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The Development of the New Assistant Practitioner Role in the English National Health Service: A Critical Realist Perspective

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Abstract (122 words)

Adopting a critical realist perspective, this article examines the emergence of a relatively new non-professional healthcare role, the assistant practitioner (AP). The role is presented as a malleable construct cascading through and sensitive to structure-agency interaction at different levels of NHS England: the sector, organisation and department. At the core of the analysis is the permissiveness of structures established at the respective levels of the NHS, facilitating or restricting agency as the role progresses through the healthcare system. A permissive regulatory framework at the sector level is reflected in the different choices made by two case study NHS acute hospital trusts, in their engagement with the AP role. These different choices have consequences for how the AP impacts at the departmental level.

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Key words: workforce, assistant practitioners, NHS England, critical realism, case studies

1. Introduction

The structure and management of the healthcare workforce has been subject to intense debate amongst policy makers and practitioners in most advanced countries as they search for improved service efficiency and effectiveness in the context of growing user demand and resource constraints (Addati et al, 2017). In a labour-intensive sector where despite technological advances the delivery of frontline care still principally rests on the unmediated relationship between the employee and the patient, organisational responses to the pressures on service provision have increasingly centred on the workforce. Noting healthcare management's traditional reliance on crude cost controls rather than on more sophisticated workforce strategies, Buchan (2004:1) stresses that 'getting human resources policy and management right has now become core to any sustainable solution to health system performance.'

Much of the emphasis on staff management in healthcare has concentrated on changes to ways of managing and working (Burgess and Radnor, 2013). However, the most challenging type of change has been the development of new work roles, a process which involves the re-distribution of tasks, and confronts delicately contrived occupational territories (Abbott,1988). Indeed, given the occupational complexity and regulated nature of the healthcare workforce, a literature has highlighted battles over occupational jurisdictions as new work roles emerge (Pickard, 2010; Currie et al, 2012;). As Nancarrow and Borthwick (2005) note such battles involve shifts in job boundaries within healthcare disciplines, for example, as specialist jobs develop, as well as between them, as tasks are horizontally or vertically transferred between work roles in the occupational hierarchy.

Our article explores the emergence of a relatively new healthcare role in the English National Health Service (NHS): the assistant practitioner (AP). The role attracts research interest for various reasons. First, positioned immediately below the registered nurse and other non-medical professionals in the workforce hierarchy and designed to provide them with advanced clinical support, the AP role encourages an interest in shifting job boundaries, particularly the vertical transfer of tasks (Nancarrow and Borthwick, 2005). Second, a focus on the assistant practitioner moves debate on from the

traditional pre-occupation with the healthcare professions (Larson, 1977), and their search for occupational closure in pursuit of labour market status and privilege (Daykin and Clarke, 2000). While positioned at band 4 in the (nine band) NHS pay structure, above band 2 and 3 healthcare assistants, APs are still **not** registered, lacking a regulatory body to ensure the achievement and maintence of educational and occupational standards. Third, healthcare providers retain discretion over engagement with the assistant practitioner role, opening the possibility of variable organisational responses to it. Part of a broader programme of service reform designed to 'modernise' the English NHS (Department of Health (DH), 2000), the AP role was loosely conceived and constructed, allowing variable employer take-up.

We consider the emergence of the assistant practitioner from a critical realist perspective (Bhaskar, 1989), presenting the role as a malleable construct cascading through different layers of NHS England and shaped by structure -agent interaction at the respective levels. These processes are principally explored through a comparison of two case study hospitals (NHS trusts), exercising the discretion provided by a permissive national policy framework to adopt different approaches to the AP role. The findings suggest that the development of the role has an indeterminant and situated quality.

The article provides: a review of the literature on new healthcare roles framed by our critical realist approach and generating our research questions; an overview of the methods used in the fieldwork; a presentation of the findings; and a concluding discussion.

2. Critical Realism and the Healthcare Workforce

As a meta-theoretical approach, critical realism has attracted increasing attention within the sociology of healthcare. This has been largely manifest in discussion of critical realism's philosophical foundations (Cruickshank, 2011), especially how epistemological and ontological assumptions are distinctively configured to distinguish the approach from the previously dominant positivist and constructivist paradigms. In particular, critical realism's exposure of an 'epistemic fallacy' (Bhaskar, 1989) which suggests that knowledge alone drives our understanding of reality, gives way to a stratified social ontology rooted in: the empirical – what is experienced; the actual- events which

might but also might not be experienced; and the real- underlying generative causal mechanisms explaining (demi-) regularities in the realms of the empirical and the real. Such an approach has been viewed inter alia as adding explanatory depth and sensitivity to the complexities associated with the implementation and impact of healthcare policy and practice in different contexts including nursing (McEvoy and Richards, 2003), chronic illness (Williams, 1999) and healthcare inequalities (Srambler and Scambler, 2015). Data-driven research rooted in critical realism has been less common (Fletcher, 2017) although Williams et el (2016) present various healthcare studies illustrating the approach's analytical value.

There have, however, been few explicit attempts, to use critical realism to explore how, why and with what effect new healthcare roles develop. In addressing this lacuna, we privilege three of critical realism's key tenets.

The first relates to **structure-agency dualism.** Rejecting analytical approaches based on the duality of structure that conflate the structure-agency distinction and view structures as embodied actor practice (Giddens, 1984), critical realism assumes that structure and agency can and need to be retained as distinct causal constructs. The presence of powerful, independent structures is essential to the ontological realm of 'the real' with its generative causal mechanisms. However, while constrained by such structures, residual agency remains, with the capacity to modify them. From within critical realism, this structure-agency dynamic has been most precisely captured by Archer's (1995) morphogenetic cycle. Conceptualised as a cycle, structure-agency interaction can be presented as comprising sequential and temporal qualities. Indeed, Archer conceives the morphogenetic cycle as resting on overlapping stages: Time (T) 1, 'structures', which pre-date and socially condition agents; T2, 'action', as agents interact with a degree of discretion; and T3, 'elaboration', as pre-existing structures emerge as modified by such interaction.

An emphasis on structure-agency dualism has increasingly informed the sociological interest in new roles and ways of working in healthcare. Although this interest has typically been framed by neo-institutionalism rather than critical realism, commentators have argued that the two approaches share many defining features (Nielsen, 2001). As Hesketh and Fleetwood (2006: 684) note 'the difference

(between critical realism and neo-institutionalism) is largely semantic because there is general agreement that institutions are a specific kind of social structure'. Certainly, in terms of focus the structure-agency dualism essential to critical realism has also underpinned themes pursued by neo-institutional researchers, including those centred on organisational change. Thus, the weight placed on the potency of structures to constrain, or in Archer's terms socially condition, agents, has presented organisational change as problematic for neo-institutionalists. It has heightened interest in agency amongst neo-institutionalists, as a distinct analytical construct with the capacity to change structure. This is reflected, for example, in the notion of the institutional entrepreneur (Leca and Naccache, 2006), an agent with the contingent capacity (Lockett et al, 2012) to act and secure structural change. The contribution of an institutional entrepreneur is illustrated in a study by Reay et al's (2006) on the development of a new nurse practitioner role in a Canadian healthcare system. With long experience, the nurse middle manager is presented as the key agent leveraging their social conditioning as a resource rather than a constraint, to facilitate the introduction of the new role, and in doing so elaborating the structure of the system's healthcare workforce.

Similarly, there are echoes of critical realism's emphasis on structure-agency dualism in various institutional studies on the management of occupational boundaries. Such boundaries retain structural properties, with established rules and practices socially conditioning agents. However, as Abbott (1988) highlights, agency remains as competing actors seek to elaborate these boundaries. Indeed the concept of 'institutional work' (Lawrence and Suddaby, 2006), captures the ongoing dynamic of agents 'creating, maintaining and disrupting' structures, as reflected in various studies on the tactics used by established healthcare professions to protect themselves from the challenge of new roles (Currie et al, 2012; Kitchener and Mertz, 2012).

The second of critical realism's tenet drawn upon relates to the notion of **stratified social entities** (Elder-Vass, 2010: 48-53). Narrower than the emphasis placed on stratified social ontologies, this notion connects to a traditional sociological interest in the relationship between different systems levels- the macro, meso and micro (Fine, 1991). Within critical realism, these respective levels provide a site for structure-agent dualism to play itself out. More importantly, they encourage a focus

on how the outcome of this dynamic at one level might have 'knock-on' consequences, shaping the same dynamic at lower levels. As Mouzelis (1995:140) notes:

> 'Decisions taken at a certain hierarchical level tend to become the taken-for-granted decision premise at lower hierarchical levels. These decision premises then become the basis on which lower placed organisational participants take decisions of a more limited or circumscribed nature.'

This interest in how structure-agency dualism plays out at different systems levels is apparent in studies on workforce organisation and structure in healthcare, although again seldom framed by critical realism. Thus, structural elaboration, especially at the national level, has been highlighted as stimulating the (re-) distribution of tasks and responsibilities at lower levels of the healthcare system. Kronus (1976), for example, reveals how such elaboration in the form of legal protections established at the national level then influenced the outcome of jurisdictional disputes between physician and pharmacists. Similarly, Abbott (1988) places weight on structural elaboration in the form of the statutory mandate secured by occupational agents to perform specified tasks as the basis for furthering their jurisdictional claims at the workplace level. Zetka's (2011) historical study outlines how structural elaboration re-regulating national training regimes, allowed for the emergence of gynaecologic oncology as a new occupational specialism with the US medical profession.

Our final tenet re-engages with critical realism's stratified social ontology, especially the domain of the 'real' predicated on **generative causal mechanisms** which explain patterned outcomes from structure-agency interaction. Uncovering these mechanisms is acknowledged by critical realists as challenging. Presenting critical realism as an open-paradigm, Elder-Vass (2010:21) notes that the emergence of patterns or regularities is 'above all a product of coupled, context dependent interactions.' In placing weight on contextual contingency, the researcher risks being drawn into situated explanations which obscure more deep-seated, systemic sources of causation. Indeed, as generative casual mechanisms are mediated by contingencies at different levels of a social entity, critical realist explanations rest on mapping what Reed (2011:5) refers to as 'complex casual chains.'

The literature on the sociology of healthcare has only tentatively sought to excavate the generative casual mechanism underlying changes to the distribution of work tasks and responsibilities in the sector. Many of the studies outlined above have remained ontologically rooted in 'the 'empirical' and 'the actual', describing the process and tactics of workforce re-organisation rather than uncovering the deeper-seated forces driving them. A concentration on the micro-dynamics of institutional work has often deflected interest from the 'complex causal chains' explaining workforce reconfiguration to be found at meso and micro levels in the stratified healthcare system.

This focus may well reflect the difficulties faced in exposing generative causal mechanisms in a healthcare context, difficulties typically addressed by critical realism through a retroductive approach to theory-building (Reed, 2011). Retroduction sits between the abstract deductive and the immersive inductive, and involves moving back-and-forth between data, methods and possible explanations to uncover patterns and their causes. Methodologically, the purposeful selection of comparative case studies also provides a means of revealing causal mechanisms (Saka-Helmhout, 2014), and it is a paired comparison approach which underlies our study on the emergence of the AP role. Indeed, we draw upon all three critical realist tenets in presenting our research approach in the next section.

3. Research Approach

Our principle research questions are why, how and with what consequences the new assistant practitioner role emerged and developed in NHS England. In addressing these questions, we draw upon the critical realist notion of **the stratified social entity**, presenting the NHS as comprising:

- The sector, NHS England;
- The healthcare provider, NHS trust; and
- The department, that is the clinical unit or ward.

In examining approaches to the role, we then rely on critical realism's emphasis on structure-agency dualism as enacted at these different levels of NHS England. This involves examining whether and how policy and practice related to the AP role at a **given level** of the NHS establishes the structural context for agents acting at lower levels. In other words, we focus on the **permissiveness** of structures in allowing residual agency at the organisational and departmental levels to engage with and shape the

AP role. In doing so we can track how Archer's (1995) morphogenic cycle unwinds: the extent to which agents are socially conditioned by structures at the respective levels of NHS England and whether as the AP role progresses through these levels, there are opportunities for agents to structurally elaborate. As the AP role moves through the layers of NHS England, interacting with various proximate contingencies, we can also map the complex causal chains (Read, 2011) explaining the form taken by the role and its impact on stakeholders.

The study uses different data sources to explore structure-agency interaction at the levels of NHS England. At the NHS, level, secondary material is relied upon: national policy documents and statements. A trawl of material produced by key government departments, such as the DH and the Cabinet Office, was undertaken to reveal how and why the assistant practitioner role emerged and the underlying national infrastructure set up to support it. The core of the article uses primary data collected from two trust case studies which tracked the development of the AP role at organisational and departmental levels. Our case approach was characterised by a degree of methodological opportunism. Drawn from a broader study of healthcare support workers in acute healthcare, the case studies were being undertaken in different research streams. However, it became increasingly apparent that both hospitals were introducing a new AP role albeit in markedly different ways.
In organisational terms, the trusts were similar, presenting an opportunity to explore the influence of agency on approaches to the AP role. As Table 1 below indicates, both cases were single site, medium-sized district general hospitals located in secluded, non-urban communities: one in a small rural town in the East of England (henceforth EH); the other in a coastal area in the West Country (henceforth WH). There were, however, a few noteworthy organisational differences between the cases. WH was a larger trust in terms of budget and workforce, serving a geographically more concentrated population: 300,000 residents across 300 square miles, compared to EH's 280,000 residents over 600 square miles. WH was also in a stronger financial position having generated a surplus of 2.2% of total budget compared to EH's 0.4% in the year research was conducted (2011-12). Indeed, EH's annual report notes that their surplus for the year was £381,000 'less than planned'.

INSERT TABLE 1 ABOUT HERE

There were methodological differences in our approach to the respective case studies. At EH the research was longitudinal, tracking a cohort of trainee assistant practitioners (TAPs) at the outset and on completion of their training. At WH a retrospective approach was adopted, looking back at the development of the AP role. However, in both cases the aim was to interview actors taking a vertical (different trust levels) and a horizontal (different clinical areas) organisational slices.

As noted in Table 2 below, a total of 60 interviews were conducted across the two cases. While the majority of interviewees came from EH, we still managed to interview a range of key actors at WH. In seeking to pick-up differences in the development and use of the AP role by workplace context interviewees in both cases came from a variety of clinical departments.

The study findings are presented in three sections - sector, organisation and department- providing an opportunity to unpack structure-agent interaction between and within different levels on NHS England.

INSERT 2 ABOUT HERE

Findings

Sector Level: NHS England

The emergence of the assistant practitioner role can be traced to public policy developments in the late 1990s when a New Labour Government came to power in Britain seeking to 'modernise' the public services (Cabinet Office, 1999). This 'modernisation' project rested on the development of user-centred public services, in part requiring a loosening of rigid organisational practices seen as undermining the effective delivery of services. As the Cabinet Office White Paper on public service modernisation (1999:3) noted:

> Public servants must be the agents of the changes citizens and businesses want. We will build on the many strengths in the public sector to equip it with a culture of improvement, innovation and collaborative purpose.

There were elements of continuity with previous attempts to reform the public services (Bevir, 2005), presented by commentators as similarly drawing on the market-driven principles of New Public Management (Hood, 1991). However, New Labour 'modernisation' was presented by national policy makers in less 'aggressive' ideological terms as a pragmatic 'Third Way' response to new service needs and pressures (Giddens, 2000), and supported by historically high levels of public investment in the sector (Chote et al, 2010).

New Labour's modernisation agenda was distinctive in seeking a 'constructive' engagement with workforce issues (Bach and Kessler, 2012), viewing more flexible forms of work organisation as integral to the delivery of user-centred public services. This was especially the case in the NHS with its regulated workforce, based on a model of statutory registration where professionals met defined occupational standards, delivered by approved educational programmes, and assured by ongoing conformance to a code of practice. Presented as a 'public good', a means of ensuring transparency, reducing patient risk and safeguarding care standards (Department of Health, 2007), this registration model could also be framed as the protection of labour market privilege and status by self-seeking professional groups. Indeed, on these grounds, it was challenged by the government as inhibiting work practices more sensitive to patient needs. The Department of Health (DH) noted:

> Changes in working practices will be fundamental to delivering (service) improvement. In the way staff are employed and paid the NHS retains too many of its 1940s employment practices- overly demarcated and inflexible. (DH, 2002:34)

Created in 2000 by the government, the NHS Modernisation Agency sought to address these perceived rigidities with a Changing Workforce Programme. The programme involved the development of new work roles, including the Assistant Practitioner (AP). However, while rooted in a broadly conceived national job description, the nature of the established AP role, its management and responsibilities, remained elusive (Skills for Health, 2009). A scoping review of the role noted, 'There is no universally accepted definition of the assistant practitioner' (Mackinnon and Kearney, 2009:2). Indeed, while post holders were expected to hold a formal (level 5) qualification (typically a Foundation Degree) a requirement which distinguished the AP from the 'unqualified' lower level

healthcare assistant, the training and entry routes into the AP role remained broadly defined (Skills for Health, 2009).

The decision to make the AP an unregistered role was made by national policy makers in the context of other available options (Griffiths, 2009). There had been a longstanding policy debate in the UK on the regulation support roles, particularly within nursing (Abel-Smith, 1970). From the early 1960s, the NHS had developed an accredited and registered second tier nursing role, the State Enrolled Nurse (SEN) (Seccombe et al, 1997). From the mid-eighties with the establishment of nursing as a graduate profession, the SEN role was phased-out (Bradshaw, 2001). However, with such a regulated role until recently integral to the healthcare workforce, it is difficult to view the decision by national policy makers to introduce the assistant practitioner as an unregistered role, as other than a considered one. Indeed, an unregistered assistant practitioner role accorded with a government interest in breaking through the professional demarcations in service delivery. This was apparent in Skills for Health's (2009:2) description of the AP role as 'transcending professional boundaries…..undertaking clinical work in domains that have previously only been within the remit of registered professionals.'

Such a description, and the light-touch regulation of the AP role prompted concerns amongst the registered professions. These concerns centred on the rationale for introduction of the role which, while plausibly being linked to improved service design and quality, might also be viewed as a means of cost reduction through skill mix dilution (Griffiths, 2009). A cost-driven rationale tapped into longstanding professional fears about the substitution of registered staff with cheaper support workers, particularly in periods of financial strain (Thornley, 1997). As the Royal College of Nursing (RCN), the professional association for nurses, noted:

> We recognise the value of the (AP) role for patients and the nursing team. However, we would become concerned if the assistant practitioner role were to be introduced as a means of reducing the costs of the nursing workforce (RCN, 2009:6).

Professional unease implicitly reflected a statutory framework, which despite government claims, weakly regulated work organisation in parts of the healthcare workforce. The research literature has

typically drawn attention to the full occupational closure and tight regulatory control typically secured by doctors (Larson, 1977). Non-medical professions such as nurses have, however, been less effective in regulating entry into their occupation, encouraging some commentators to classify them as a quasi-profession (Etzioni, 1969). The capacity of the unregistered assistant practitioner to break through the regulatory framework to perform the technical tasks of the non-medical professional should not be overstated, raising clinical governance issues and requiring the drafting of detailed organisational protocols. However, the structural barriers to the development of AP role have arguably been more imagined than real, allowing considerable fluidity in the performance of care tasks across the care workforce (Abel-Smith, 1970).

These weak institutional constraints established a permissive context for structure-agency dualism to the play itself out at the lower levels, to which attention now turns.

The Organisational Level: The Healthcare Provider

The permissiveness of the national context and the scope provided for choice at the organisational level were apparent in the contrasting approaches to the assistant practitioner role taken by our two case study trusts. The approaches comprised three elements- aims, strategies and processes- which unfolded in different ways at East Hospital (EH) and West Hospital (WH).

At EH the introduction of the AP role was underpinned by a mix of senior management aims, suggesting the role's virtuosity in pursuing a variety of ends. These aims combined expediency with a more considered response to the challenges facing the trust's nursing workforce. The proposed use of the role to relieve registered nurses of certain routine tasks and establish the AP as a leader for a team of healthcare assistants, represented a planned move to re-calibrate the distribution of tasks and responsibilities. As a response to nurse shortages, the AP was viewed more opportunistically as providing a stepping-stone into registered nursing, or more directly ensuring aggregate staff numbers were met.

Notwithstanding this range of aims, cost reduction was perceived by many trust actors as the main driver for introduction of the role at EH, reflected in changes to the staff funding model

accompanying the introduction of the role. The trust board decided to fund the AP role by removing at least one registered nurse post from each department's staff establishment. In contrast to the other broadly conceived aspirational goals noted above, the replacement of registered nurses by APs to make financial savings constituted a tangible change with consequences for departmental management and work organisation.

The financial savings available to EH from the AP role were tied to, arguably dependent on, the strategy chosen to introduce them. As a nurse manager noted:

> If you introduce an initiative such as this wholesale within an organisation, which we have done, there are efficiency savings and cost savings to be made (EH_MGR2).

In short, cost savings were viewed as most likely to accrue if the AP role was introduced at scale, and the trust board took the decision to establish at least two trainee assistant practitioners (TAPs) in each of its main clinical departments, a total cohort of twenty-five:

> (The AP initiative) came in from a strategic level rather than from the ward level. It was a case of 'this is going to happen', 'you will participate'. That was part of the rationale for putting two on each ward. (The TAPs) were going to need mutual support because life wasn't going to be easy for them: not every area was going to welcome them with open arms (EH_MGR1).

To deliver a co-ordinated trust-wide AP programme, a highly regulated organisational process was instituted. Set out in Figure 1 below, this process can be characterised as a tightly managed top-down project:

> It (the AP initiative) was driven forward very quickly when the trust finally signed up. It came from senior management as this is going to happen whether you ward managers want it or not. (EH_MGR2)

An implementation group was formed comprising key stakeholders- nurse, service and human resource managers- who then appointed a dedicated project co-ordinator. The group drew-up a

generic AP job description as the basis for the recruitment of the first cohort of trainee assistant practitioners and for the design of a standard training programme. The centrepiece of the training programme was a two-year Foundation Degree delivered by the local college and based on workplace learning which allowed for the development of relevant AP competences. Both the recruitment and training of Trainee Assistant Practitioners (TAPs) was informed by a series of conditions: TAPs were recruited from internal and external applicants; they were placed on pay band 3 for the duration of their training; they were allowed two study days per week; and automatically moved into the AP role (at pay band 4) on completion of their training.

INSERT FIGURE 1 ABOUT HERE

By contrast, **at WH** the aims underpinning the introduction of the AP role were tied to service quality and design. Such clarity of purpose took some time to achieve. Initially, there was a degree of opportunism with the trust taking regional funding to support AP training:

> We didn't know whether it (the AP role) would work or not. I think maybe we saw pound signs and, "we've some money coming in, let's take it", without understanding what that job [AP] role would be. (WH_MGR5)

However, the AP role quickly became connected by senior trust managers to departmental service design:

> Some trusts see the (AP) as a cheaper alternative to registered nurses, and the ones that have gone down this path haven't really thought through what you want these people to do ... whereas (WH) has very much thought around where do you want these people and what do you want them to do (WH_MGR4).

Trust management at WH framed the development of AP role in terms of service improvement, highlighting opportunities to mould the role to meet departmental needs:

> [APs] are not mini nurses. We're trying to create the competencies around the patients that they look after rather than the competencies around a professional sort of remit. (WH_MGR1).

Equally striking was the discretion given to clinical areas, deemed best placed to decide whether and how the AP could contribute to service delivery:

> We asked for (clinical) areas that would be interested (in the AP role), and a number came forward. These were areas that said, "we could see a need for that, we could see that would work" (WH_MGR5).

A departmental expression of interest marked the beginning of an extended and inclusive process by which the contribution of the AP to service routines was worked through with the local clinical team, shaping the final form assumed by the role. Set out in Figure 2 below, this process involved three key actors- the trust education lead for unregistered staff, senior nurses in the clinical department and the education provider- interacting in a fluid way. The interface between the education lead and the clinical department was the crucial first stage in chiselling out a bespoke role:

> At meetings between the senior nurses and our matron and the education lead, we said this is what we think they [APs] can do, and [the education lead] would go and investigate, look around the legalities, and come back and say, "yes, they can, but you'd need to do this specific piece of work with them or have this PGD [patient guidance directive] in place" (WH_MGR7).

INSERT FIGURE 2 ABOUT HERE

As the tailored AP roles took shape so the relationship between the education lead and the education provider became crucial. The nature of the role dictated the type of knowledge and competencies required from the two-year Foundation Degree delivered by the local college. A standard first year gave way to a second with specialist modules to equip the AP for their future departmental role. College adaptability was required, allowing the FD to constantly evolve in accommodating these new bespoke second year modules.

The contrasting approaches adopted by EH and WH to the development of the AP role, in the former top-down, tightly regulated and, in the latter, bottom-up weakly regulated, were reflected in the distribution of assistant practitioners across the different clinical departments. As indicated in Table 3

below, EH's broad initiative resulted in an even distribution of assistant practitioners across the trust's clinical departments. It can be seen from the table that the role was introduced in nine clinical areas, and within general medicine and surgery, in a number of wards. At WH departmental discretion led to the introduction of a smaller number of APs in the trust and their patchy distribution across clinical departments. Some WH departments- Trauma and Orthopaedics and Cancer Services- took-up the AP role with greater enthusiasm than others- care of the elderly and the coronary care unit. The consequences of these different trust approaches can be more fully appreciated by a consideration of how the role was received and viewed at the final level: the clinical department.

INSERT TABLE 3 ABOUT HERE

Department Level: Clinical Area

The different organisational approaches to the adoption of the AP role unfolded at the departmental level in the respective trusts in predictable ways. While WH's permissive approach allowed the role to become readily accepted and embedded, at EH a much tighter regulatory approach, opened-up tensions.

At **EH**, acceptance of the AP at departmental level was hampered by a fragmented narrative presenting the AP role as a vehicle for organisational goals largely perceived as incompatible. For example, the recruitment of external applicants onto the TAP programme sat uncomfortably with the AP role as providing career opportunities for the hospital's existing healthcare assistants. More tellingly, the use of the AP to save costs 'tainted' workplace views on the role, especially amongst registered nurses and nurse managers:

> A real big problem was that we sold it as a cost improvement: we're getting rid of a registered nurse out of your budget to fund an AP, and that immediately upset people (EH_MGR2).

For registered nurses the use of the AP role in this way raised concerns about substitution and trespass onto occupational territory;

> To begin with a lot of the newly qualified nurses were convinced we were there to take their jobs (AP emergency services) (EH_AP2).

Equally striking, departmental difficulties derived from the imposition of the role, with departments unable to work-through the form it would take and how it would fit into ward systems and routines:

> When it came to the implementation (of the AP role) there was a lot of resistance clinically from quite senior staff who didn't see the point. Some areas wouldn't embrace it at all (EH_MGR3).

The departmental responses to the role at EH were not overwhelmingly hostile. In some of the trust's settings the AP found an accepted niche in service delivery. In the endoscopy and the stroke units there were clinical tasks that registered nurses felt confident in delegating to the APs:

> I (as an AP) can look at the holistic care of the patient and think I can do that dressing, I can set that feed up, I can do that urine sample, and I would do that all in one go with a patient. I find that I do help, and I fit in quite well (EH_AP1).

In other departments the AP role took some time to establish its worth, but eventually gained legitimacy. An AP in the gastroenterology ward noted:

> There was a lot of hostility when I first started on the ward, not only from nurses, from nursing assistants as well. It has very much changed overtime, as they've seen how much knowledge we could bring to the ward (EH_AP10).

However, there were departments, particularly general medical and surgical wards, where the role struggled to fit in. With their newly acquired competences not being used, APs became frustrated:

> The staff are just not embracing us and using us as we need to be used. They still see us as care assistants (EH_AP2).

In part, these APs were coming up against established routines unable to accommodate their role. For example, in general wards with two nurses required to administer controlled drugs - a dispenser and

checker- it was difficult to replace one with an AP, especially on the lightly staffed night shift. However, managerial style at the departmental level also accounted for resistance to the role:

> (The ward manager) said our nursing assistants are very capable, therefore we don't need assistant practitioners. We've got nursing assistants that have been on the ward years and know their job, so she doesn't seem to see the point (of APs) (EH_AP2).

INSERT TABLE ABOUT HERE

While uneven, the concerns emerging at the departmental level were significant enough to prompt organisational modifications to the arrangements for the EH's second cohort of TAPs. Highlighted in Table 4 above, these changes included: a loosening in the trust's regulatory regime with departments now able to volunteer rather than being required to introduce the AP role (hence the significant reduction in the size of the TAP Cohort 2); shifting to the internal recruitment of TAPs to Cohort 2, so ruling out external applicants and re-establishing the AP role as part of a career pathway exclusively for existing staff; and reducing the number of study days from two to one, ensuring that TAPs had greater scope to learn on the job, while also being available to the ward team for the delivery care.

At WH, departmental engagement with the AP role was not unproblematic. Some registered nurses at the trust were concerned about professional territories as APs took-up clinically complex tasks:

> I see a future where they (APs) are doing more, perhaps administering chemotherapy. This would really help us, but then you think where's the crossover here between being an associate practitioner and a staff nurse? That's my only concern: that slowly but surely boundaries are being crossed (WH_N1).

Yet despite such worries, the AP role was more fully embraced at the workplace level at WH, reflected in Table 5, which presents the range of tasks performed by APs in their respective department.

INSERT TABLE 5 ABOUT HERE

In contrast to the difficulties faced at EH in accommodating APs within embedded service routines, the role was clearly seen to contribute delivery in various ways at WH:

- **Direct care**:

  Now the APs can chat to the benign (cancer) patients, give them information and doing the breast awareness and things, so that's taken a lot of pressure off (us nurses) (WH_MGR2).

- **Continuous care:**

  On the chest ward (patients) come in and follow an algorithm of care which necessitates that they have these two antibiotics. With APs doing the antibiotics on time every six hours or every eight hours, it means antibiotic cover is continued, and you will reduce the likelihood of infection and the length of stay (WH_MGR3).

- **Timely care**:

  You've got three patients all on chemotherapy and there's no one there to change the regimes over and you've got to be in different places at the same time. Without them (APs), it's a real gaping hole because no one's there going to you, "oh by the way, the chemo's here, do you want to put it up and I'll stand and check you?" (WH_MGR4).

Discussion and Conclusions

The dynamic between the diverse range of occupations comprising the healthcare workforce has long attracted the interest of researchers, but principally with a focus on the construction of healthcare professions (Larson, 19977) and their jurisdictional battles (Abbott, 1988; Nancarrow and Borthwick, 2005). In this article we have concentrated on a non-professional healthcare role, the assistant practitioner, and in adopting a critical realist perspective have presented it as a malleable construct cascading through and sensitive to structure-agency interaction at different levels of the NHS. Central to our analysis was the permissiveness of structures established at the sector, organisational and departmental levels of NHS England, which determined the residual agency available to actors at the respective levels, as the assistant practitioner role moved through the healthcare system. The balance

between structure and agency at the different system levels and within our two case studies is summarised in Figure 3 below.

INSERT FIGURE 3 ABOUT HERE

As Figure 3 indicates, structural permissiveness at the sector level, with the construction of a lightly regulated AP role, provided considerable scope for agency at the organisational level, illustrated by the adoption of different approaches to the development of the AP role in the case study trusts. At EH, the implementation of the AP role was principally tied to the search for cost savings, an end secured through a top-down trust-wide approach. Senior management used their agency to establish structural arrangements which tightly regulated the use of the role across the trust. In contrast, at WH the AP was used to support service re-design, with departments allowed to assess their need for the role and to work through the form it would take. At WH, agency had been used to retain an organisationally permissive regulatory regime, with the AP role being taken-up in bespoke ways.

These contrasting organisational approaches were enacted at the departmental level, with different consequences for how the role was viewed. At EH, the limited agency available to departmental actors generated tensions: the need for the role was challenged; its accommodation with the existing routines questioned; threats to occupational territories raised. At WH, the permissiveness of the organisational regime enabled departments to either side-step these tensions by declining to take-up the role or work them through before the role was introduced. The scope for agency at WH resulted in an occupational crafting of the role within departments, ensuring its acceptance by local actors and its contribution to service delivery in context-specific ways.

In drawing upon three key tenets of critical realism, we have been able to adopt a distinctive approach to the development of a new healthcare role. Certainly, our emphasise on **structure-agent dualism** aligns with the assumptions of neo-institutional studies, particularly those re-discovering the residual capacity of agents to elaborate structures, breaking through or leveraging their social conditioning (Reay et al, 2006). Indeed, our study has cast light on the type of agent, or institutional entrepreneur, required to develop a new healthcare role, and the qualities required for them to be effective in this

context (Lockett et al, 2012). At EH, the trust decision to adopt a standard approach to the AP role limited scope for institutional entrepreneurialism at the departmental level. However, at WH departmental discretion to develop the role brought to the fore as change agents the trust's education lead and departmental nurse managers, essential to chiselling out an AP role sensitive to local circumstances and needs.

More significantly Archer's (1995) morphogenetic cycle provides an analytically sharper framework to explore how this dualism played itself out in the development of the AP role, stressing the temporal and sequential qualities of this process, and, in particular, the scope for socially conditioned agents to still engage in structural elaboration. This structural elaboration was twice in evidence in our EH case: initially when the trust chose to develop a dense network of rules on how the AP role was to be implemented across the trust; and then, as a response to emerging departmental tensions, with the trust relaxing these very rules to allow greater departmental choice in engagement with the role as a second cohort of trainee assistant practitioners was taken-on.

The value of the critical realist approach is even more apparent as our interest in structure-agent dualism is combined with the presentation of NHS England as a **stratified social whole.** This allowed us to examine how this dualism played-out at and between different levels of the healthcare system as the assistant practitioner role developed. Viewing the NHS as layered enabled us to move beyond a neo-institutional concentration on the minutiae of local or workplace interaction (Pickard, 2010; Currie et al, 2012), a distraction from more general influences on working practices emerging at the sector and organisational levels. We were able to illustrate how the structures- rules, policies, practices- emerging at these different, superordinate levels of NHS in turn generated constraints and choices on how agents engaged with the role at lower levels.

In broader terms, the presentation of a healthcare role as a malleable construct progressing through and being shaped at different levels of a healthcare system, raises questions about the crafting of occupational positions. The tight regulation of healthcare professions, typically given effect through registration, creates non-permissive structural arrangements which limit agency's capacity to shape such roles at lower levels. However, whether there is residual agency at these levels to mould even

registered professional roles in response to local contingencies continues as a valid empirical question. Indeed, it is worth noting the imminent (at the time of writing) introduction of another new senior support role in NHS England-the nursing associate (NA) role. Similarly positioned to the AP at pay band 4, the NA will, nonetheless, be a registered role (Health Education England, 2016). This begs the question whether a tightly regulated senior support role, the NA, cascades differently through the NHS than a lightly regulated senior support role, the AP.

Finally, an emphasis on **generative causal mechanisms,** re-connecting with critical realism's interest in stratified social ontologies, prompted the mapping of complex causal chains (Read, 2011) to explain the emergence of the AP role. This search was facilitated by our layered approach, tracing the role's source to the sector level and allowing us to relate its introduction to the broader political economy of healthcare. Thus, the AP role was presented as closely tied to a New Labour government 'modernisation' agenda, designed to breakdown structural rigidities in pursuit of a 'patient-centred' healthcare service. Indeed, reflecting Nancarrow and Borthwick's (2005) notion of vertical substitution, the AP role was explicitly conceived by national policy makers as 'transcending' arguably fragile professional boundaries (Etzioni, 1969).

In addition, our critical realist approach presented causation as linked to contingencies at different levels of the NHS moulding the AP role and its use. Similar as medium sized district general hospitals, distinctive organisational contingencies still shaped approaches to the role adopted by the two case trusts. Thus, the financial pressures facing EH, pushed the trust towards using the AP role as a cost saving measure, while less intense pressures allowed WH to deploy it more imaginatively to address service design. As the AP role moved to departmental level, there were further contingencies affecting responses to it. Even at EH, with a general local resistance to the role, there were clinical areas where APs was adopted with alacrity being seen to add value to care delivery. At WH, these departmental contingencies - for example, the nature of the service provided and the character of staff-patient interactions – had an even greater influence, determining whether the role was taken up at all and, if so, how.

In conclusion, our approach to the introduction of the AP encourages consideration of the broader adoption of a critical realist perspective in analysing workforce developments in healthcare. Such an approach might be used not only to explore the development of new occupational roles but workforce policy and practice more generally. This is particularly so where such policies and practices are loosely conceived at national level, for example, in the case of guidelines on safe staffing or medicine administration. providing scope for them to move through the NHS, in a manner sensitive to the structure-agency dynamic at different levels and subject to the influence of different contingent factors explaining how and why they are adopted and with what effect.

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Table 1: Profile of Case Studies		
	East (EH)	**West (WH)**
Workforce (Head count)	2950	3838
Budget	£159.5 million	£218.3 million
Financial surplus	£619,000	£4.7ml
Financial surplus as % of budget	0.4	2.2
Sites	Single	Single
Area covered	600 square miles	300 square miles
Resident population	280,000	300,000

Table 2: Interviews by Case and Actor		
	East	**West**
Interviews:		
(T) AP	19 (Including 7 at times 1 and 2)	2
Nurse	6	3
Senior Nurse Manager	6	3
Matron	1	1
Trainer	4 (Including 1 at times 1 and 2)	4
Ward Manager	7 (Including 1 at times 1 and 2)	4
Total	**43**	**17**

Figure 1: Implementation the AP Role at EH

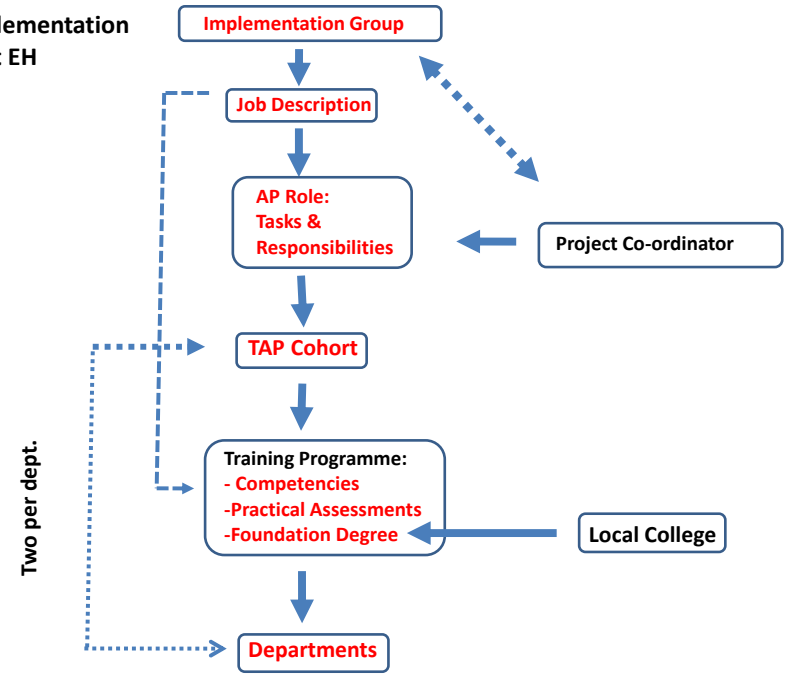

Figure 2: The Implementation Process at WH

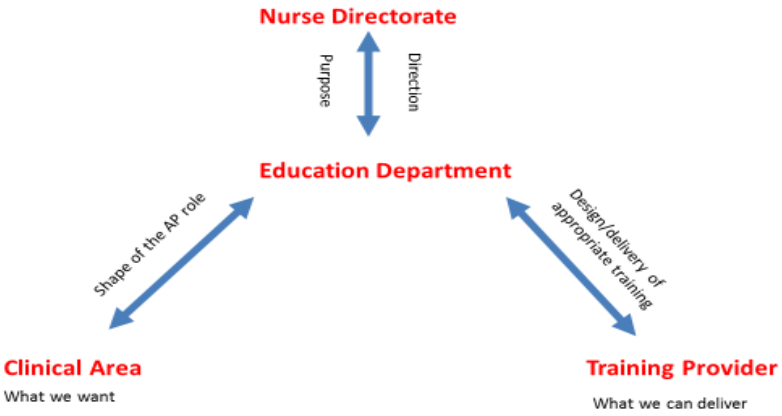

Table 3: Distribution of APs by Clinical Department (Number of APs)	
Hospital	
EH	**WH**
1. Emergency Assessment Unit (2) 2. Trauma and Orthopaedics (2) 3. Respiratory Medicine (2) 4. Gastroenterology (2) 5. General Medicine: • Ward G4 (2) • Ward G5 (2) • Ward G6 (2) 6. General Surgery: • Ward F4 (2) • Ward F5 (3) 7. Rehabilitation (2) 8. Endoscopy (2) 9. Stroke Unit (2)	1. Breast Care (2) 2. Cancer Services (4) 3. Emergency Assessment Unit (2) 4. Endoscopy (2) 5. Accident and Emergency (2) 6. Trauma and Orthopaedics (4) 7. Coronary Care Unit (1) 8. Care of the Elderly (1)

Table 4: Changes to Programme Design

	TAP Cohort 1	TAP Cohort 2
Numbers	21	10
Clinical areas/ funding	Top Down	Bottom up: wards volunteer
Recruitment	Internal & External	Internal Only
Training/Learning	-FD -Competences - Practical assessments	No Change
Pay Banding/ Progressions	Guaranteed Band 4 pay grade	Band 4 only if role available
Study Days	2	1
Supervision	1 practice supervisor	2 practice supervisors
AP Co-ordinator	30 hours a week	15 hours a week

Table 5: AP Tasks at WH	
Clinical Area	**AP Role**
A&E	Administering: paracetamol, ibuprofen, nebulizers and simple analgesia; 2nd nurse role in resuscitation room
Emergency Assessment Unit	Limited because cannot give drugs; occasionally managing group of patients
Trauma/ Orthopaedics	Working as 3rd trained nurse Plastering; removing casts
Breast Care	Booking appointments; informing on their condition; fitting prosthesis; simple wounds; most of health promotion work
Endoscopy	Running out-patient clinics
Cancer Services	Owning caseload; giving monoclonal antibodies; blood transfusions; intravenous immunoglobulin therapy; assisting with the bone marrow biopsy clinic; administering antibodies for analgesia.
Care of the Elderly	Managing complex discharges

Figure 3: Summary Findings		
	EH	**WH**
Sector level	**Permissive structure** 	
Organisational Level	**Agency**  **Restrictive structure**	**Agency**  **Permissive structure**
Department Level	**Weak agency**  **Workplace tensions**	**Strong agency**  **Workplace acceptance**