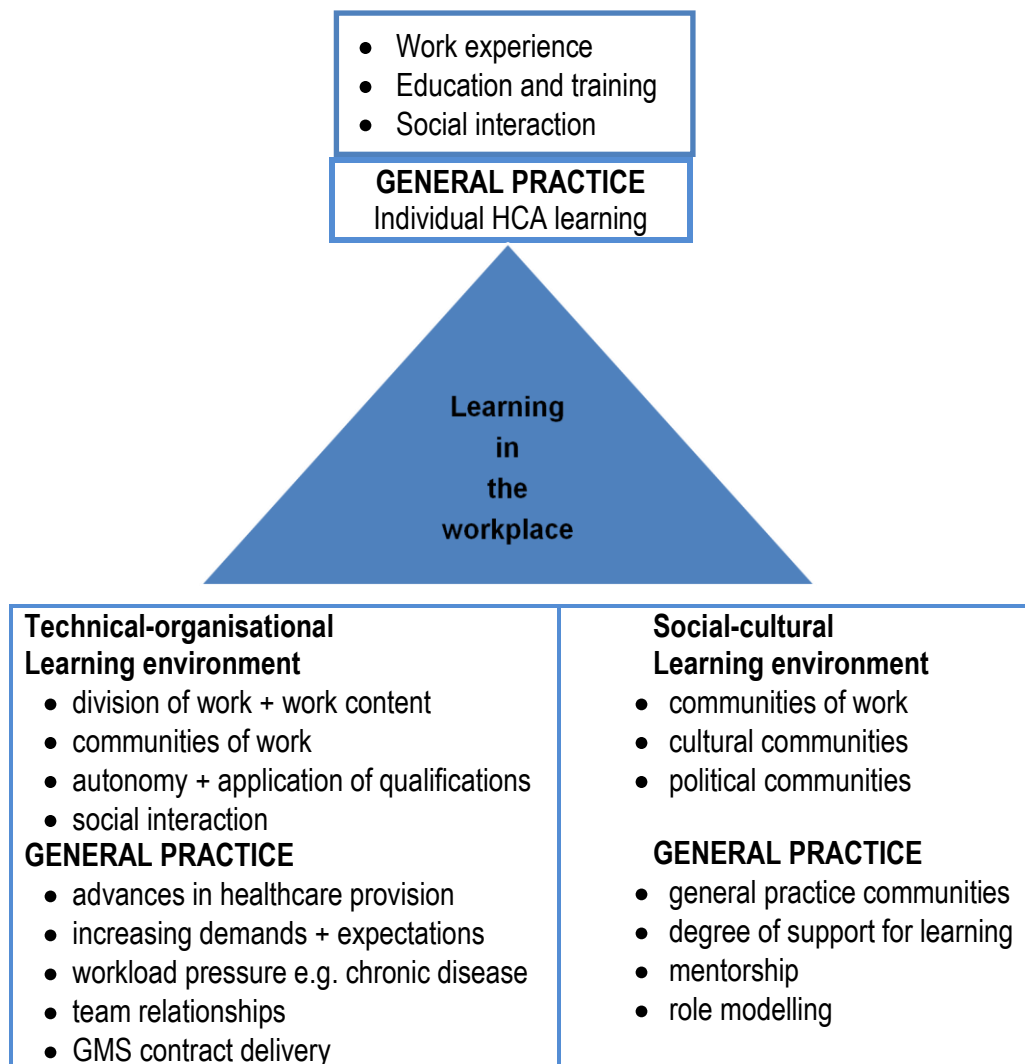


Diagram 7.4: Conditions of working life for learning adapted from Illeris (2004)

Illeris (2004) refers to communities of work and a similar term 'communities of practice' has been used by others to describe supportive environments for learning (Lave and Wenger 1991; Wenger 2004). Communities of practice are defined as groups of people who have shared interest and concern for something that they do and who interact regularly and learn how to improve their practice. The three components of communities of practice are defined by Lave and Wenger (1991) and Wenger (2004) as: a *domain* of shared interest; members of the specific domain who interact as a *community* and thirdly there has to be *practice* that is persons who are practitioners developing and sharing practice by interacting with others. General Practices may be described as individual communities of practice and another community of practice made up of HCAs in General Practice could be said to be in its infancy with HCAs seeking to band together and consider practice as identified in the code '*getting together*' in Chapter 5.

Illeris (2004) also attached importance to work identity and to the interconnection between workplace learning and workplace identity. Learning related to working life should be viewed as being influenced by an individual's work identity and vice versa as learning also plays a part in influencing the development of work identity. This view of the interconnected nature of learning and identity at work is very relevant to my emergent theory as the HCAs were establishing their own occupational identity and were growing in confidence and competence. This will be explored further later in this Chapter under the heading named occupational identity.

The work of Eraut (2004) regarding the processes involved in informal learning in the workplace should be noted in relation to my emergent theory. Eraut (2004:250) defined the nature of informal learning in the workplace as '*learning that comes closer to the informal end than the formal end of a continuum*' including characteristics such as unstructured, opportunistic, unintended and implicit learning without the presence of a teacher.

Some informal learning by HCAs inevitably took place in General Practice and those who had already been employed in other roles within General Practice could be observed to have a wealth of informal learning experiences to bring to bear upon their new HCA role.

Eraut (2004) examined theoretical frameworks for understanding informal learning in the workplace developed through a series of research projects. Eraut (2004) when attempting to identify what is being learned in the workplace categorised learning under the following headings; task performance; awareness and understanding; personal development; teamwork; role performance; academic knowledge and skills; decision making and problem solving and judgement.

Eraut concluded that working in groups and alongside others enables insight into new practices and leads to different perspectives being gained and he also identified that HCSWs gain insight and knowledge from working and communicating with clients. The work of Eraut (2004) also identified that increased confidence arises from individuals being able to meet challenges at work and noted a triangular relationship between challenge, support and confidence. Confidence at work influences individual learning. Challenge and support encourage staff to seek or respond to learning opportunities but if these are absent at work then confidence decreases and also motivation to learn. This theory has particular relevance to my own emergent theory and particularly later in this Chapter in Phase 2 where increasing confidence and respect are linked to establishing occupational identity. My own emergent theory and the work of Eraut (2004) also remind me of the words of PN Leah quoted in Chapter 4 who recognised that the HCA needed to be supported in taking on and coping with challenges in her role:

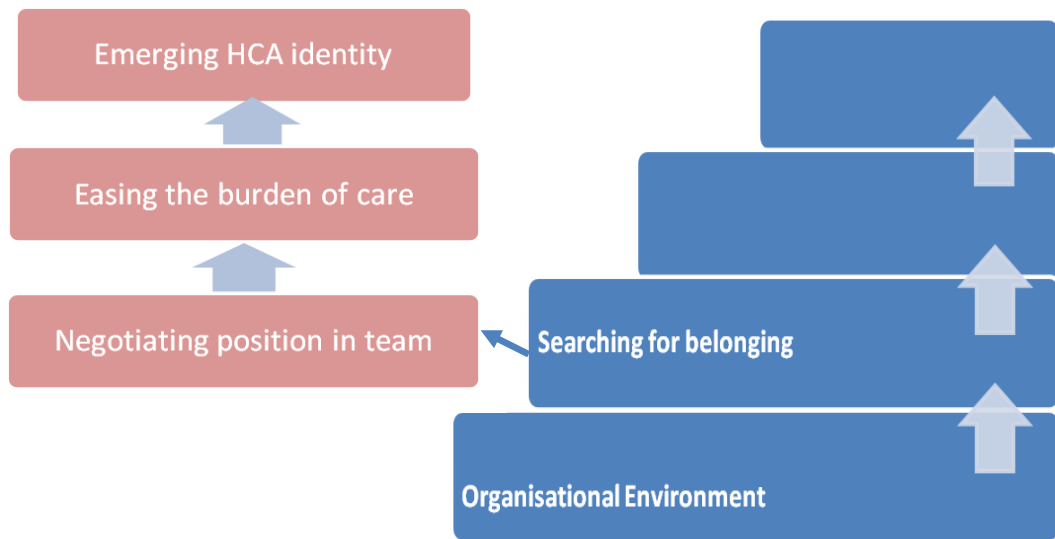
“I said to the practice manager ‘you need to make her job interesting you know. Don’t let her think that she is starting here to be a phlebotomist because that will just be soul destroying...we need to identify what her role is going to be to give her some job satisfaction and make sure that she can follow patients through”
(Leah interview 1 p2).

The work of Herzberg *et al.*, (1959) has been discussed in Chapter 5 and will be re-examined later in this chapter but it is worth noting again here that this research also identified the working environment as very significant and the features of this were named '*hygiene factors*'. Maslow's theory (1957) of the hierarchy of need is also of relevance again here in relation to the General Practice environment. In Diagram 5.2 in Chapter 5 Maslow's hierarchy of need is related to the workplace environment. Further examination of the learning environment in relation to identity will be examined under the heading Phase 2.

7.4.2 Summary of the organisational environment of General Practice

The environment in the General Practices where the HCAs were learning and developing in their new role proved of fundamental importance to their progress. The predominance of cultures with an emphasis on a people orientation, loyalty, collaboration and teamwork was evidenced in my study. As has been related to organisational and learning theory, the supportive and enabling environments in General Practices provided the crucial foundation for the HCA role and identity to develop and flourish. Nevertheless as has been examined in Chapter 4 there were noted to be increasing pressures arising within practices over the delivery of the new GMS Contract to ensure financial security for the practices. The importance of the organisational environment is reinforced over the three phases of my emergent theory. Theory in relation to Phase 1 of my study will now be examined.

7.5 Phase 1 - Searching for belonging



Year 1 – Phase 1

Searching for belonging - Getting going and proving worth

Diagram 7.5: Phase 1 - year one- searching for belonging

My emergent theory relating to Phase 1, the first year of data collection and analysis in my study, is illustrated in Diagram 7.5 in which the HCAs were seeking to belong in their new roles within the General Practice teams. Getting into the new HCA role and proving of value in the new role was important to the HCAs as encapsulated in the first major category named *getting going and proving worth*. The HCAs sought to prove themselves of value and support to staff and patients. It mattered greatly to them to be accepted and to feel that they belonged in the practices in the HCA role. The social processes of proving themselves to be worthy and searching to belong in their HCA role were significant during Phase 1 of data collection and analysis and this was connected and led to the further development of their identity. There was negotiation by the HCAs around their position in the team within General Practice. They had moved from one accepted position within the team, for example from working as a receptionist to another role in which they had to take on a new identity and prove themselves to be useful in the team.

Those who had a dual role felt a degree of conflicting loyalty in their work. They needed to be released at certain times to undertake direct patient care and were not so able to respond to and take on extra administration duties. However some HCAs enjoyed undertaking a dual role and derived satisfaction from providing care for patients across the differing duties.

In my emergent theory this identified need by the HCAs to feel that they belonged in their role within the General Practice teams led me to examine belongingness as a concept and the work of Baumeister and Leary (1995) has relevance here. Baumeister and Leary carried out a literature review examining the belongingness hypothesis that people form social attachments readily under most conditions and resist the removal of existing bonds and indicated that humans have a drive towards belonging in that they seek to form and maintain lasting positive and significant relationships with one another. Conversely a lack of attachments and a sense of belonging are linked to ill effects upon health and well-being. Baumeister and Leary (1995) affirm that the psychological evidence available supports the hypothesis that the need to belong is a powerful and fundamental human motivation.

Further work examining belongingness and the link to social acceptance as opposed to rejection upon self-regulation was undertaken by DeWall *et al.*, (2008). The results of seven experiments were examined and found to support the premise that a drive that has been satisfied may temporarily diminish in strength and one that remains unsatisfied may increase in strength. The results support the premise that one can become satiated with belongingness while rejected persons are found to have an increased desire to make new social bonds. Linking this work with my emergent theory the HCAs sought to belong in their new role within the General Practices and this differing role that they had taken on did put them in a position of having to prove themselves and so this increased their drive to belong.

The research undertaken by Levett- Jones and colleagues (2007; 2008; 2009a; b; c) is also worthy of examination in relation to my emergent theory. Levett- Jones *et al.*, focused particularly upon student nurses' belonging when in practice placement and they found a sense of belonging to be crucial to optimising practice learning experience. Levett-Jones *et al.*, (2008;2009) undertook a mixed method cross national case study of student nurses across 3 sites (n=362) using an online survey and eighteen student nurses also took part in semi-structured interviews. Levett-Jones *et al.*, subsequently devised an Ascent to Competence Conceptual Framework to reflect the development of student nurses that was modified from Maslow's hierarchy of need (1987). They developed a comprehensive definition of belongingness which is very applicable to belongingness identified in my emergent theory:

'Belongingness is a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group and (c) that their professional and/or personal values are in harmony with those of the group. The experience of belonging may evolve passively in response to the actions of the group to which one aspires to belong and/or actively through the actions initiated by the individual.' (Levett-Jones *et al.*, 2009a:2872).

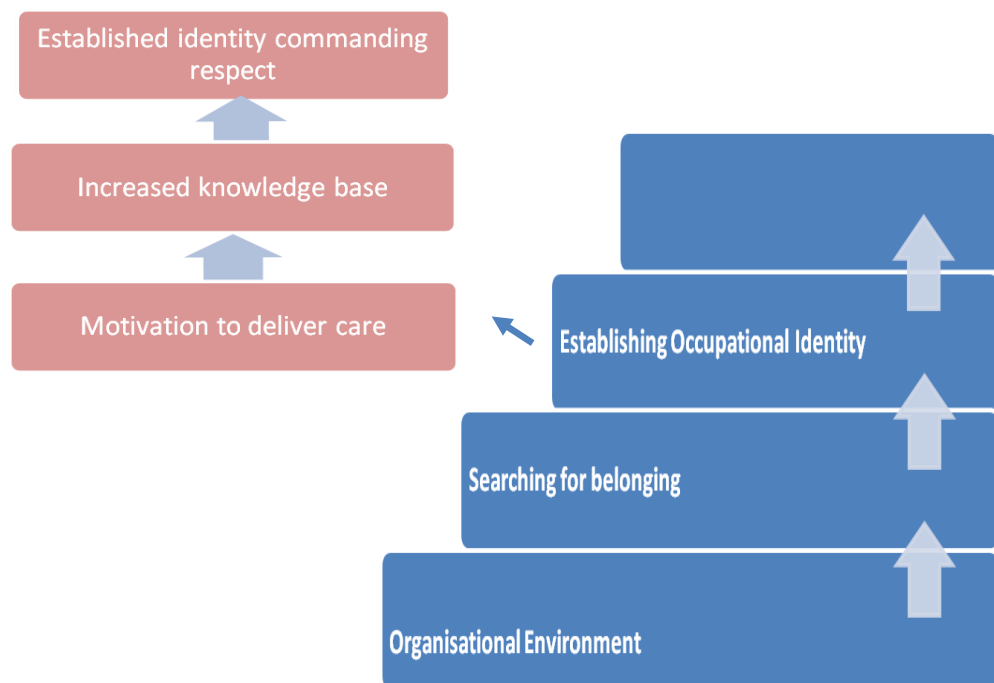
The supportive practice environment generally and in particular being welcomed and supported by key individuals in the team at work was highlighted within my study. The role of the PN mentor was found to be of pivotal importance in this search for belonging by the HCAs in General Practice and the supportive educative role of the PN contributed to the HCAs sense of belonging in their own role. Similarly the importance of a good mentoring relationship is reflected in the work of Levett- Jones and colleagues.

7.5.1 Phase 1- Summary in relation to emerging theory

Belongingness theory can be very closely related to the developing HCA role identity in Phase 1 of my study. The HCAs in my study were searching to belong in their role in General Practice. They worked hard to assist their colleagues in the primary care teams and to prove themselves to be of value to the team. As the HCAs sense of belonging increased then there was movement towards the establishment of HCAs identity. Phase 2 of my emergent theory relates to the establishment of this occupational identity.

7.6 Phase 2 - Establishing occupational identity

The HCA occupational identity has grown over time and they felt more accepted in their role and also their confidence and competence increased. Diagram 7.6 illustrates Phase 2 in my emergent theory and this relates to the second year of comparative data collection and analysis.



Phase 2 – Year 1 – 2

Occupational Identity - Building confidence and respect

Diagram 7.6: Phase two – year 1-2 Establishing occupational identity

The second phase in the evolution of the HCA role identity in my emergent theory encapsulates the major category named *building confidence and respect*. Patients were accepting of their role, patterns of repeat patient visits to the HCA were well established and the patients reported to prefer to return to see a familiar HCA regularly than see anyone else.

Any initial doubts about the HCA role appear to have dissipated within the practices and some PNs who may have felt initially somewhat threatened by the new HCA role now increasingly valued the support offered to them by the HCAs. The HCAs had increasing confidence in their abilities and felt that they commanded more respect from patients and staff within the General Practices.

In Phase 2 of my emergent theory the identity of the HCAs in General Practice was observed to be formed and becoming very firmly embedded in the General Practices. The HCAs were motivated to progress in their role and placed value on and sought out new opportunities to learn more about their every aspect of their role. Identity formation has been explored within the literature and identity has also been related to learning within organisations by theorists such as (Illeris 2004; Eraut 2004). Psychologist Erikson (1968) was an early theorist interested in identity formation over the lifespan and he differentiated between the ego identity (self), cultural identity and social identity and postulated that ego identity could be charted in a series of stages in life in which identity is formed in response to increasingly complex challenges. A more recent theorist, Baumeister (1997), mentioned earlier in relation to belongingness, described identity as the definitions that are created for and are superimposed on the self.

Key aspects of identity theory should be viewed against my emergent theory as there are parallels. In identity theory motivation has been linked to commitment and to salience and so the greater the commitment to an identity and the greater the salience of the identity then the more effort would be put into enacting the identity (Stets and Burke 2000).

The evaluation of individuals' role identity can be seen to influence feelings of self-esteem and the motivation to perform well in the role. Within identity theory, in a role that evaluated positively the person's self-esteem would become higher and also it is argued that if the person performed well in their role then they would feel good about themselves.

Self-efficacy is also significant here in that those who perform well in a role gain a sense of control over the environment and thus self-esteem and self-efficacy are increased by the self-verification occurring when a role is performed well (Burke and Stets 1999; Stets and Burke 2000). This can be related directly to my emergent theory where the HCAs are regarded very positively by team members and patients and the confidence, motivation and job satisfaction of the HCAs has grown.

The first theorist to connect occupation and personal and social identity in occupation-based literature was Christiansen (1999; 2000; 2004) (Phelan and Kinsella 2009). Christiansen indicated that an individuals' participation in occupation contributed to the construction of their identity and will be the primary means of communicating identity. Christiansen stated

'when we build our identities through occupations, we provide ourselves with the contexts necessary for creating meaningful lives, and life meaning helps us to be well' (1999,547).

Christiansen proposed 4 central concepts surrounding occupational identity. Firstly, that the concept of identity is overarching and shapes and is shaped by our relationships with others. Secondly, identities are closely related to our actions and our interpretations of these actions within the context of our relationship with others. Thirdly, identities are central to a self-narrative or life story providing meaning for events and for living. Fourthly, life meaning is derived in the context of identity and is essential to satisfaction with life and well-being (Christiansen 1999). Similarly my emergent theory identified that firstly the HCA identities were overarching and were formed by relationships with others and were closely related to actions and interpretations.

The HCAs were motivated and sought a greater understanding of and meaning within their role at work. They valued the increased knowledge gained and reported a high level of job satisfaction.

Kielhofner (2008:106) provides a definition of occupational identity that is applicable to my emergent theory;

'a composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation. One's volition, habituation and experience as a lived body are all integrated into occupational identity'.

Hammell (2004) in a paper on the dimensions of meaning in the occupations of daily life proposes that finding meaning within occupation is fundamental to peoples' lives comprising of dimensions of meaning, doing, being, belonging and becoming. The role of meaning, job satisfaction and quality of life are important themes arising within the literature in relation to occupational identity and they have strong parallels to my emerging theory.

More recently Phelan and Kinsella (2009) also postulated that occupational identity is more complex than individual identity formation and the social dimensions and relationships are not just a means of social approval relating to occupations but they may form, shape and even produce identities. They call for greater recognition of the variation between individual and socially orientated dimensions in how identities are shaped. Phelan and Kinsella illustrate this point by referring to the fact that some people do not have the opportunity to develop a personal sense of identity because they live in dangerous, chaotic or severely restricted environments which provide only limited roles and activities to them in order to just survive. This insight into and affirmation of the significance of occupational identity is further developed in my emergent theory. The HCAs were afforded the opportunity to flourish and to develop their occupational identity which was also hugely important to them in their individual lives and some sought to undertake further training or to become registered nurses.

The HCAs in General Practice were very proactive in developing their skills and identity and others within the primary care team enabled and facilitated the establishment of their identity and in exceptional cases controlled the extent to which the HCAs could access learning. Blaka and Filstad (2007) theorised about how newcomers to the workplace construct identity. The newcomers need to be proactive in obtaining and developing new knowledge and by establishing relationships with others in the workplace but their ability to do this is controlled by the extent to which others in the group allow the newcomer access to learning arenas. The PNs were pivotal in allowing the HCAs access to learning, as examined in Chapter 4 under the code named *PN pivotal*. This work also links back to earlier in this Chapter where the importance of the organisational learning environment is examined.

The HCAs enjoyed job satisfaction and were motivated to deliver good care for their patients despite the fact that they did not consider that the pay they received was commensurate with duties performed. They had a high level of job satisfaction which they derived from working in the supportive climate of General Practice. This can be related to Herzberg and colleagues theory of motivation to work (1959) that identified a multiplicity of diverse contributing factors.

In relation to my emergent theory it is also useful to again refer to Maslow's hierarchy of need taking into account the need for esteem, recognition, promotion, participation in decisions (Maslow 1987). The HCAs remained very motivated to learn more about all aspects of their job, for example they wished to increase their understanding of the various blood tests they were taking. They valued the education provided to them and they wished to undertake further training and education. They particularly valued coming together to participate in training as a group with other HCAs from General Practice as referred to earlier in this Chapter they sought their own community of practice and learned from one another (Lave and Wenger 1991).

This also appeared to serve to assist in reinforcing their identity as a distinct group of health care staff and to reiterate links made earlier in this chapter with organisational environment learning has been named as influential upon the establishment of identity (Eraut 2004; Illeris 2004; Billet and Somerville 2004; Ahlgren and Tett 2010).

7.6.1 Phase 2- Summary in relation to my emergent theory

The HCAs role identity was established building upon the HCAs achievement of a sense of belonging in their role within the General Practices. Motivation to learn was high and an increased level of knowledge and understanding engendered an increased level of confidence in the HCAs. They felt that they commanded more respect from colleagues and patients at work. Aspects of occupational identity theory, Herzberg *et al.*,’s motivation to work theory (1959) and Maslow’s hierarchy of need (1987) can be linked to my emergent theory here. The HCAs felt valued and supported in their role and so fundamental needs identified by Maslow (1987) were being met and they were motivated by multiple factors that could be construed as *hygiene factors* identified by Herzberg *et al.*, (1959) contributing greatly to their job satisfaction. The HCAs established role identity led to occupational role growth and this will be examined next in Phase 3.

7.7 Phase 3 - Occupational role growth

Phase 3 of my emergent theory is illustrated in Diagram 7.6 with this final developmental step named occupational role growth derived from the third year of comparative data collection and analysis. This part of the emergent theory is related to the social processes taking place in the final major category named *shifting and shaping roles*.



Phase 3 – Year 2 +

Occupational Role Growth - Shifting and Shaping Roles

Diagram 7.7: Phase 3 – Year 2+ Occupational role growth

At this time the HCAs had already an established identity within General Practice and were commanding the respect of other team members and patients. There is no doubt that the introduction of HCAs into General Practice was related to the drive to cope with increasing demands upon practices. In response to work pressures the PN role had also been extended into work previously undertaken by GPs. The developing roles of these three staff groups are interlinked and in a changing state.

My emergent theory identified occupational role growth as fundamental in this third phase of analysis. The relationship between the shifting roles of the PNs and HCAs examined in Chapter 6 is recognised as very significant.

Tasks and some role functions have been handed on from PNs to HCAs and this has continued through time. The HCA role growth and development was not however a matter of simple role substitution but rather a result of the development of reciprocal support strategies in response to the increasing practice demands. HCAs and PNs supported one another in a variety of different ways. The role growth was observed to be more evident within practices that had an enabling and supportive climate and role changes had been embraced. As Kathleen a PN (Interview 2 p2) had observed '*you are allowed to evolve here*' meaning that the practice was supportive of staff development in terms of providing some funding and time and by personal support. Some PNs had undertaken or were undertaking courses that required them to have supervised time with general practitioner colleagues in order to develop assessment and diagnostic skills. This could be viewed as evidence of learning organisations in action. In light of the above it is useful here to briefly examine the PN role and then dynamic role developments in General Practice.

7.7.1 Extended nursing roles in General Practice

Practice nurse roles in General Practice have extended and developed since the 1990s and are explored briefly here in order to cast light upon this in relation to the emerging HCA role in General Practice. In 2006 the RCN undertook a postal survey of nurse practitioner (NP) members (RCN 2006c). There were 1,201 responses giving a 38% response rate and two thirds of NPs were identified as worked in a primary care setting. NPs were typically well qualified with 72% (n=804) holding a degree and in 35% (n=207) of cases a Masters level qualification.

Ninety eight percent (n=1177) made referrals to other health professionals. Of those responding 92% (n=1105) felt part of the team in which they worked and there were high levels of job satisfaction and almost all (98% n=1177) felt that nursing skills were very important to their role as opposed to describing themselves as working as a lesser level of doctor.

The role development of qualified nurses working in General Practice require to be appreciated as differing by individual General Practice as has the HCA role. Similarly there has also been confusion amongst staff and patients about exact role and functions of HCAs and qualified nurses with extended roles (Carr *et al.*, 2001; 2005; Bryant *et al.*, 2004; Marsden and Street 2004; Currie and Watterson 2009). Nevertheless the development of PN roles is closely linked to the introduction and development of the HCA role and is related to the shifting roles that have been evidenced in General Practice.

The redistribution of work in General Practice was considered by Charles-Jones *et al.*, (2003) who undertook semi structured interviews (n=26) with GPs practice managers and nurses in nine General Practices in England and carried out thematic analysis of the interviews. Charles-Jones *et al.*, found that the changes taking place in practices following the introduction of skill mix were leading to a tendency to reduce medical work to sets of biomedical problems or tasks. They also point to the influence of the changed nature of the GMS Contract requiring delivery in chronic disease management and health promotion and other distinct areas leading to an increased emphasis upon managerial systems of efficiency. Patients are categorised on the basis of complexity of their presenting complaint and who can deal with them most cost effectively and efficiently but this can be at odds with holistic person centred care approach. Nurses were found to get emotional off load from patients more frequently and this was linked to longer appointments. The premise is that nurses are cheaper than doctors for appointments. Charles-Jones *et al.*, point to doctors being taken away from viewing of patients as psycho social beings towards consideration of only biomedical problems because of the way work is now set up in General Practice.

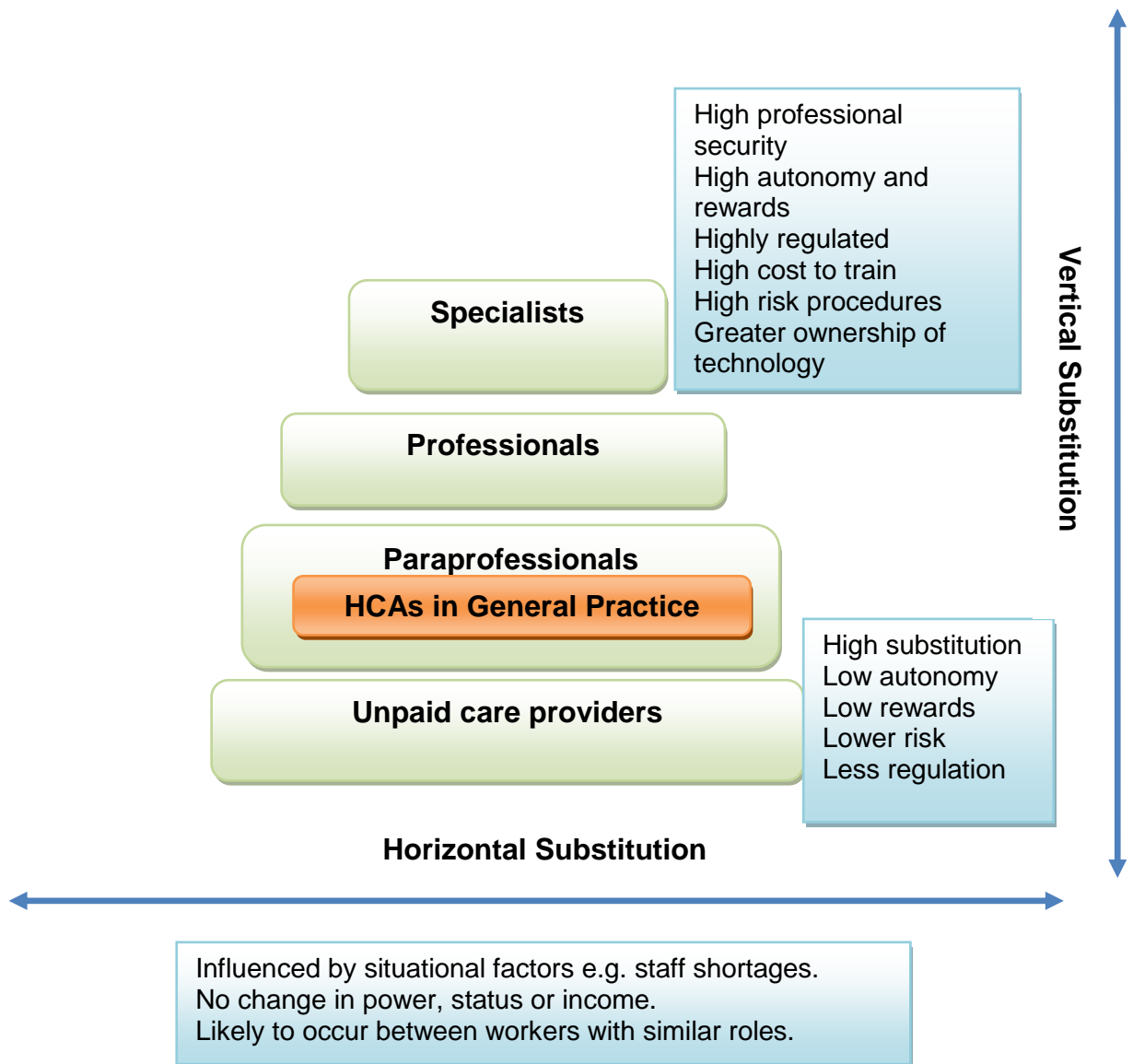
The role changes identified in my study did have the potential to fragment care but good team communication and planning and staff taking the initiative also appeared to reduce possible negative effects.

The PNs and HCAs were proactive in their role and for example if a patient came for a blood test they stopped to consider if there were any other health issues that may need to be followed up. They did actively shape the roles according to General Practice demands.

7.7.2 Dynamic roles in health care

Dynamic HCA and PN roles in General Practice are identified in my emergent theory. The work of Nancarrow and Borthwick (2005) examined the changing roles of health care professions in service provision. They highlight how in the 20th century in Britain and North American countries the medical profession has been dominant. The medical professions rise to power in the 19th century and university training limited access to the wealthy elite whilst professional associations for the medical profession provided powerful political influence. Regulation and licensure for medical practice in new technologies have served to maintain medical dominance in specific areas for example in anaesthesia. The position of power held by the medical profession enabled it to control the evolution of other health practitioners.

Professional boundaries in healthcare are subject to implicit and explicit controls and regulations. Health practitioner boundaries may be affected by the dominance of other disciplines, regulatory frameworks and legislation and also demand for the professions services. Changes in the boundaries of the health workforce have been described as movement in four directions: diversification, specialisation, horizontal substitution and vertical substitution (Nancarrow and Borthwick 2005) and is illustrated in Diagram 7.8.



**Diagram 7.8: The influence of vertical and horizontal substitution
(Adapted from Nancarrow and Borthwick 2005)**

Specialisation and diversification take place within professional disciplines whereas vertical and horizontal substitution relates to change that is outside traditional discipline boundaries. Diagram 7.8 illustrates this theory and shows specialisms within medicine accorded the highest regard and prestige. Horizontal substitution takes place across disciplines between similar practitioner roles. Vertical substitution is controlled by the more powerful disciplines, medicine in particular, and can lead to the development of paraprofessional groups. The term paraprofessional refers to posts that are normally technically subordinate and dependent upon a professional group.

Within the theory of Nancarrow and Borthwick (2005) the role of the HCA in General Practice could be viewed as situated within this paraprofessional group. However I would contend that whilst very illuminating this theory cannot account for all of the complexity of roles specialist, professional and paraprofessional that have developed in health care systems today. The use of the term 'substitution' in my theory is contested within the role development of the HCAs in General Practice as this suggests there is simple replacement of part of the PN role, whereas in reality the supervisory role of the PNs with the HCAs has remained. There has also been found to be reciprocal support, close mutually dependent working relationships between HCAs and PNs. The HCAs in General Practice function to enhance the service provided by the health care team.

In 2005 Nancarrow and Borthwick stated 'The impact of role changes on professional status remains to be seen' (2005: 913). To date no professions have ceased to be associated with particular services or ownership of knowledge and de-professionalisation has not occurred as a result of workforce changes. High demand for services leads to specialists releasing less technical and prestigious tasks to be redistributed to a wider workforce and has the effect of reducing costs. However, in recent years it is true that medical practitioners have had less control over professional roles of other groups. Professions that have traditionally been subordinate to medicine for example nurses, physiotherapists and occupational therapists are now creating their own subordinates. These subordinate roles have higher skills and some autonomy for example in the new assistant practitioner role in the NHS. The theory of Nancarrow and Borthwick does not offer a complete explanation for the changing roles in General Practice although it certainly has some application.

I do contest that there has been simple vertical substitution of work from PN to HCA as the changes and developments in General Practices are more complex than this with role development of HCAs inclusive of new skills and administrative duties related to delivering the GMS Contract for example HCAs have commenced administering influenza vaccinations while working alongside PNs and further training has been put in place to support this development (McGrouther, Burns and Walters 2012).

Nancarrow and Borthwick (2005) also theorise that the release of lesser tasks at times of pressure may result in these then being taken back when resources are more plentiful within health care and cite the example of orthopaedic surgeons in America whose role was supplemented by emergency room medics and plaster room staff and then an over production of orthopaedic surgeons meant that they sought jobs within these new areas. Today it is difficult to envisage when a situation of recoument of role and status could arise give the financial and demographic pressure and technological advances in health care now. However as qualified nurses and allied health professionals seek decreasing employment opportunities they may be employed in the short term to work in jobs that do not require their professional registration. The gathering pace and extent of change that has taken place within paraprofessional roles in healthcare is extensive and looks set to continue. With regard to the HCA role in General Practice it has grown and it does *'remains to be seen'* where it will evolve to in future. In light of the growth in paraprofessional roles in general and the HCA role in General Practice in particular it is useful to consider how they relate to the concept of professionalism.

7.7.3 Professionalism

It is pertinent here to examine theory pertaining to professionalism in its broadest meaning (Aguilar *et al.*, 2011). The research examining professionalism has predominantly concentrated upon the medical profession and subject in general has received little research attention until recently. There has been more of a focus upon it in recent years due in part to the increasing number of complaints about professional practice that have become more centred around generally poor professional behaviours. These identify attitudes, personal and institutional failure to recognise the humanity and individuality of people and not responding to them with sensitivity and compassion (HPC 2011). Recently there has been a research programme established by the NHS to explore aspects of professional practice (HPC 2011).

The HCAs although not professionally qualified have established an identity within General Practices, they were also regarded positively and aspects of professional behaviour were evident in my study. The HCAs for example acted by putting patient needs foremost as illustrated in the following quote from HCA Morven in the code *identifying health needs* in Chapter 6:

“It happens regularly you notice things especially with elderly people. You may get someone in who is looking after a partner with dementia and they come in with them and you can see the strain on their face. You recognise the stress that they are under and you think ‘oh dear’ and I then pass this on so that they can be assessed for more help with care”

(Morven interview 2 p5).

There has been work undertaken into the constituent components of professionalism and how to teach and measure professionalism in the medical profession by Stern (2006). Diagram 7.9 shows the principles of professionalism defined by Stern. It can be seen that these principles are not exclusive to medicine and indeed reflect some of the behaviours demonstrated by the HCAs within my study. They were committed to doing a good job, interested in improving the standards of their practice by education and were acting in the best interest of patients.

In particular the codes *fulfilling patient needs* and *identifying health needs* analysed in Chapter 6 relate to the HCAs extending focus upon responsibility and improving practice.

It is also evident that professional behaviour can be learned by role modelling. The HCAs in General Practice had close working relationships with PNs and other staff. It could be claimed that role modelling has taken place to some extent within the General Practices and professional behaviours has been learned by the HCAs directly from the observed behaviours of professionals. As previously discussed when considering workplace learning theories many HCAs had worked as receptionists in the practices prior to coming into post it could be construed that they already had first-hand experience in dealing with patient requests and so may have some well-developed skills in communicating with patients. They had developed a wealth of informal knowledge from the work place (Eraut 2004).

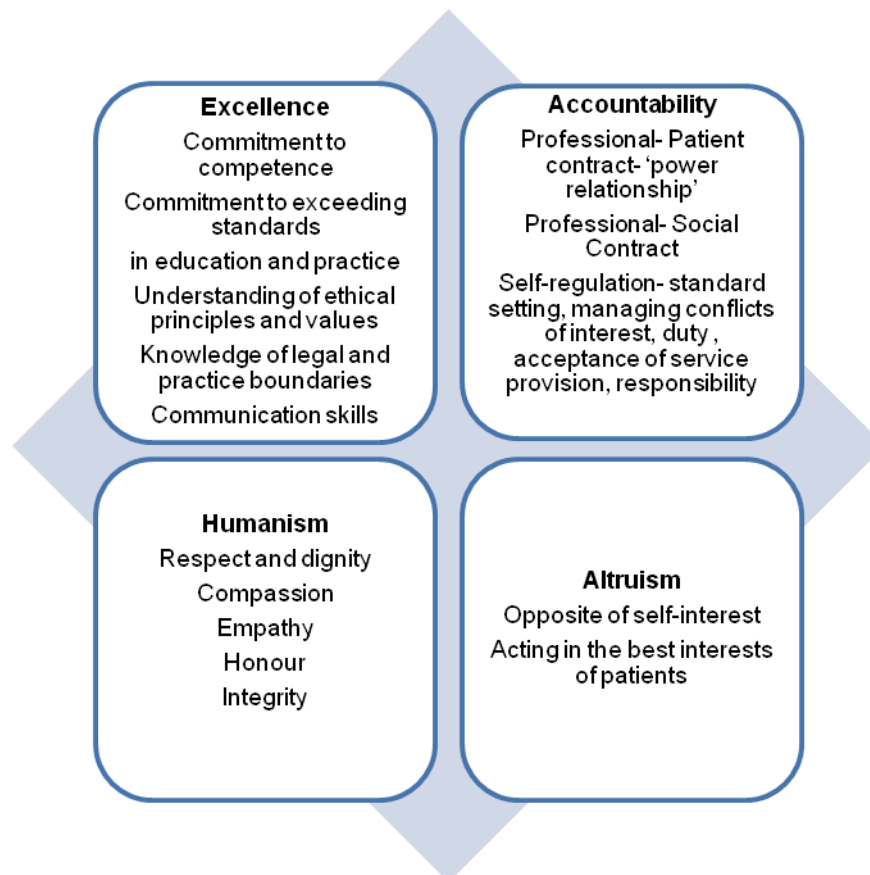


Diagram 7.9: Professionalism- Stern's Principles and Related Concepts (Stern 2006)

The literature also draws attention to the tensions in professional behaviour between the increasing demands of commercialism and the altruist relationship that should be at the heart of health care practice (Passi *et al.*, 2010). An example of this tension could arise as skill mix in General Practices changes and develops more over time and HCAs are now being employed in practices to replace retiring experienced PNs. The balancing of professional practice and supervision is an issue for consideration alongside the push for more cost effective care. As support worker roles are growing in many areas of healthcare and AP and senior HCSWs take on more responsibility and autonomy in their roles then the issue of regulation that has been explored previously must come into focus. There is now a Code of Conduct for HCSWs in Scotland and guidelines for education and induction standards apply (NES 2009). The HCSWs work under supervision and they are not registered or regulated as professional healthcare staff are and so adequate supervision measures and the organisational environment and culture remain key to good practice.

7.7.4 Phase 3- Summary in relation to emerging theory

The HCAs in General Practice have experienced growth in their role. Their occupational identity has become firmly embedded in General Practice whilst still being subject to change and development as are other roles in General Practice. Increasing economic demands, pressure upon care provision and growing complexity of care provided in General Practice has ensured that further changes and development are set to continue. The shift in roles in General Practice between health care staff that has taken place is complex and cannot be viewed simply as role substitution. My emergent theory indicates that reciprocal support strategies have developed between HCAs and PNs and the growing recognition of the professional attributes adopted by the HCAs.

Whether the shift in roles can continue indefinitely is not clear. A GP in baseline study observed that there would '*need to be some kind of watershed between skills and knowledge*' (Burns and Blair 2007).

It would appear that there does need to be a distinct division between roles but the roles are continuing to develop and boundaries are changing and with the appropriate supervision, training and skills HCAs have taken on new tasks but it may be that development does diminish and the role functions become more static. However with the ever changing and increasing demands being put upon primary care settings and General Practice in particular it seems very unlikely that developments within the HCA role will halt.

7.7.5 Summary of emergent theory

My emergent theory of the evolving HCA role identity is:

'The HCA role in General Practice is incremental and is predicated on a search for belonging and occupational identity. It is developed and influenced according to the organisational dynamics and support for learning from within the specific small business environments of individual General Practices.'

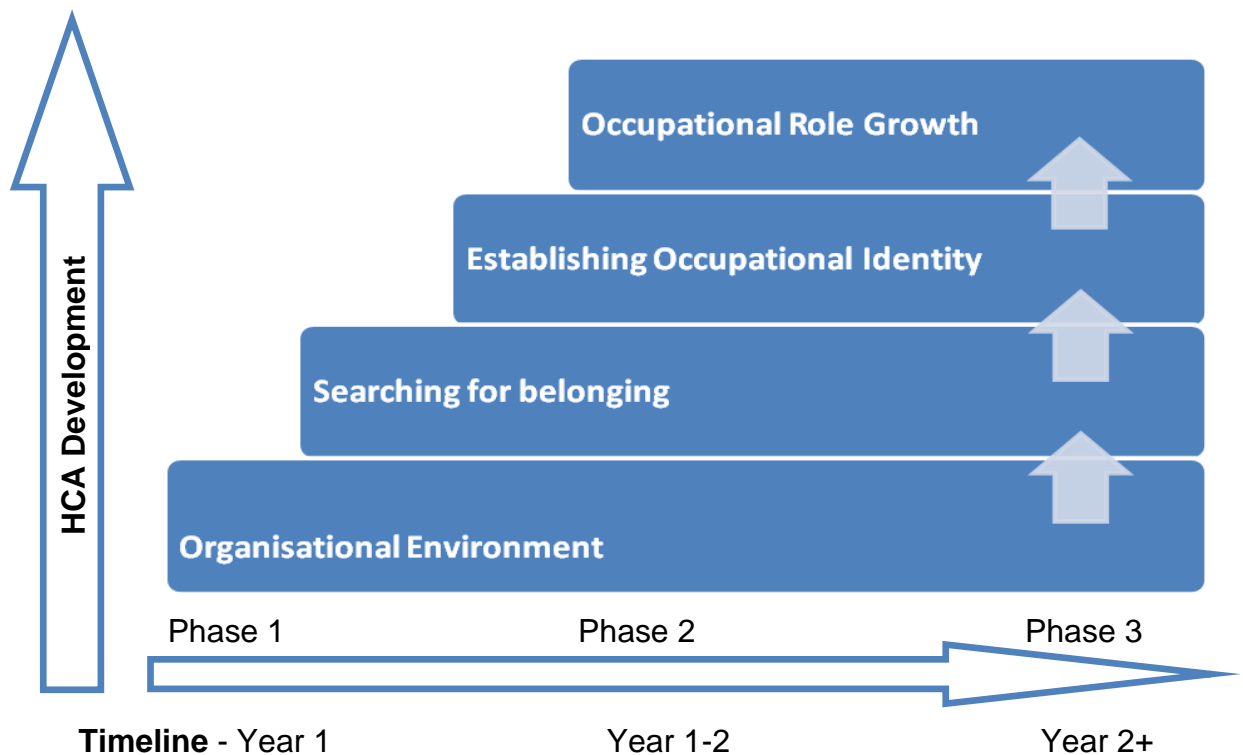


Diagram 7.0: Emergent Theory- Steps in the development of HCA role identity in General Practice

Diagram 7.0 (repeated from Section 7.2) illustrates the incremental development of HCA role identity in General Practice over the three time phases identified in my study. There is an important foundation identified as the prevailing organisational environment, the culture and support available within the individual General Practice. The HCAs searched for belonging within their new role. Following on from this the HCA occupational identity became more established as they became well known, accepted and comfortable in their new role. Occupational role growth occurred overtime where the HCA role was further shaped and developed.

7.8 Strengths of study

My study has added new understanding to the body of work available regarding HCSW roles within the UK. The HCA role in the General Practice context is unique and separate from other HCA roles in hospital and community environments within the NHS in the UK. The HCA role in General Practice in Scotland has developed after and in varying ways from developments in England. My study offers the first illumination of the occupational role identity and role growth of the HCAs in General Practice in Scotland.

Saturation was achieved in my study in that a point was reached where no new codes or categories were identified from the interviews. However as previously discussed in Chapter 3 the concept of saturation and the extent to which the likelihood of no new data presenting in a study is contentious. My study aim was to explore over a two year period the perceptions and experiences of HCAs and PNs within the General Practice setting following the introduction of the HCA role with a view to informing future practice, support and education.

My study questions were answered fully:

i) What are the perceptions and experiences through time of HCAs working in general practice?

The HCA role changed and developed through time and there was team acceptance of the new role. The HCAs grew in confidence and had particularly close working relationships with the PNs supervising them. Initially the HCAs searched for belonging and later they established a role identity that developed and grew.

My longitudinal study resulted in the development of my emergent theory based on the perceptions and experiences of the HCAs and indicates that the HCA role in General Practice is incremental and the phases were found to be a search for belonging, the establishment of a role identity and occupational role growth. Although the three phases are approximated to my three phases of data collection, development was not necessarily at the same rate for all of the HCAs. There was incremental development of the HCA role through time but this varied with organisational environment and with the education and support available. The supportive relationships that HCA had with PNs were found to be very influential upon HCA progress through the three developmental phases.

The HCAs enjoyed their role and they reported a high level of job satisfaction. They greatly valued working closely with patients and they often had great knowledge of patients and families within their practices and whose welfare they cared about greatly. There was loyalty to other team members in the General Practices and the HCAs worked to prove themselves of value and were keen to learn more and be of greater assistance to their colleagues.

All the HCAs in my study had undertaken some formal training and some had undertaken multiple educational courses. They valued this education and the PN support and mentorship was pivotal to their ongoing development.

ii) How do practice nurses supervising HCAs perceive and experience the role of the HCA on an on-going basis?

The PNs valued and worked closely with the HCAs and supervised their clinical practice. The PNs were positive about the HCAs contribution to General Practice recognising that they helped to relieve some workload pressures within the practices and together they reorganised work in order to streamline care provision and deliver the GMS Contract.

The PNs worked hard to supervise and develop the HCAs initially and their role as mentor to the HCAs continued whilst the support became very much more reciprocal. The PNs advocated for the HCAs within the General Practices and were found to have requested extra payment for the HCAs and supported those who wished to go on to enter nurse education. The HCAs worked to support the PNs and the PNs were careful to ensure that the HCAs were able to take on fulfilling roles under their supervision rather than being confined to undertaking tasks mechanistically. The PNs participated in and supported the HCAs to obtain and complete education and training courses. The HCA and PN roles developed alongside one another in many practices with PNs extending their own role further. HCAs and PN support was reciprocal in nature. The PNs themselves were often in the process of undertaking educational courses and some were being mentored by the GPs within their practices and so supportive learning environments were in evidence and occupational role growth was occurring for HCAs and PNs.

Initially some PNs had felt threatened by the introduction of HCAs but this had dissipated quickly and the PNs changed from not really wanting a HCA to looking for more HCA support. However in two cases in my study the resistance to the HCA role remained and the code 'total threat' indicates how this pivotal supportive relationship between the HCA and PN was not always positive. The General Practices acted in support of the HCAs and problems were resolved in both these exceptional cases.

iii) What do HCAs consider aids and hinders their ability to carry out their role in general practice?

The local organisational 'climate' in the GP practices was found to be hugely significant to the HCA role and also appropriate training and education was important to the HCA role. Where there was evidence of learning supported across the practice environment then role boundaries appeared to be more fluid and open to development and change. The attitudes of other team members in General Practice and their support were also influential upon the HCAs development.

Patient acceptance and support was also hugely important to the HCAs. There was patient acceptance of the HCA role and many patients showed a preference to return to see a familiar HCA on a regular basis which was appreciated by the HCAs and aided their sense of job satisfaction.

As noted above the support of the PNs was of pivotal importance to the HCAs. The supervision and support of the PNs was reciprocated by the HCA support in return. Clinics often operated with HCA and PN working closely together sharing patient care. The PNs were also supportive of the education of the HCAs and their role development.

The HCAs indicated that putting on the uniform helped them to get into the HCA role and was an outward sign to others of their status. Some initially struggled to get space in the General Practices to see patients and this did hinder progression of their role in some cases. However practices were generally innovative in converting space to give HCAs space to provide patient care.

The perceptions and experiences of HCAs and PNs have been explored and analysed and an emergent theory developed. As stated above the importance of the learning environment has been identified and also the supervisory role of the PN. HCA access to support, education and on-going supervision were found to be very significant.

7.9 Limitations

The study participants came from two differing health board regions in Scotland. However, a sample consisting of participants from more of the regions in Scotland could have added more value to my study. Although there was saturation within my data there is always the possibility of other regional variations in experiences and perceptions. There is also the possibility that those participants who responded and opted into my study may mean that only the most motivated participated and so experiences and perceptions may not be completely representative of HCAs.

However, when checking the findings in the form of the created HCA and PN diaries with PNs and HCAs who did not participate in my study agreement was identified (see Appendices XIII and XIV). These responses have helped to demonstrate the reduced likelihood of study limitation for this reason.

7.10 Recommendations

The recommendations have been divided into three sections those for General Practice, education and further research.

7.10.1 Recommendations for General Practice

There was found to be a lack of complete data on the number of HCAs in General Practice in Scotland. There is a need for accurate data about employment of HCAs in General Practice in Scotland as the HCAs form a significant group of staff making a contribution to health care. The statistical information collected for the Information Services Department (ISD) regarding numbers and types of patient contacts in General Practices in Scotland does not at present differentiate between registered PN activity and HCA activity and so the HCA role is not being directly quantified. It is therefore recommended that HCA and PN activity data is recorded separately for ISD purposes enabling some quantification of the HCA contribution to care.

7.10.2 Recommendations for Education of HCAs

There is a need for accessible tailor-made training programmes for HCAs in General Practice to support developments taking place. HCAs working in General Practice are often trained on the job within practices having worked in administrative roles or transferred from HCA roles within secondary care. They are a group of staff with some distinct educational needs. Initial preparation and on-going role development training are important to ensure safe and effective practice.

Distinct on-going training needs also arise for example HCAs locally required training in order to ensure knowledge and understanding to ensure safe administration of influenza vaccinations and this was successfully negotiated between all relevant stakeholders and successful provision of a two day course. An overview of this can be found in Appendix IX (McGrouther, Burns and Walters 2012).

7.10.3 Recommendations for further research

There is a need for further research in general into HCA / HCSW role in UK and more particularly into the role within General Practice. Support worker roles will be of great significance in the health workforce of the future given the increasing complexity of care and economic pressures upon health care provision. There is also a need for more research into support roles in general in health care. Kessler *et al.*, (2010) in the only recent large scale study examining the role of HCSWs across multiple NHS hospitals, called for further research to:

- *‘Exploring the nature and consequences of support roles beyond medical and general surgical divisions*
- *Further examine the link between types of HCA and patient outcomes.*
- *Unpacking the deep structures, systems and values which explain the distribution of HCA by type and by Trust’*

(Kessler 2010:15)

HCA's in General Practice form a distinct and significant group of support workers and should be the focus of more research attention:

- The nature and contribution of the HCA role in General Practice are particularly relevant to further research examination given the rising significance attached to care provision in primary care. Building up detailed knowledge of the HCA workforce in General Practice and their input into General Practices throughout the UK would provide very useful insight and assist in planning future care provision.
- Further research into the developing HCA role within the distinctive General Practice set up in Scotland is recommended. Capturing the unique HCA contribution into General Practice in the achievement of the patient outcomes within the quality outcomes framework QOF would be usefully explored in further research.

7.11 Conclusion

My emergent theory is:

'The HCA role in General Practice is incremental and is predicated on a search for belonging and occupational identity. It is developed and influenced according to the organisational dynamics and support for learning from within the specific small business environments of individual General Practices.'

There appears to be variable HCA employment patterns in General Practices in Scotland but, as previously stated, there is no accurate data on the actual number and characteristics of these HCAs. The introduction of HCAs into General Practice following the recommendations of the Review of Nursing in General Practice (SE 2004) has proven to be valued and successful. The General Practices position of sitting out with the greater NHS has enabled development HCAs on a very individual basis to some extent. My study also shows that within participating practices there has been compliance in the provision of training and appropriate supervision for HCAs.

In Phase 1 of my study the HCAs were searching to belong in their new role in General Practice. In Phase 2 they were establishing their identity firmly and gaining confidence and the respect of other team members. In Phase 3 the HCAs occupational role growth continued and was bound up with reciprocal support between the HCAs and PNs in the individual practices. Responding to increasing pressure of work upon General Practices was established as a key driver for change. My emergent theory offers a unique contribution to understanding of the development of the HCA role in General Practice in Scotland. This provides useful insight to inform further developments in General Practice in Scotland and also support worker developments in other similar settings.

There is certainly great scope for more research into HCA role in General Practice. The nature of General Practice has been subject to change not least because of the changed GMS Contract and the target driven agenda now evident. It has been indicated that a move to a more hierarchical structure has been associated with GMS delivery (Huby *et al.*, 2008).

There are also tensions between the commercial function of practices and advocating for patients. New NHS reforms on the horizon in England putting GPs at the centre of commissioning health care also mean changes within the General Practice environment look set to continue (DoH 2011; DoH 2012).

I have found completion of this study very satisfying and although the journey has been long and sometimes tortuous it has always been interesting. I have built up an in-depth understanding and insight into the role of the HCA in General Practice in Scotland and have made a new contribution to knowledge. I know that the work on my PhD has enabled me to be a better supervisor and lecturer within my employed role. I have become more confident, able to critique work more readily and have learned to keep focused in working towards a desired goal.

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Appendix I

Thematic Summary of the Literature

Systematic Reviews

Lewin <i>et al.</i> , (2006)	<p>Type of study. Systematic review of global RCTS. Conducted in South Africa with support from Germany.</p> <p>Aim. Review of research to evaluate the effectiveness of lay health workers in community settings</p> <p>Method. Inclusion criteria for the systematic review were RCTs of interventions undertaken by lay health workers to manage or promote health or provide support to patients in community or primary care settings. Found 43 studies meeting the study requirements of which 35 were from high income countries.</p> <p>Key messages. Concluded lay health workers showed benefits in certain health intervention areas for example promoting immunisation uptake, improving outcomes of acute respiratory infections and malaria.</p>
Centre for Allied Health Evidence (2006)	<p>Type of study. Systematic review conducted in Queensland Australia.</p> <p>Aim. Review of literature on use of community rehabilitation support workers</p> <p>Method. Inclusion of all relevant qualitative and quantitative studies, inclusion of support workers, health care assistants, assistant therapist and related titles. Excluded drug and alcohol and mental health care support workers</p> <p>Key messages. Value of support worker roles, need for clearly defined roles, need for training and supervision, called for clarity of accountability</p>

Education of HCAs

<p>Thornley (2000)</p>	<p>Type of study. Qualitative/ quantitative, England Aim. Examination of numbers, pay arrangements, duties and significance of HCAs in NHS Method. Analysis of information from 3 survey questionnaires 1997-1999 forming a national sample of NAs and HCAs in NHS. (Survey in 1997 managers n=70,HCAs n=1031) (1998 NAs n=862) (1999 further case study interviews with HR managers and nurse managers). Key messages. Need for re-appraisal of real skills and experiences of HCAs and NAs. NVQs a means of recognition of learning and progress to nurse training. Called for more fluid and progressive roles for HCAs.</p>
<p>Warr (2002)</p>	<p>Type of study. Qualitative, England Aim. Experiences and perceptions of HCAs trained to NVQ level 3 Method. Phenomenological study of HCAs n=6, interviews Key messages. Identified 4 themes - 'changing role boundaries and lack of clarity', 'pecking order', 'being in-between' and 'real nursing'. Hierarchical nature of nursing and tensions with HCA role development.</p>
<p>Chang, Lin (2005)</p>	<p>Type of study. Quantitative, Taiwan. Aim. Investigation into the effects of feeding skills training programme for nursing assistants with dementia patients Method. Quasi-experimental study in 2 long term dementia care facilities in Taiwan nursing assistants n=67 assigned randomly to control (n=36) or intervention group (n=31). Intervention group attended feeding skills training programme, control group no training. 4 instruments used including Formal Caregivers' Knowledge of Feeding Dementia Patients Questionnaire and Formal Caregivers' Attitude Toward Feeding Dementia Patient Questionnaire Key messages. Intervention group had significantly more knowledge, more positive attitude and better behaviours.</p>
<p>Hancock et al. (2005)</p>	<p>Type of study. Qualitative, England Aim. Evaluation of the impact of HCA development programme on care delivery in hospital and preparedness of HCAs to take on training and new roles Method. A 360 degree approach to data collection, semi structured interviews with HCAs n=3, colleagues n=24 and patients n=9. Key messages. HCAs taking on roles normally associated with nursing and the ability to apply knowledge to practice was influenced by the culture of the ward in which the HCAs worked. The existence of trusting and supportive relationships with colleagues enabled the HCAs to develop their role.</p>
<p>Keeney, et al., (2005)</p>	<p>Type of study. Qualitative/ quantitative, Ireland. Aim. To obtain views of managers of health care agencies about whether or not they would employ HCAs. Method. Self administered postal survey, content analysis and descriptive statistics. Key messages. Positive view of HCA training, called for training to continue and expand.</p>

McKenna <i>et al.</i> , (2005)	<p>Type of study. Qualitative, Ireland.</p> <p>Aim. To ascertain views of teaching staff and clinical assessors regarding HCA training</p> <p>Method. Interviews with clinical assessors n=16 and teaching staff n=26, content analysis.</p> <p>Key messages. Lack of experience and preparation for roles evident. Commitment and value attached to training programme but frustration at competing demands in practice.</p>
Benson, Smith (2006)	<p>Type of study. Qualitative/ quantitative, Greater Manchester, England.</p> <p>Aim. Evaluation of training and position of assistant practitioners at the end of a 2 year training programme in 7 NHS sites in Greater Manchester</p> <p>Method. Questionnaires to trainee assistant practitioners (APs) n=50, interviews n=34 with some trainee APs and various stakeholders directly involved with APs. Thematic analysis and descriptive statistics</p> <p>Key messages. Foundation degree supportive of trainee APs. Difficulties identified in securing placements and some resistance in practice to AP roles</p>
Gould <i>et al.</i> , (2006)	<p>Type of study. Qualitative, England.</p> <p>Aim. Exploration of role transition of HCAs seconded to nurse education upon registered nurse qualification.</p> <p>Method. Interviews with nurses who had previously been HCAs n=4 and other staff working alongside these nurses n=12. Thematic analysis.</p> <p>Key messages. Indicated limited benefits to previous HCA experience in preparing the nurses for registration and the participants described fear of failure as being great due to the public consequence of returning to their workplace as a HCA.</p>
Wood (2006)	<p>Type of study. Qualitative, England</p> <p>Aim. To compare the clinical practice experiences of seconded HCAs with four major socialisation concepts</p> <p>Method. HCAs n=8 seconded to pre-registration mental health nursing. Yearly focus groups.</p> <p>Key messages. Practice learning experiences of seconded HCAs indicated a unique socialisation process</p>
Hibbert (2006)	<p>Type of study. Qualitative, England</p> <p>Aim. A scoping study to give insight into progression for HCAs</p> <p>Method. Semi structured telephone interviews with 28 strategic health authorities</p> <p>Key messages. Number of HCAs accessing learning opportunities is low, need for agreed definition of HCA role and accurate picture of progression.</p>
West <i>et al.</i> , (2006)	<p>Type of study. Qualitative, Scotland</p> <p>Aim. Evaluation of national education programme for healthcare workers on healthcare associated infection</p> <p>Method. Self-administered questionnaires total health care workers responses n=369 of which HCAs n=8</p> <p>Key messages. HCA respondents were positive about programme, there was recognition that there were difficulties for them in challenging the bad practices of more senior staff.</p>
Brennan, McSherry (2007)	<p>Type of study. Qualitative, England</p> <p>Aim. Exploration of the transition and professional socialisation from HCA to student nurse</p> <p>Method. Student nurses n=14 took part in 4 focus groups at intervals during adult nurse education. Content analysis.</p> <p>Key messages. Themes identified - 'culture shock', 'comfort zone' and 'clinical issues'</p>

Multidisciplinary HCA/Support Workers Roles

Murray <i>et al.</i> , (1997)	<p>Type of study. Qualitative / Quantitative, England</p> <p>Aim. Investigation of support worker role in community mental health services</p> <p>Method. Questionnaire survey of expectations of managers, clinical staff, unions, service users. Statistical analysis</p> <p>Key messages. Support workers satisfied with level of supervision, overlap in support worker and registered nurses roles</p>
Morrell <i>et al.</i> , (2000)	<p>Type of study. Quantitative, England.</p> <p>Aim. Investigation into the effectiveness of postnatal support workers.</p> <p>Method. RCT with 6 month follow up. Total women n=623, intervention group n=311 and control n=312. Intervention group received up to 10 home visits over first postnatal months. Outcome measures of women's health, breast feeding rates and satisfaction with care.</p> <p>Key messages. No significant differences between intervention and control group outcomes. Women very satisfied with care provided by postnatal support workers. No evidence that postnatal support worker visits lower access to other services in NHS.</p>
Ellis, Connell (2001)	<p>Type of study. Qualitative, England.</p> <p>Aim. To investigate the changing role of physiotherapy assistants, identify the factors that affect the development of the physiotherapy assistants' role and determine the views of physiotherapy assistants and physiotherapists on the future work of physiotherapy assistants.</p> <p>Method. Semi-structured interviews with a stratified random sample of 18 physiotherapy assistants from a variety of care settings. Content analysis.</p> <p>Key messages. Variation in scope of activities and in levels of supervision physiotherapy assistants. Supervision reduced particularly in specialty areas, such as elderly and primary care. Shortages of trained staff, training, levels of responsibility and supervision, and the development of generic workers were issues of concern.</p>
Knight <i>et al.</i> , (2004)	<p>Type of study. Qualitative/ quantitative, England..</p> <p>Aim. Evaluation of rehabilitation assistant role.</p> <p>Method. Semi structured interviews, analysis of timesheets, use of think aloud technique</p> <p>Key messages. All rehabilitation assistants participating displayed the ability to be able to think about the reasons behind the tasks they carried out. Reported roles differing across teams and need for definitive role boundaries highlighted.</p>
Nancarrow, <i>et al.</i> , (2004;2005)	<p>Type of study. Qualitative/ quantitative, England.</p> <p>Aim. Investigation of support worker roles in intermediate care teams and to identify any changes associated with an Accelerated Development Programme provided for support workers (ADP)</p> <p>Method. Baseline survey questionnaire with open and closed questions to 50 intermediate care services that had participated in ADP. Responses from 33 services (response rate = 66%)</p> <p>Key messages. Support worker roles included multidisciplinary working to meet rehab needs, most common sources of training were NVQs and in-house trainings, differing models of supervision, diversity of employment ranging across health and social care boundaries.</p>

<p>Hasson, <i>et al.</i>, (2005)</p>	<p>Type of study. Qualitative, Ireland Aim. Exploration of HCA duties in a maternity department Method. Exploratory research. Non participant observation of trained HCAs n=6 to assess skills and competence following training Key messages. Highlighted HCA activities to support midwives, called for further investigation of relationship between HCAs and midwives.</p>
<p>Nancarrow, Mackey (2005)</p>	<p>Type of study. Qualitative, England in one NHS Trust. Aim. Evaluation of occupational therapy assistant practitioner role Method. Four focus group interviews with assistant practitioners n=5, supervising OTs n=5, team managers n=4, clients and carers n=3. Content analysis. Key messages. Identified need for clear career structures and accountability relationships. Indicated need for appropriate training for support staff in new roles.</p>
<p>Stanmore <i>et al.</i>, (2006)</p>	<p>Type of study. Qualitative, England Aim. Evaluation of the impact of rehabilitation assistant (RA) role from the perspective of patients, nurses, therapists managers and RAs. Method. Ethnography. Semi-structured interviews n=55. Thematic analysis Key messages. Great satisfaction with RA role, barriers to effective rehabilitation owing to ward routines. Called for unified approach by all care workers in rehabilitation</p>

HCA /support worker roles in Nursing Homes

<p>Friedman <i>et al.</i>, (1999)</p>	<p>Type of study. Quantitative, USA. Aim. Investigation into job satisfaction amongst support workers in Nursing Homes (1999) and programme of all inclusive care for elderly (PACE) Method. Questionnaire survey, statistical analysis n=349 support workers Key messages. Job satisfaction higher in support workers on PACE programme, this satisfaction linked to being able to have more control over suggestions made about patient care.</p>
<p>Jervis (2002)</p>	<p>Type of study. Qualitative, USA. Aim. Exploration of the relationship between registered nurses and support workers in one urban Nursing Home Method. Participant observation, semi structured interviews residents n=14 and staff (n=16). Thematic analysis. Key messages. Tensions between support workers and registered nurses over power and professional prestige. Support workers resisted registered nurses domination.</p>
<p>Coffey (2004)</p>	<p>Type of study. Qualitative, Ireland, care of older people in various settings Aim. Explore perceptions of nurses and HCAs regarding formal HCA training Method. Questionnaires to staff in 2 long term care settings - Nurses n=40, HCAs n=40 Key messages. Identified a need for role clarity. Positive view of HCA role. Nurses wish to be involved in HCA training.</p>

HCA/ Support Worker Roles in Acute Care

Chang <i>et al.</i> , (1998)	<p>Type of study. Quantitative, Hong Kong</p> <p>Aim. Investigation of nursing activities following the introduction of HCAs</p> <p>Method. Quasi experimental study design. Non participant observation. Compared observed activities of 8 HCAs with nurses in 4 hospital wards (2 HCAs in each ward) before and after the introduction of HCAs. A control group made up of 4 ward areas without HCAs and with similar patient numbers, gender, diagnoses and staffing levels were included in the study.</p> <p>Key messages. A reduction in both direct and indirect care provided by nurses was noticed. HCAs had the potential to help overcome difficulties associated with shortages of nurses but increased work of nurses in delegation and supervision of HCAs need consideration.</p>
Wainwright (2002)	<p>Type of study. Qualitative, England.</p> <p>Aim. To ascertain nurses perceived function of HCAs in intensive care.</p> <p>Method. Descriptive study. Questionnaires completed by intensive care nurses n=24.</p> <p>Key messages. Consensus of recognition of the supportive role of HCAs. Concern expressed about the scope to develop the HCA role into direct patient care within the complex intensive care environment. Expressed fear of HCA only completing routine tasks without investment in development could lead to frustration and complacency over time.</p>
British Ass. of Critical Care Nurses (2003)	<p>Type of study. Qualitative/ quantitative, UK</p> <p>Aim. Views on the health care assistant role in critical care, function and development.</p> <p>Method. Survey. Postal questionnaire sent to 645 critical care units, 376 returned (response rate 58%).</p> <p>Key messages. Impact of HCA upon the role of the nurse in critical care is not fully understood. Identified that there is a role for HCA in critical care but the impact of this needs to be fully analysed with regard to the impact upon registered nurses</p>
Keeney, <i>et al.</i> , (2005)	<p>Type of study. Qualitative/ quantitative, Ireland</p> <p>Aim. To ascertain registered nurses and midwives and patients perceptions of and satisfaction with trained HCAs in a regional hospital setting (part of a larger national study).</p> <p>Method. Survey. Self-administered questionnaires with Likert scales and open ended questions to staff n=24 and interviews with women who had received care from HCAs in a maternity unit n=6. Analysis using SPSS statistical package and thematic analysis of qualitative data</p> <p>Key messages. Nurses satisfied with HCAs. Maternity clients reported HCAs involved mostly in direct care and their availability was perceived to be better than that of qualified staff. Some nurses reluctant to take responsibility for delegation of duties to HCAs.</p>

Spilsbury, Meyer (2004); (2005)	<p>Type of study. Qualitative / quantitative, England.</p> <p>Aim. To explore HCAs work and the implications for registered nurse roles.</p> <p>Method. Case study of an NHS Hospital using survey, interviews, participant observation, focus groups and documentary analysis.</p> <p>Key messages. Identified registered nurses taking on extra duties and conceding some of their role to HCAs. Important for registered nurses to consider and plan supervision and monitoring of HCAs.</p>
Atwal <i>et al.</i> , (2006)	<p>Type of study. Qualitative, England, London</p> <p>Aim. Exploration of the perceptions of nurses, HCAs, doctors and therapists of rehabilitation and the role of nurses and HCAs in one older adult hospital ward</p> <p>Method. Action research. Semi-structured interviews n=24. Thematic content analysis</p> <p>Key messages. Therapists relied on nurses and particularly HCAs for therapy carry-over. Indicated that HCAs should be more involved in decision making and discharge planning</p>
Herbertson <i>et al.</i> , (2007)	<p>Type of study. Quantitative, England</p> <p>Aim. To identify whether the introduction of clinical support workers (CSW) in a teaching hospital reduced the medical work intensity of junior doctors without compromising patient care</p> <p>Method. Two audits 8 months apart. First to identify the areas where the introduction of CSW would have the greatest impact. Second to determine if that impact had had an effect upon the intensity of work carried out by junior doctors. 1st part-Junior doctors (n=50) completed audit forms when on call during 32 day period. 2nd part- 32 day period junior doctors (n=49) completed forms.</p> <p>Key messages. CSW greatly reduced the number of cannulations and venepunctures performed by doctors without any compromise to patient care. Identified fewer delays for patients waiting for procedures.</p>
McGuire <i>et al.</i> , (2007)	<p>Type of study. Qualitative, England</p> <p>Aim. Evaluation of critical care assistant role in 6 NHS critical care units</p> <p>Method. Focus group interviews, questionnaires over 6 month period with CCAs, mentors, nursing and medical staff. Views of patients and relatives were also sought.</p> <p>Key messages. Some easing of workload pressures on qualified nursing staff time allowing them to focus on more dependent patients. Patients and relatives satisfied with standard of care provided.</p>

HCA in Primary Care Nursing Teams

McIntosh <i>et al.</i> ,(2000)	Type of study. Qualitative, Scotland. Aim. Exploration of ways in which grade and skill are taken into consideration in the delegation of nursing care in community nursing Method. Ethnographic study of nursing assistants and district nurses in 21 nursing teams in 2 health boards n=76. Key messages. Variation in responsibilities delegated, supervisory role of G Grade District Nurse important.
England, Lester (2007)	Type of study. Qualitative, England Aim. To explore the views of GPs, primary care teams (PCTs) and patients on the value and development of the new role of primary care mental health workers Method. Interviews mental health workers n=7, patients n=21. Focus groups involving 38 members of 6 PCTs. Thematic analysis. Key messages. Primary care mental health workers provided a range of skills valued by patients and PCTs.

HCA's in General Practice

Holmes (1998)	<p>Type of study. Qualitative, England, London, Aim. Evaluation of the impact of employment of HCAs in general practice in Camden and Islington Method. Survey evaluation collating views of HCAs n=7, entire practice team and by using a patient survey Key messages. Waiting times decreased, patient survey identified a quality service provided by HCAs.</p>
Schermer <i>et al.</i> , (2003)	<p>Type of study. Quantitative, Netherlands. Aim. Evaluation of spirometry testing by practice assistants in general practice Method. 2 year comparison of spirometric tests undertaken in general practice by GPs and practice assistants with those in specialist pulmonary function laboratories in hospitals. Total participants n=388 in 61 general practices and 4 specialist laboratories Key messages. Positive view of general practices as alternative for good quality spirometric testing.</p>
Hesselink <i>et al.</i> , (2004)	<p>Type of study. Quantitative, Netherlands Aim. Explore effectiveness of inhaler technique in asthma and COPD patients after individual training by practice assistants in general practices Method. RCT- 2 year period of study. Control group patients n=137, intervention group patients n=139 Key messages. Sustained improvement in inhaler technique after education, Support for structured education programmes.</p>
Burns (2006)	<p>Type of study: Qualitative, Scotland Aim: HCA foundation course evaluation Method: Self-administered questionnaires and focus groups HCAs n=8 + supervising PNs n=8. Key messages: Positive course evaluation, HCA role well received by PNs.</p>
Philip, Turnbull (2006)	<p>Type of study. Qualitative, Scotland Aim. To review the efficacy of unqualified GP assistants in their new role Method. Grounded theory, interviews n=6 and supervisors n=6 Key messages. Training had strengthened knowledge and added diversity to GP assistant role. GPs and PNs allowed to focus on chronic illness targets</p>
Longbottom <i>et al.</i> , (2006)	<p>Type of study. Qualitative/quantitative; Scoping study, England Aim. A focused national rapid review of the role and impact of the general practice nurse and health care assistant within general practice. A scoping exercise to inform the NHS Working in Partnership Programme (WiPP) general practice nursing and HCA projects Method. Template created of the expected fields of rapid review. Total of 19 fields covered in the scope of practice nursing and HCAs. Team online search of literature and hand search Key messages. Themes identified- Provision of health care services moving from secondary to primary care. Roles and responsibilities introduced and expanded in line with practice and community needs.</p>

Andrews, Vaughan (2007)	<p>Type of study. Quantitative, England</p> <p>Aim. To estimate the numbers of HCAs working in general practice in England</p> <p>Method. Telephone survey of reception staff. Sample 922 practices (11.1% of total no of practices)</p> <p>Key messages. 55% of all sample practices employed one or more HCA.</p>
Burns, Blair (2007)	<p>Type of study. Qualitative/ quantitative, Scotland.</p> <p>Aim. HCA role evaluation</p> <p>Method. Self-administered questionnaires, patients n=60, GPs n=4, admin staff n=6, practice managers n= 5 thematic content analysis, descriptive statistics.</p> <p>Key messages. Positive views of HCA role. Identified need for patients to be given more information regarding HCA role. Evidence of cut in patient waiting times for appointments.</p>

Appendix II

Schedule for data collection

Data Collection Schedule

Int= interview F= follow up ---- Urban area

January 2008	February	March	April	May	June
	Int HCA 1			1 st F HCA 1	Int HCA 9
	Int HCA 2			1 st F HCA 2	
	Int HCA 3			1 st F HCA 3	
				Int HCA 4	
				Int HCA 5	
				Int HCA 6	
				Int HCA 7&8	
				Int PN 1	Int PN 8
				Int PN 2	
				Int PN 3	
				Int PN 4	
				Int PN 5	
				Int PN 6	
				Int PN 7	
July	August	September	October	November	December
Int HCA10	2 nd F HCA1	1 st F SN2	1 st F HCA10	3 rd F HCA1	2 nd F HCA 9
	2 nd F HCA2	Int HCA11		3 rd F HCA2	1 st F HCA11
	2 nd F HCA3	Int HCA12		3 rd F HCA3	1 st F HCA12
	1 st F HCA4			2 nd F HCA4	
	1 st F HCA5			2 nd F HCA5	
	1 st F HCA6			2 nd F HCA6	
	1 st F HCA7			2 nd F HCA7	
	1 st F HCA8			2 nd F SN1	
	1 st F PN 1	1 st F PN 8		2 nd F PN 1	2 nd F PN 8
	1 st F PN 2	Int PN9		2 nd F PN 2	1 st F PN9
	1 st F PN 3	Int PN10		2 nd F PN 3	1 st F PN10
	1 st F PN 4	Int PN11		2 nd F PN 4	1 st F PN11
	1 st F PN 5			2 nd F PN 5	
	1 st F PN 6			2 nd F PN 6	
	1 st F PN 7			2 nd F PN 7	

Int= interview F= follow up ---- Urban area

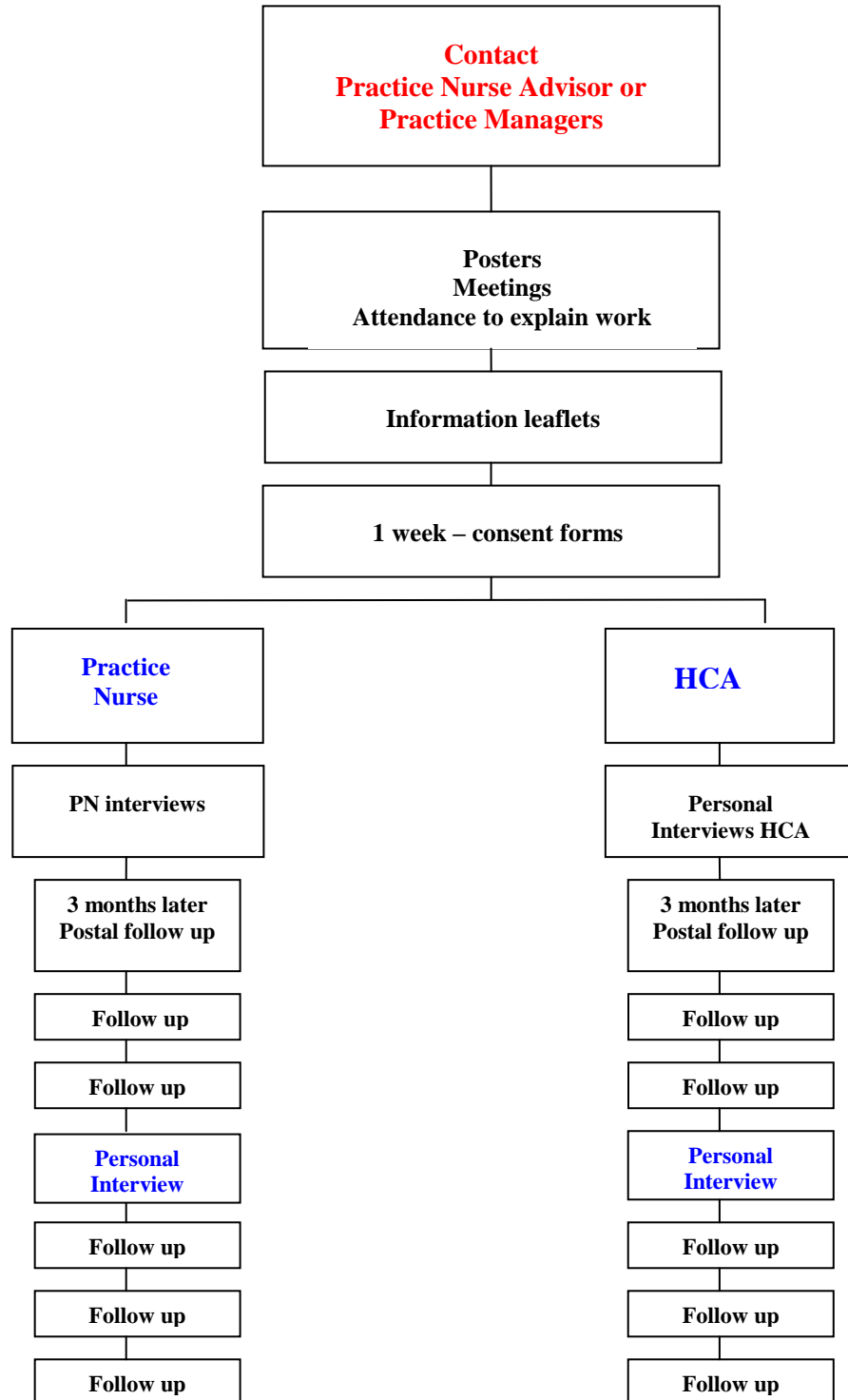
2009

January	February	March	April	May	June
2 nd F HCA10	2 nd Int HCA1		3 rd F HCA10	4 th F HCA1	2 nd Int SN2
1 st Int HCA13	2 nd Int HCA2	2 nd F HCA11	1 st F HCA13	4 th F HCA2	3 rd F HCA11
1 st Int HCA14	2 nd Int HCA3	2 nd F HCA12	1 st F HCA14	4 th F HCA3	3 rd F HCA12
	3 rd F HCA4			2 nd Int HCA4	
	3 rd F HCA5			2 nd Int HCA5	
	3 rd F HCA6			2 nd Int HCA6	
	3 rd F HCA7			2 nd Int HCA7	
	3 rd F SN1			2 nd Int SN1	
1 st Int PN12	3 rd F PN 1	3 rd F PN 8	1 st F PN12	2 nd Int PN 1	2 nd Int PN 8
1 st Int PN13	3 rd F PN 2	2 nd F PN9	1 st F PN13	2 nd Int PN 2	3 rd F PN9
	3 rd F PN 3	2 nd F PN10		2 nd Int PN 3	3 rd F PN10
	3 rd F PN 4	2 nd F PN11		2 nd Int PN 4	3 rd F PN11
	3 rd F PN 5			2 nd Int PN 5	
	3 rd F PN 6			2 nd Int PN 6	
	3 rd F PN 7			2 nd Int PN 7	
July	August	September	October	November	December
2 nd Int HCA10	5 th F HCA1	4 th F SN2	4 th F HCA10	6 th F HCA1	5 th F SN2
2 nd F HCA13	5 th F HCA2	2 nd Int HCA11	3 rd F HCA13	6 th F HCA2	4 th F HCA11
2 nd F HCA14	5 th F HCA3	2 nd Int HCA12	3 rd F HCA14	6 th F HCA3	4 th F HCA12
	4 th F HCA4			5 th F HCA4	
	4 th F HCA5			5 th F HCA5	
	4 th F HCA6			5 th F HCA6	
	4 th F HCA7			5 th F HCA7	
	4 th F SN1			5 th F SN1	
2 nd F PN12	4 th F PN 1	4 th F PN 8	3 rd F PN12	5 th F PN 1	5 th F PN 8
2 nd F PN13	4 th F PN 2	2 nd Int PN9	3 rd F PN13	5 th F PN 2	4 th F PN9
	4 th F PN 3	2 nd Int PN10		5 th F PN 3	4 th F PN10
	4 th F PN 4	2 nd Int PN11		5 th F PN 4	4 th F PN11
	4 th F PN 5			5 th F PN 5	
	4 th F PN 6			5 th F PN 6	
	4 th F PN 7			5 th F PN 7	

Appendix III

Flow chart of recruitment and data collection

An investigation into perceptions and experiences following the introduction of HCAs into General Practice



Appendix IV

Letter of invitation HCAs and PNs and information leaflets

Dear Sir or Madam

An investigation into perceptions and experiences following the introduction of health care assistants into General Practice

I would like to invite you to explore aspects of changes that have been introduced into General practices. Health care assistants have been employed in recent years within General Practice and now routinely work alongside practice nurses in some areas. My PhD study aims to look at the experiences and perceptions of health care assistants over time and also at how practice nurses perceive and experience the health care assistant role. This is a subject that has not been the focus of much research attention and a better understanding could help to inform future practice, support and education. Further details of my study are in the enclosed information sheet. If you are interested in taking part in my study please could you complete the attached slip and return it in the envelope provided.

Thank you.

Yours faithfully

SHIRLEY BURNS



Contact for Further Information or to indicate your willingness to take part

**Mrs Shirley Burns- Principal Researcher
Bell College
(address and contact details)**

For independent advice

**Mrs XXXXXX – lecturer / specialist practitioner in
practice nursing
(address and contact details)**



Health Care Assistants

An investigation into perceptions and experiences following the introduction of health care assistants into general practice

Research undertaken for PhD Studies at Napier University

You are being invited to take part in a research study. Before you decide it is important to you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Over the last few years GP Practices in different areas of Scotland introduced Health Care Assistants to assist GPs and practice nurses. The role of the health care assistant is new and has developed differently across Scotland. This study aims to examine the perceptions and experiences of health care assistants through time in order to better inform future practice support and education

Why have I been chosen?

You are being invited to take part as you are a health care assistant working in general practice and have experience of working in this new role.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not adversely affect you in any way.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete two individual interviews, one in 2007-2008 and another in 2008-2009. You will also be asked to respond to emails from the researcher at 3 month intervals during 2007-8 and 2008-9. All responses will be anonymised and not attributable to any individual.

What do I have to do?

A suitable time and place will be arranged to undertake interviews which will with your consent be audiotaped. The researcher will also contact you by email at intervals of 3 months to enquire about your views and experiences of working as a health care assistant in general practice. Emails may be followed up by telephone contact occasionally if and when agreeable to you.

What are the possible disadvantages?

The potential disadvantage of taking part is the time taken to complete the interviews and to respond to email. It is hope that the interviews can be completed at times and in places most suitable to yourself in order to minimise any inconvenience to you.

What are the possible benefits of taking part?

The information gained from this research study will be fed back to GP practices, nurses and educators to help to inform future practice, support and education provision.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. All data will be stored in a locked filing cabinet by the principal researcher and any electronic information will be stored on a password protected computer. All data will be stored and destroyed in accordance with the Central Office for Research and Ethics Committees guidelines.

What will happen to the results of the research study?

The information from the research will be included in the production of a PhD thesis and a report will be fed back to individual participants, to general practices and to educators.

The results of the study may be published in peer reviewed journals or at local and national conferences. In all reports and presentations all data will be anonymised and not attributable to any individual.

Who is organising and funding the research?

The study is being undertaken by Mrs Shirley Burns who is a research student at Napier University and who works as Senior Lecturer at Bell College, Dumfries Campus.

Who has reviewed the study?

The appropriate NHS Research Ethics Committees and Napier University Ethic Committee have reviewed this study proposal and provide permission to proceed.



Contact for Further Information or to indicate your willingness to take part

**Mrs Shirley Burns- Principal Researcher
Bell College
(address and phone details)**

for independent advice

**Mrs XXXXXX – Lecturer / specialist practitioner in
practice nursing
Bell College**

(address and phone details)



Practice Nurses

An investigation into perceptions and experiences following the introduction of health care assistants into general practice

Research undertaken for PhD Studies at Napier University

You are being invited to take part in a research study. Before you decide it is important to you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Over the last few years GP Practices in different areas of Scotland introduced Health Care Assistants to assist GPs and practice nurses. The role of the health care assistant is new and has developed differently across Scotland. This study aims to examine the perceptions and experiences of health care assistants through time in order to better inform future practice, support and education. The study is also interested in how practice nurses perceive and experience the health care assistant role.

Why have I been chosen?

You are being invited to take part as you are a practice nurse working in general practice and have experience of working with health care assistants.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not adversely affect you in any way.

What will happen to me if I take part?

If you decide to take part, you will be asked to take part in a focus group with other practice nurses in 2007-8 and another in 2008-9. You will also be asked to reply briefly to individual email at 3 month intervals during 2007-8 and 2008-9. Email may be followed up by telephone contact occasionally if and when agreeable to you. All responses will be anonymised and not attributable to any individual.

What do I have to do?

A suitable time and place will be arranged to meet locally to undertake the focus group with other practice nurses. The focus group will make an agreement to confidentiality and will, with the consent of participants, be audiotaped.

What are the possible disadvantages?

The potential disadvantage of taking part is the time taken to complete the interviews and to respond to email. It is hoped that the interviews can be completed at times and in places most suitable to yourself in order to minimise any inconvenience to you.

What are the possible benefits of taking part?

The information gained from this research study will be fed back to GP practices, nurses and educators to help to inform future practice, support and education provision.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. All data will be stored in a locked filing cabinet by the principal researcher and any electronic information will be stored on a password protected computer. All data will be stored and destroyed in accordance with the Central Office for Research and Ethics Committees guidelines.

What will happen to the results of the research study?

The information from the research will be included in the production of a PhD thesis and a report will be fed back to individual participants, to general practices and to educators.

The results of the study may be published in peer reviewed journals or at local and national conferences. In all reports and presentations all data will be anonymised and not attributable to any individual.

Who is organising and funding the research?

The study is being undertaken by Mrs Shirley Burns who is a post graduate research student at Napier University and who works as Senior Lecturer at Bell College, Dumfries Campus.

Who has reviewed the study?

The appropriate NHS Research Ethics Committees and Napier University Ethic Committee have reviewed this study proposal and provide permission to proceed.

Appendix V

Participant consent form



CONSENT FORM

An investigation into perceptions and experiences following the introduction of health care assistants into general practice

Please Initial Box

1. I confirm that I have read and understand the information sheet dated January 2007 for the above study and have had the opportunity to ask questions and have understood the answers provided.

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

3. I agree to take part in the above study.

Name of Staff Member

Date

Signature

Researcher

Date

Signature

(1 copy for staff and 1 for researcher)

Appendix VI

Interview, contact guidelines and follow up

Guideline for Interview 1 with HCA

- 1) Welcome and Introductions
- 2) Audiotape permission
Make clear that audio recorder can be stopped and the interview can be terminated at anytime
- 3) What has been your experience of working as a health care assistant in general practice?

- probe as required
- 4) How do you see (understand / view) your role as a health care assistant working in general practice?

- probe as required
- 5) What has helped (been useful to you) you in your role as a health care assistant in general practice?

- probe as required
- 6) What has been difficult (has hindered) for you in your role as a health care assistant in general practice?

- probe as required

End recording

Thanks and check willingness to proceed with follow up contact and possible phone call.

- Post interview
- Write up field notes
- Write up reflective account

- **Letter of thanks to participants**

Guideline for Interview 2 with HCA

- 1) Welcome and introductions
- 2) Audiotape permission
Make clear that audio recorder can be stopped and the interview can be terminated at anytime
- 3) What has been your recent experience of working as a health care assistant in general practice?
 - probe as required
- 4) Has your experience changed over time?
 - probe as required
- 5) How do you now view your role as health care assistant?
 - probe as required
- 6) What has helped you in your role as a health care assistant in general practice?
 - probe as required
- 7) What has been difficult for you in your role in general practice?
 - probe as required

Interview conclusion

End recording

Thanks and check willingness to proceed with follow up and possibly telephone contact

- Write up field notes
- Write reflective account
- **Letter of thanks to participants**

Guideline for Interview 1 with practice nurses

Welcome Introduction

Permission to audiotape

Make clear that the audio recorder can be stopped at any point.

1) What have been your experiences of working with health care assistants in general practice?

- probe as required

2) How do you view the role of health care assistants in general practice?

- probe as required

3) What factors have helped in your work with health care assistants?

- probe as required

4) What factors have created difficulties in working with health care assistants in general practice?

- probe as required

Conclusion

End recording

Thanks to participants and check willingness to proceed

Post interview –

- Write up field notes
- Write reflective account
- **Letters of thanks to participants**

Guideline for Interview 2 with practice nurses

Welcome and Introduction

Audio tape permission

Make clear that the audio recorder can be stopped at any point.

- 1) What have been your recent experiences of working with health care assistants in general practice
 probe as required
- 2) How do you now view the role of the health care assistant in general practice?
 - probe as required
- 3) Are there any other factors that have helped in working with health care assistants in general practice?
 - refer back to previous answers
 - probe as required
- 4) Are there any other factors that have created difficulties for you in working with health care assistants in general practice?
 - refer back to previous answers
 - probe as required

Conclusion

End recording

Thanks to participant and check willingness to proceed with follow up contact and possible telephone contact.

Post interview

- Write up field notes
- Write up reflective account

- **Letter of thanks to all participants**

HCA follow up

DATE

Dear _____,

**Perceptions and experiences following the introduction of
health care assistants into general practice**

Thank you for agreeing to take part in my research study which is being conducted towards my PhD at Napier University Edinburgh. As discussed when we last met I am now contacting you to ask about your experiences over the last three months of working as health care assistant in general practice. I would be grateful if you would consider completing the attached form and returning it to me in the envelope provided.

Thank you again for your time and support in this study, it is very much appreciated.

Yours sincerely

SHIRLEY BURNS
Postgraduate Research Student /
Senior Lecturer UWS

Perceptions and experiences following the introduction of HCAs into general practice

DATE

1. Have you experienced any changes or developments in your role as a HCA over the last 3 months?
Yes / No

2. If you have experienced changes or developments please could you describe your experiences of these below?

.....
.....
.....
.....
.....
.....

3. Are there any other issues about working as a HCA that you feel are significant? Please specify below

.....
.....
.....
.....
.....
.....

4. Would you mind me contacting you by telephone to talk further about any of the issues?
Yes / No

If it is acceptable please could you provide:-

Name
Telephone no.....

Please add any further issues on the reverse side of this sheet.

Many thanks for your assistance.

Shirley Burns

PN follow up

DATE

Dear ,

**Perceptions and experiences following the introduction of
health care assistants into general practice**

Thank you for agreeing to take part in my research study which is being conducted towards my PhD at Napier University Edinburgh. As discussed when we last met I am now contacting you to ask about your experiences over the last three months of working as practice nurse with HCAs in general practice. I would be grateful if you would consider completing the attached form and returning it to me in the envelope provided.

Thank you again for your time and support in this study. It is very much appreciated

Yours sincerely

SHIRLEY BURNS
Postgraduate Research Student /
Senior Lecturer UWS

Perceptions and experiences following the introduction of HCAs into general practice

DATE

1. Have you experienced any changes or developments in your role as a practice nurse working with a health care assistant over the last 3 months?

Yes / No

2. If you have experienced changes or developments please could you describe your experiences of these below?

.....
.....
.....
.....
.....
.....

3. Are there any other issues about working with HCAs that you feel are significant? Please specify below

.....
.....
.....
.....
.....
.....

4. Would you mind me contacting you by telephone to talk further about any of the issues?

Yes / No

If it is acceptable please could you provide:-

Name.....

Telephone no.....

Best times to phone.....

Please add any further issues on the reverse side of this sheet.

Many thanks for your assistance.

Shirley Burns

Appendix VII

Letter of support from sponsor

20/02/07

NHS Central Office for Research Ethics Committees

To the Chair of the NHS Central Office for Research Ethics Committees

Study title: An investigation into perceptions and experiences following the introduction of health care assistants into general practice

CI: Shirley Burns

Dear Sir/Madam

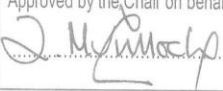
I would like to confirm that Shirley Burns, Senior Lecturer, School of Health Studies is undertaking the above study. Bell College have agreed to act as sponsor for this research. Bell College provides indemnity as part of this sponsorship.

Yours sincerely

Heather Simpson
Head of School

Appendix VIII

Ethical Approval Form

<div style="background-color: black; color: black;">[REDACTED]</div> Research Ethics Committee LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION					
For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.					
REC reference number:	07/S0401/5	Issue number:	1	Date of issue:	12 April 2007
Chief Investigator:	Mrs Shirley A Burns				
Full title of study:	An investigation into perceptions and experiences following the introduction of health care assistants into general practice				
This study was given a favourable ethical opinion by <div style="background-color: black; color: black;">[REDACTED]</div> Research Ethics Committee on 30 March 2007. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.					
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes ⁽¹⁾
		<div style="background-color: black; color: black;">[REDACTED]</div>	SSA Exempt	12/04/2007	
Approved by the Chair on behalf of the REC: <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;">  (Signature of Chair/Co-ordinator) (delete as applicable) </div> <div style="text-align: center;"> Manager JAN McCULLOCH (Name) </div> </div>					

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension or termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

Appendix IX

Professional Development

Record of Presentations and Publications

Burns, S., (2006). Developing the Health Care Assistant Role, *Primary Health Care*. 16 (2), pp.21-25.

Burns, S., Blair, V., (2006). Experiences of the introduction of HCAs into General Practice, study from Bell College, Dumfries.

29/01/07, 2/02/07, 5/02/07 Core Module for PhD at Edinburgh Napier- oral presentation on research project.

22/03/07 PG Research Conference at Edinburgh Napier - oral presentation on research proposal.

Burns, S., Blair, V., (2007). Health Care Assistants in General Practice, *Primary Health Care*. 17(6), 35-39.

02/04/08 PG Research Conference Edinburgh Napier - Poster presentation – on research proposal

23/05/08 National Practice Managers Conference- Sustaining Quality Glasgow- presenting and conducting a workshop on HCAs in General Practice with Pauline Brown- Advanced Nurse Practitioner

2/09/08 Health QWest Graduate School Research Conference- Glasgow Caledonian University- Oral presentation on research proposal

22/04/09 PG Research Conference Edinburgh Napier- Oral presentation of preliminary findings

18/04/11 PG Research Conference Edinburgh Napier - Oral presentation of research analysis

23/02/12 McGrouther S, Burns S, Walters M, Collaborative working to provide education and support to HCSWs undertaking 'flu' vaccinations in General Practice- Poster presentation at RCN Education Conference, Harrogate

Record of attendance at study days and conferences

15/12 /06

NVivo foundation training at Edinburgh, Napier University

29/01/07, 2/02/07, 5/02/07

Core Module for PhD at Edinburgh, Napier University

18/09/07

Working Together- 1st National and Network Practice Nurse Conference- Edinburgh
NHS Education Scotland

10/10/07

Research Seminar at Napier – Review of nursing in the community in Scotland 2006:
the literature review by Dr. Catriona Kennedy and Fiona Maxton

25/04/08

NVivo 7 training –Edinburgh, Napier University

30/06/09

HCA's 2009- A practical guide to developing and managing HCA's Conference,
London, Nursing Times

29/01/10

Making Sense of Assistant Practitioner and Health Care Assistant Roles Conference,
London, RCN

2/02/10

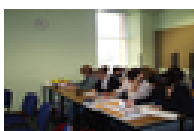
Workforce Planning and Workforce Development for HCSWs and Assistant
Practitioners Conference, Edinburgh, NES

26/10/10, 27/10/10

3rd Annual Regulation Conference, Edinburgh, Scottish Government

25/10/11, 26/10/11

4th Annual Regulation Conference, Edinburgh, Scottish Government



Perceptions And Experiences Following The Introduction Of Health Care Assistants Into General Practice



Shirley Burns

School of Nursing, Midwifery and Social Care

Introduction and Aim

Pressure upon resources within the NHS has meant that innovative ways of working and maintaining safe practice are imperative to future care delivery. In general practices the role of practice nurses has expanded to alleviate pressure upon GPs time and now the role of health care assistant (HCA) has been introduced to assist in care provision. A small initial research project to evaluate the HCA role in general practice followed introductory training for HCAs (Burns 2006). Practice and patient responses to self administered questionnaires were very positive and there was some evidence that waiting time for appointments within practices were reduced (Burns and Blair 2007). This initial research raised further questions.

How do HCAs and practice nurses perceive and experience the HCA role on an ongoing basis?

How has the HCA role developed overtime?

What aids and hinders the HCA role in general practice?

The aim of this research is to explore the ongoing perceptions and experiences of HCAs and practice nurses within general practice following the introduction of the HCA role.

Key Statement by GP in Initial research

"..... There will have to be some kind of watershed between skills and knowledge for example compared to nurses or even doctors. Areas of judgement may arise"

Table 3.

The four levels of understanding related to this study

Levels of Understanding	Questions	Issues
1. Descriptive	What are the issues?	What are the issues?
2. Exploratory	What are the issues? How are they related?	What are the issues? How are they related?
3. Analytical	How are the issues related? What are the issues?	What are the issues? How are they related?
4. Synthesis	What are the issues? How are they related? What are the issues?	What are the issues? How are they related?

Adapted from Parahoo (2006); Grbich (2007)

Table 4 – Data Collection

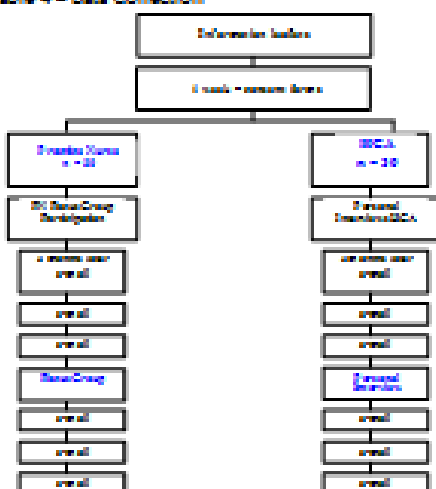


Table 1. Age of patients attending HCA- Initial Baseline Study n = 80

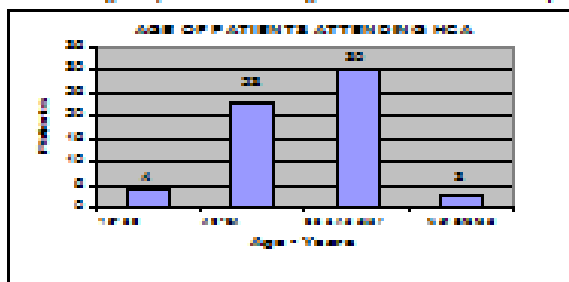
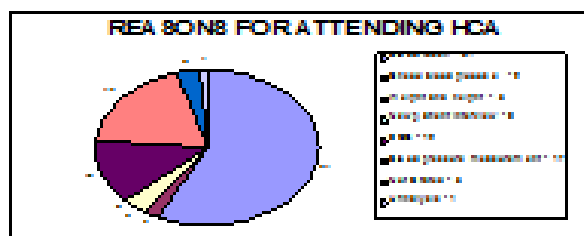


Table 2. Reasons for patients attending HCA are summarised in table below n = 80 – Initial Baseline Study



Methods

Qualitative research methodology was considered suitable for this research as it aims to investigate phenomena in a holistic and in depth way through the use of narrative materials. After lengthy consideration, constructivist grounded theory methodology was identified as the most suitable approach allowing insight into social and psychological experiences by examining the processes occurring within a situation (Charmaz 2006). Grounded theory involves the constant comparative method of analysing qualitative data to produce conceptual theory. Constructivist grounded theory recognises that an interpretative picture of the studied world results from grounded theory research (Charmaz 2006). Data collection methods include personal interviews for individual HCAs and focus groups for practice nurses. Participants will be followed up by email contact over a 2 year period. The research is taking place in two contrasting Scottish NHS regions.

Summary of Progress

The research has been approved for doctoral studies and received ethical approval by the NHS research and ethics committee in two NHS regions. Information has now been circulated and agreement of interest and signed consent forms have now been obtained. Initial interest in one region is proving very positive. Personal interviews with HCAs have commenced.

References

Burns S (2006) Developing the Health Care Assistant Role *Primary Health Care* 16 (2) 21-25
 Burns S and Blair V (2007) Health Care Assistants in General Practice *Primary Health Care* 17(8) 25-29
 Charmaz K (2006) *Constructing Grounded Theory*, London, Sage

Appendix X Example of coding

Example of coding *changing uniform/changing role* Dates and identities have been omitted in order to protect anonymity

HCA's first interviews

'What I find is that when you put a uniform on it makes a difference and the role is separated and patients have come to understand that.'

'I am able to separate the two roles. Yes as I say the uniform and face to face contact is important. When people see you in uniform it is completely different.'

'So when I have got a uniform on I know what day it is and where I am going to be that day' (laughs)

When asked to see a patient when she was not in HCA uniform
'I said so long as the patient doesn't mind because I am not in my health care assistant uniform...She said "no I don't mind." It was then ok.'

'With the uniform it is good. We do not look too much like the qualified nurses either.'

'Although everyone knew me right enough, the uniform helped me and the patients, emmm. They were used to seeing me going around with a Hoover and then I was in uniform'

PNs first interviews

'We did try to help everyone appreciate the dual role. There is a different role and she changes uniform and she has a different badge and she works in a different area.'

'It helps that we got them (HCAs) proper uniforms and badges you know and what have you.'

'She works as a HCA and then she goes away home and changes. She comes back and she is a receptionist but this change must be difficult.'

21/6/08 Journal notes

In the interviews I have been transcribing and analysing HCAs have talked about their uniform during their interviews. The uniform is significant for them to get into role. Code called **uniform** created in initial line by line coding.

20/10/08

The code **uniform** has been renamed **changing uniform** after discussion with my supervisors, as it is the act of changing rather than the uniform itself that is significant. Must remember to use gerunds

HCAs 2 second interviews

When talking about working some extra hours and getting used to the changes between roles:

'I am here anyway and it is just two or three more hours.. it is just a different uniform and so a different hat on for the morning'

'I have on occasions had to step in and do bloods but I felt really awkward in this uniform (receptionist uniform) having to do bloods in that circumstance. I think having the right uniform on you are trained you know you are psyched into the role that you are in.'

29/5/09

This code is related to the HCAs getting into role by putting on their HCA uniform and this was important to those that undertake a dual role. The code *changing uniform* has come up in relation to the dual role HCAs. It is associated with the change of role and getting into role. This code is renamed '*changing uniform, changing role*' as it is more explicit. The act of changing into the HCA uniform assisted the HCAs to prepare for their role and the uniform also gave them status and allowed staff and patients to recognise this.

'Stuck in the middle' is the in vivo subcategory relating specifically to the dual role HCAs who belonged to two different staff groups of General Practice staff and sometimes trying to be responsive and flexible between the two staff groups created a sense of being '*stuck in the middle*' and unable to please everyone all the time for example providing cover on staff rotas or moving between certain consulting areas to see patients.

Examples of the 5 codes within sub-category ‘*Stuck in the middle*’ illustrating the nature of the dual role

Pushing to get more

‘We are desperate to get more (HCA work)’

Dedicated time

‘I do have dedicated time (between the dual roles) and this helps’

‘just drop everything’

‘If we are asked, we just drop everything (to help in HCA role)’

Spatial constraints

‘Some days I am in the treatment room in the middle of a blood clinic and somebody need seen so I have to move’

Changing uniform, changing role

“What I find is that when you put a uniform on it makes a difference and the role is separated and patients have come to understand that”

The code ‘changing uniform, changing role’ was referred to predominantly in first interviews with HCAs and PNs and was mentioned in relation to first experiences in the HCA role and so was associated with the initial phase of getting going and proving worth. In view of this initial predominance and connection to role commencement then when examining the timeline and 3 phases of this study this code is situated in Phase 1 of my study in subcategory ‘*stuck in the middle*’ and within the major category *getting going and proving worth*.

Appendix XI

Created diaries of HCA and PN

Diary of a Health Care Assistant working in General Practice

Getting going and proving worth

(This extract relates to the period of time when the health care assistant was first starting out and getting established within the practice- approximately 6 months to 1 year in post.)

I have moved from previously working as a receptionist in the same general practice to become a health care assistant. So it was good that I knew generally how the practice worked. The practice nurse has taken on the responsibility of being my mentor and she looks out for me, she supervises what I do and teaches me new skills **PN mentoring**. If I have any concerns about what I am doing with the patients that I am seeing then she is always at hand to support me. **PN pivotal** The GPs are pretty good too and would step in to help at any time if I asked them.

I am building up experience doing bloods and blood pressures and also heights and weights. **HCA activities** I am learning fast.

I remember the first time I took blood from a patient. It was really nerve wracking. It really felt so strange stick a needle into someone but my practice nurse mentor was great and was there to support and encourage me **PN mentoring**. The patients were great too and then it very quickly became just second nature. What a sense of achievement I had. **Really great**

Sometimes I think that the kind of satisfaction I get with this job is knowing that I am making things better for the patients. It is the best thing about being a health care assistant. I know that we don't get paid a huge amount to do this job but there are more things to life than money. **Recognition and reward**

Patients treat me differently, they are nicer to me than when I was a receptionist but they also expect more of me. They keep asking me about different things when I am taking their bloods. They expect me to know the answers to their questions. They think that I am a qualified nurse although I keep telling them who I am and I wear a name badge. **Considered qualified** ☐

I feel that I am really helping the doctors and nurses by saving them time so that they can now spend more time with the patients that really need them and they are able to concentrate on more complex things. **Saving time** ☐

I know I also help by keeping the practice tidy and the consulting rooms stocked up with all needles, syringes, dressings and everything else. I also order all the various vaccinations we use. They are kept in the drugs fridge and they need to be stored carefully and kept in date order. Honestly you need to keep on top of this job and make sure that everything is in the right place **Introducing order** ☐. This really helps with the smooth running of surgeries and I think everyone has noticed what a difference I have made and the place is certainly much tidier and cleaner. **Proving worth in team** ☐

The practice nurse and I do help a lot with delivering the GP contract. We help by ticking the right boxes on the computer and by chasing patients up for review. Some patients are reluctant to come in to see the doctor but they will come in to see me after a little persuasion on the telephone. It is important that the practice gets all of the Contract points that it can get because that means money for all of our salaries. **Delivering GP contract, ticking the right boxes chasing up patients** ☐

My practice nurse is great though and I am sure that she sticks up for me within the practice. **PN advocating** ☐ I am so glad that she is helpful and supportive. It would be dreadful if she was someone who didn't like health care assistants. **Total threat** ☐

Optional extract for dual role health care assistants - HCA / Admin role

(Please complete this section if you are in a dual role or know colleagues in dual roles)

It is really hard sometimes being a member of both the admin and the nursing team. You are just stuck in the middle of things with two lots of holidays cover and work demands to juggle. **Stuck in the middle** I really enjoy the health care assistant part of my job and would like to spend more time doing this. I keep suggesting that I could take on more in my health care assistant role. **Pushing to get more**

It has been such a change doing this job. It is amazing I put on my health care assistant uniform and then everything completely changes **Changing uniform** . There is dedicated time allocated to do the two different parts of my job **Dedicated time** and when I move into health care assistant mode I put on my uniform and I feel this is important in marking the change. People know what you are about when you have your uniform on. **Changing uniform**

Lack of consulting room space is a bit of a problem in the practice at the moment. I don't have my own room to see patients in and I have to work moving from room to room on different days as rooms become free. I don't really mind but it is a pain sometimes when you don't have all the things you need to hand. The doctors and our practice manager are working on a plan to convert some extra space in the practice into a room for me. The long term plan is to move to another building. That will be really good. **Spatial constraints**

Sometimes I do get asked to do clinical things when I am not meant to be working as a health care assistant. The GPs could ask for an ECG for instance and you have to just drop everything and go to do it. I don't mind this because it means that the patient gets the care that they need more quickly but it can be difficult being caught in the middle of things. **Just drop everything**

Building confidence and respect

(This extract relates to a period of time when the health care assistant has become established within the practice- approximately 1 year to 2 years in post)

I do really love this job. **Really great** ☐ I enjoy most the contact with the patients and feeling that you are doing something worthwhile **Job satisfaction** ☐. It is good to be contributing to making them feel better and helping by caring for them. **Pride in work/caring** ☐ The patients are getting to know me now and some of them always ask to come back to see me. When I have my holidays, there are a few of the patients who don't want to be seen by anyone else. **Patient preference** ☐

The training courses that I have done recently have been good and have made me feel more confident in my role. **Valuing increased knowledge** ☐ The practice sent me on a course for health care assistants working in general practice and I have attended some other training days. **HCA training** ☐ Training courses do give you a good foundation but most of the learning has taken place on the job. It has been good to do the different courses and get together with other health care assistants. We don't get much chance to get together with each other very often and I feel that we always learn things from one another when we do meet up. **Getting together** ☐ I think I would like to do some more training. Some other health care assistants have been doing SVQ training or HNCs. **HCA training** ☐ I think I would possibly be interested in going on to train as a nurse at some point in the future. **Towards nursing** ☐

I do feel generally much more confident and secure in my role now. It feels as though I have a recognised and respected role to play in the general practice team. **Building confidence and respect** ☐ I have a friend who is a health care assistant in another general practice and a patient complained that she was only a receptionist and that he did not know if she should be looking after him. She said that she felt good when she was able to answer him by saying that she had completed a training course to do her job. You don't tend to get many patients who complain at all but I suppose there is always one isn't there!!! **Good foundations** ☐

When patients come in and talk to me I can now often pick up on issues and concerns regarding their health **Identifying health issues** ☐ and then I get them seen by the doctors or nurse.

Developing responsibilities

(This extract relates to recent experiences- over two years in post)

The job is certainly developing more. You don't really notice it until you stop and think about it properly. **Developing responsibilities** □ I have been doing some simple dressings and flu vaccinations and recently it was all hands on deck to complete the swine flu vaccination programme. I really have been developing and expanding my experience. **Developing responsibilities** □

I am sure about where my responsibilities start and end. I would never step over the line and do anything that I have not been trained to do. I think I have always been careful about this but now I do feel extra sure about this. **Role boundaries** □ My practice nurse mentor and I have put in place protocols and guidelines for me to refer to regarding the scope of my practice. These have helped keep me right. I find that I don't always need to look at these very much now as I just know them inside out **Using protocols and guidelines** □. With greater experience and knowing the patients well I do tend to be able to identify patients' problems and can get them referred on, sometimes urgently. Regarding this I now know exactly when to act and when things can wait. I am also happy to give advice to patients within my own capabilities **Identifying health issues** □

My practice nurse and I don't get to spend as much time together now. We are always still there for one another but it is difficult to get time to just talk when we are both so busy. We do try to make time and I feel it is important to keep in the loop with each other and with others in the practice. **Keeping in the loop** □

My practice nurse has been doing more studying herself and is now taking on more and developing her own role. This means that I am taking on more too now **personal development** □. The practice nurse and I support one another and all the time we will do things to help each other. **Reciprocal support** □ We have considered how we set clinics up and how we can best work together to make sure that we fulfil patients needs as effectively as possible. For instance for the diabetic clinics I bring the patients in and takes all the bloods and I do BPs and weight etc before booking the patients back in with the practice nurse when the blood results are back and she can then complete everything else with them. This really allows her to get on and concentrate on the more complex patient issues and spend more time with the patients. **Fulfilling patient needs** □

The practice is finding it hard to cope when I go on holiday now as the practice nurse cannot absorb all the work left. The practice has decided to train up another health care assistant to help provide more cover. This has made me feel very proud of my contribution to the practice **Training up more** □.

I do feel settled in my job as a health care assistant. I feel that my role will continue to develop more in future. **Developing responsibilities** □

Diary of a Practice Nurse/ Nurse Practitioner supervising a HCA working in General Practice

In this diary the words practice nurse and nurse practitioner are used synonymously.

Getting them going and proving their worth

(This extract relates to the period of time when the health care assistant was first starting out and getting established within the practice. – approximately 6 months to 1 year after HCA started in post)

The practice has just appointed a health care assistant and I am to supervise her in her new role. I really glad to be getting some assistance at last as my role just seems to have expanded and expanded over recent years. There are more and more patients coming in on a regular and on-going basis to have their asthma, COPD, heart disease and diabetes managed. Work is just so busy at times and it feels as though something has to give. **PN mentoring** □

It is really great to get some assistance from the health care assistant and we have started her off doing the routine bloods for patients every morning and I am going to get her to do blood pressures, heights and weights and urinalysis **HCA Activities**. □ She works quite closely alongside me just now so that I can help her gain the necessary skills. I hope she feels that she can come to me for help at anytime **PN Pivotal**. □ Finding space for her to work in has been a challenge. Sometimes there is a room free left by one of the GPs who has a day off but sometimes she has to move from room to room to be able to see patients in privacy. It is not ideal and I look forward to the day when we can hopefully get her settled in her own room. **Spatial constraints** □

I seem to spend a significant amount of time mentoring. It is hard going at times but it is also really rewarding.

The HCA has really helped with fundamental things like taking over some of the ordering of consumables and the restocking of consulting rooms. **Introducing order** □ She is also beginning to save me a lot of time. **Saving time** □ I do speak up for the HCA too within the practice as I think that sometimes the GPs don't really appreciate just quite what a difference she is making. She has really helped with the work load in the practice. **Proving worth in the team** □ She needs to be properly trained for any skills that she takes on and she should be recognised and rewarded too. **PN Advocating, Recognition and reward** □

We have had a bit of a problem initially in the patients thought that she was a qualified nurse. This happened despite us giving her a name badge and printing information leaflets about her role. I think the patients just see a uniform and think – nurse. **Considered qualified** □

I am greatly involved in helping to deliver the GP Contract. The health care assistant also assists with this. We help by ticking the right boxes on the computers to record the appropriate level of care provided under the Contract. The health care assistant also helps me to chase up patients who default. Delivering the Contract is integral to my role. **Delivering the GP Contract, Ticking the right boxes, Chasing up patients** □

We are sending the HCA on some training days to cover all of the basic skills that she can undertake. **HCA training** □

Building up confidence of HCA

(This extract relates to a period of time when the health care assistant has become established within the practice)

The health care assistant and I are certainly getting on well with the work together now. I think that she really loves her job too. **Job satisfaction** □ She takes a great pride in her work and is very caring towards the patients. **Pride in work / caring** □ She is established in her role and the patients love her in fact they really miss her when she is off. I don't think they want to see anyone else. **Patient preference** □

The health care assistant is still proving really valuable and her role has been extending more. She has attended some training courses that have been interesting for her and have meant that I have worked alongside her as mentor □ **HCA training**. I think we all enjoy getting out of the practice and meeting up with other staff from other practices. **Getting together** □ Sometimes I think it would be good if she were to consider actually completing her nurse training. **Towards nursing** □

I have noticed that she is now more experienced and able to identify problems that patients have when they come into her. She knows better what issues to come in and talk to myself or the GP about. She knows some of the patients really well now and so she recognises when their health deviates. This is a good skill she has developed with experience overtime. **Identifying health issues** □

Developing responsibilities

(This extract relates to more recent experiences)

My health care assistant can really be trusted to know exactly where her responsibilities start and end. I trust her absolutely and she would not step over the line and do anything that she did not feel competent to do. **Role boundaries** □ We have used protocols and guidelines to ensure that she works within the appropriate scope of practice. The practice has drawn up some of these but mostly they have been available from within the local NHS. **Using protocols and guidelines** □ The HCA is really sensible and she has moved on to offer patients basic health promotion advice and support. She is able to give advice to patients within her own capabilities but she always acts cautiously and calls me in if she has any doubts at all. **Identifying health issues** □

She is doing great and this definitely feels like it is pay back time for all that early mentoring. The health care assistant and I really do support one another in the practice. **Reciprocal support** ☐ It is however really hard to find time to sit down and talk and to plan work. Communication is important and we need to keep each other in the loop and we also need to communicate with the other members of the practice team but finding time and space for this is not easy. However we usually manage somehow. **Keeping in the loop** ☐

We have worked out how best to cover the clinics between us. For the diabetic clinic she brings the patients in and takes all the bloods and does BPs and weight etc before booking the patients back in with me when the blood results are back and I can complete everything else with them. This really allows me to get on and to concentrate on the more complex issues and to spend more time with patients. **Fulfilling patient needs** ☐

I can't imagine the practice team without our health care assistant. It has been a problem when she takes holidays as the nurses struggle to provide cover for her along with their own work load. We have now started to train up another health care assistant to provide cover for holidays and days off and to keep up with demands. **Training up more** ☐

I am finding that I have taken on more and more responsibilities in the practice over time. My role has developed and I have undertaken more training too over the past couple of years. **Personal development** ☐ I have been a nurse prescriber for sometime now and this has meant more work for me. It is good to be more autonomous though and not have to call on the GPs so often. **Shifting roles** ☐

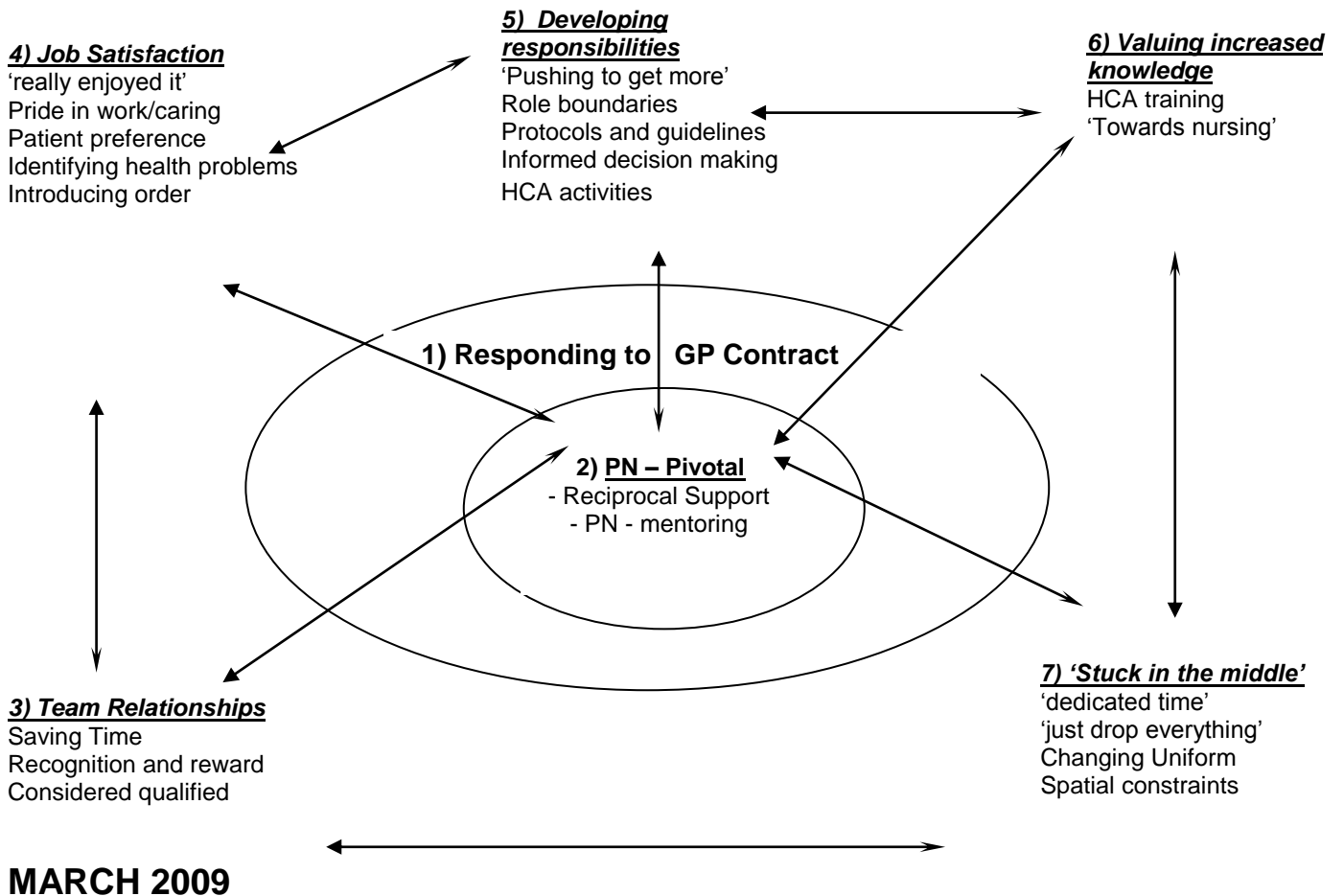
The practice nurses have all now got their asthma and COPD diplomas or heart disease and diabetes diplomas. Most of the practice nurses are nurse prescribers. I know that a few of my colleagues have undertaken a minor injury course too. All of us are doing or have just completed further work related studies. I am really lucky to have the support of the GPs on the practice with this.

They have paid for my courses and they have given of their time to support me when I have needed it. I know that not all of my fellow practice nurses have been so well supported. **Personal development**

Appendix XII

Diagram development in data analysis

HCA – PERCEPTIONS AND EXPERIENCES



HCA – PERCEPTIONS AND EXPERIENCES

4) Job Satisfaction

'Really great'
Pride in work/caring
Patient preference
Identifying health problems
Introducing order

5) Developing responsibilities

'Pushing to get more'
Role boundaries
Using protocols & guidelines
Informed decision making
HCA activities

6) Valuing increased knowledge

HCA training
'Towards nursing'
'Getting together'

3) Team Relationships

Saving Time
Recognition and reward
Considered qualified
'Total threat'

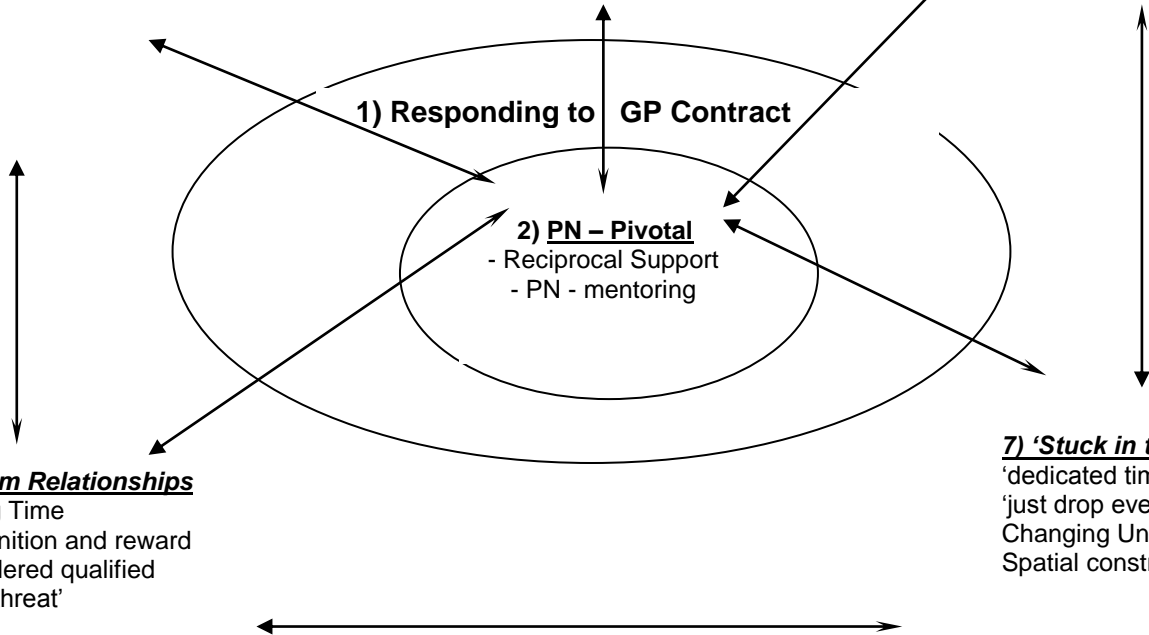
1) Responding to GP Contract

2) PN – Pivotal

- Reciprocal Support
- PN - mentoring

7) 'Stuck in the middle'

'dedicated time'
'just drop everything'
Changing Uniform
Spatial constraints



MAY 2009

Appendix XIII

HCA participants and non participant HCA responses to diaries

PN participants and non participant PN responses to diaries

HCA participants and other (non participant) HCA responses to diaries

HCA's responding	Participant HCAs (n=13)	Other HCAs (n=2)
	Number in Agreement	Number in Agreement
Getting going proving worth		
PN mentoring	13	2
PN pivotal	12	2
HCA activities	10	2
Considered qualified	11	1
Saving time	12	2
Introducing order	11	2
Proving worth in the team	11	2
Responding to the GP contract	10	1
PN advocating	12	2
● Total threat- variant code	12	2
Recognition and reward	12	2
Dual role – response requested From dual role HCAs (optional)		
Changing uniform/changing role	9	-
Stuck in the middle	6	-
Pushing to get more	7	-
Dedicated time	8	-
Just drop everything	7	-
Spatial constraints	6	1
Building confidence and respect		
Really great	13	2
Job satisfaction	13	2
Pride in work/caring	13	2
Patient preference	12	2
Valuing increased knowledge	10	2
Getting together	9	2
HCA training	7	2
Towards nursing	3	1
Building confidence and respect	12	2
Good foundations	9	1
Shifting and shaping roles		
Identifying health issues	12	2
Developing responsibilities	12	2
Role boundaries	13	2
Using protocols and guidelines	10	2
Keeping in the loop	12	2
Personal development	7	2
Reciprocal support	13	2
Fulfilling patient needs	10	2
Training up more/ doing more	6	0

●**Total threat-** code refers to the experience of intimidation of 2HCAs

PN participants and other (non participant) PN responses to diaries

PNs responding	Participant PNs Total 11	Other PNs Total 2
	Number in Agreement	Number in Agreement
Getting going proving worth		
PN mentoring	8	2
PN pivotal	8	2
HCA activities	10	2
Considered qualified	9	1
Saving time	9	2
Introducing order	7	2
Proving worth in the team	10	2
Responding to the GP contract	10	2
PN advocating	10	1
Recognition and reward	10	2
Spatial constraints	6	1
Building confidence and respect		
Job satisfaction	10	2
Pride in work/caring	10	2
Patient preference	9	2
Getting together	8	2
HCA training	10	1
Towards nursing	9	1
Shifting and shaping roles		
Identifying health issues	9	1
Developing responsibilities	10	2
Role boundaries	9	2
Using protocols and guidelines	8	2
Keeping in the loop	9	2
Personal development	8	2
Reciprocal support	10	2
Fulfilling patient needs	9	1
Training up more/ doing more	7	2
Shifting and shaping roles	6	1

Appendix XIV

Qualitative comments from HCA and PN completion of diaries

Qualitative Comments from HCA diary respondents

HCAs Spatial constraints	<ul style="list-style-type: none">• <i>I have got my own room'</i>• <i>'If only (when we get new premises)'</i>
HCAs Proving worth in the team	<ul style="list-style-type: none">• <i>'I would like to think so but nobody says this'</i>
HCAs Training up more / doing more	<ul style="list-style-type: none">• <i>'We cover holidays with other HCA within the practice'</i>
HCAs Using protocols and guidelines	<ul style="list-style-type: none">• <i>'We have some protocols'</i>
HCAs Personal development	<ul style="list-style-type: none">• <i>'GPs not prepared to develop the role more. I feel a bit let down by this'</i>
HCAs Keeping in the loop	<ul style="list-style-type: none">• <i>'I don't get the time'</i>
HCAs Developing responsibilities	<ul style="list-style-type: none">• <i>'My HCA role has expended a lot as I have been an auxiliary nurse for many years and have worked on the district. I am getting great enjoyment and fulfilment in both jobs.'</i>

Qualitative Comments from PN diary respondents

PNs PN mentoring	<ul style="list-style-type: none"> • <i>'Our other HCA is a retired nursing sister and she supervised the new HCA to begin with.'</i>
PNs Spatial constraints	<ul style="list-style-type: none"> • <i>'We are lucky to have enough space in our new surgery and the HCA is happily established in her own treatment room.'</i> • <i>'This did apply. Space was a problem but new room now available'</i>
PNs Saving time	<ul style="list-style-type: none"> • <i>'Don't think HCAs save time but task is allocated to an appropriate person allowing nurses to do other things.'</i>
PNs Considered qualified	<ul style="list-style-type: none"> • <i>'Our patients have been told +++++. There is a sign on the door. Patients know that the HCAs are not nurses.'</i>
PNs Delivering the GP Contract	<ul style="list-style-type: none"> • <i>'My HCA sits in on GP contract meetings along with the practice manager and myself.'</i>
PNs HCA Training	<ul style="list-style-type: none"> • <i>'HCA attends HCA training days and she thoroughly appreciates these.'</i>
PNs Patient preference	<ul style="list-style-type: none"> • <i>'Some patients would still rather see a GP for everything.'</i>
PNs Getting together	<ul style="list-style-type: none"> • <i>'Rarely happens'</i>
PNs Towards Nursing	<ul style="list-style-type: none"> • <i>'Both our HCAs have now commenced nurse training.'</i> • <i>'Neither of our two HCAs want to do this. I have asked them.'</i> • <i>'I have always encouraged her to do this.'</i>
PNs Identifying health issues	<ul style="list-style-type: none"> • <i>'Unfortunately this has not happened yet.'</i>
PNs Protocols and guidelines	<ul style="list-style-type: none"> • <i>'Most have been adapted to suit the practice.'</i>
PNs Keeping in the loop	<ul style="list-style-type: none"> • <i>'Can be difficult especially when a member of staff leaves and a new nurse is employed.'</i>
PNs Shifting roles	<ul style="list-style-type: none"> • <i>'The HCA and PN roles are dynamic and change is always happening.'</i> • <i>'Some tasks that the nurse did previously can be delegated to the HCA now'</i>