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Evaluating the Introduction of the Nursing Associate Role in Health and Social Care: Interim Report

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SUMMARY

The NHS People Plan (NHS 2020)[1] highlights the growing number of routes to joining the nursing workforce. One story featured in the Plan is that of a Nursing Associate working in Leeds (p45). This report focuses on how Nursing Associates, qualifying in early 2019, are being deployed across England by NHS and social care employers. It follows on from the Traverse review of the two-year training programme undertaken by the first 2,000 Trainee Nursing Associates (TNA). In general, this report explores whether and how the national policy objectives underpinning the introduction of Nursing Associates (NA) are being met, and the extent to which the consequences of the role are sensitive to the interests of various stakeholders – NAs themselves, their colleagues and services users/patients - and different contingencies such as care setting or locality.

In the first part of this evaluation, we:

- Reviewed the primary and secondary literature on support roles in health and social care;
- Conducted close to 40 expert interviews; and
- Administered a survey of Chief Nurses in NHS England.

In this interim report we present initial findings in three substantive sections:

- Context:
- Objectives and
- The NA Role in Practice.

Context: The NA role feeds into a long history of nursing support roles. It has, however, been presented by national policymakers as a new and distinctive role: registered and designed to deliver generic care while at the same time providing development opportunities for the individual postholder. With the regulatory arrangements for the role taking some time to complete, the 35 pilots were launched with considerable speed and a noteworthy degree of uncertainty about the nature of the role, leading in turn to organisational caution and incrementalism in deployment of the NAs.

Objectives: For national policy makers and practitioners, the principle objective of the role was to act as a 'bridge' between the care assistant and the registered nurse. However, reviewing the policy literature a sub-set of more refined aims was revealed:

- Supporting new care delivery models, particularly based on integrated, generic care and

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[1] https://www.england.nhs.uk/wp-content/uploads/2020/07/We_Are_The_NHS_Action_For_us_all-updated-0608.pdf

reflected in the generic nature of the new role;

- Freeing registered nurses to work in more advanced ways and in clinically complex care;

- Providing a new, more accessible stepping-stone into registered nurse training;

- Widening participation in the health and social care workforce by establishing new career opportunities especially for those often denied them in the past.

The first part of our evaluation has found that for health and social care employers the adoption of the NA role was informed by a combination of these objectives, albeit with an emphasis on its capacity to provide a stepping-stone into registered nurse training. More detailed analysis suggested that employer objectives engaging with the new role were often context specific, being rooted in local circumstances and needs: for example, in some cases the NA role was a timely opportunity to address a long running interest in re-structuring the nursing workforce; in others it was a unexpected opportunity to explore new ways of delivering care.

The NA role in Practice: In general terms, there was wide support at workplace level for the NA role, seen as a 'welcome addition' to the clinical team and plying a 'vital role' in care delivery.   At the same time, in fulfilling national and local objectives, employers were revealed as facing several challenges. In part these centred on securing stakeholder acceptance of the NA. It was striking, for example, that despite the NA being a registered role, a significant proportion of Chief Nurses still saw nurse delegation of tasks to NAs as a significant challenge. More telling as perceived challenges were finding a distinctive role for the NA and ensuring its integration into established ways of working.

The following themes emerged in a more detailed examination of the NA in practice, highlighting the nascent benefits and challenges associated with the role:

- **Strengthened partnership working**: Based on networks of health and social care provider organisations, the pilot sites had stimulated resilient forms of partnership working, and in some instances were said to be the first tangible example of the local STP/ICS (Sustainability and Transformation Partnership /Integrated Care System) working in a meaningful way.

- **New forms of work organisation**: The NA role was impacting on work organisation in a variety of ways:

- *Scale*: the number of qualified NAs in any given employer organisation remained low, limiting the role's impact to date on service delivery and the value of including them in workforce planning. Notwithstanding the pipeline of third and fourth wave TNAs, in some organisations the scope to scale-up the number of NAs remained uncertain, raising broader

questions about the employing organisation's training capacity and the level and distribution of training funds.

- **_Distribution_**: NAs had been allocated to a wide range of clinical areas, albeit with a concentration on medical and surgical wards.

- **_Workforce structure:_** Amongst some employers and more strikingly at local systems level in STPs, the NA role had prompted a strategic review of nursing workforces. These were often emergent strategies, with the introduction of the qualified NA not so much being driven by a workforce strategy as leading to the development of one. This strategy-making was underpinned by a considerable amount of detailed work on how the NA role safely fitted into different clinical areas, with implications for skills mix and establishment levels.

- **_Substantive posts_**: Almost all TNAs appeared to have found substantive posts on qualifying although there were residual concerns about whether those in the role would be working to their full potential.

- **_Improved Progression and support._** The dynamic between the development of the NA as a role valued in its own right and the use of the role as a stepping- stone into registered nurse training was still playing itself out at the organisational level. There was some variation across organisations and regions in the speed with which qualified NAs were moving into registered nurse training. However, in general, organisations appeared keener on supporting qualified NAs to bed-down in their new role and on helping them consolidate their skills, reflected not least in the widespread development of NA preceptorship programmes. There were, nonetheless, instances where qualified NAs had moved rapidly into registered nurse training.

Plans for the evaluation were for two further elements at the start of 2020:

- A survey of the 2,000 NAs from the two 2017 cohorts.

- A series of between 6-8 detailed case studies, covering different health and social care settings and exploring the deployment of the NA role in greater detail.

These activities were put on hold as the implications of the Coronavirus pandemic emerged, however two of the case studies were completed just before lockdown and are being reported separately. We are grateful to members of the Evaluation Advisory Group for their comments on these initial findings and to members of the Unit's Public and Patient Advisory Group for their help in exploring the findings and implications for patient and user experiences.

1. INTRODUCTION

The nursing associate (NA) is a new role introduced into the NHS and social care in the wake of Lord Willis' report, The Shape of Caring: Raising the Bar (Health Education England (HEE) 2015)[2]. Examining the education and training of the nursing workforce, the Willis report recommended a new role 'bridging' registered nurses and care assistants in health and social care. Following a period of deliberation by and consultation with policy makers and practitioners, the role emerged:

- with the title 'nursing associate';
- registered with the Nursing and Midwifery Council (NMC);
- positioned (in the NHS) at band 4 in the Agenda for Change (AfC) pay structure[3]; and
- requiring a two-year, level 5 qualification.

Overlapping with the development of the regulatory arrangements for the role, a government programme to employ trainee nursing associates (TNAs) was started. A set of 11 first wave sites became active in January 2017 comprising 1,000 TNAs, and, given the large number of organisational applications to develop the role, were complemented in April 2017 by 24 'fast follower' second wave sites taking-on a further 1,000 TNAs. These initial 35 sites were collectively referred to as the 'pilot sites'. The 'sites' corresponded not to a single NHS or social care employer, but to partnerships of such employers, mainly aligned to the footprint of the local Sustainability and Transformation Partnership (STP)[4]. In 2018, a third wave of 5,000 TNAs was recruited, with a fourth cohort of 7,500 TNAs announced in 2019.[5]

In Spring 2019, the NIHR Policy Research Unit in Health and Social Care Workforce (HSCWRU) at King's College London was commissioned by the Department of Health and Social Care (DHSC) to evaluate the introduction of the NA role. Health Education England (HEE) had previously commissioned the consultancy Traverse to assess the training undertaken by the 2,000 pilot-site TNAs, with reports on their findings produced in July 2018[6] (covering year 1 training) and October

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[2] https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

[3] https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-scales

[4] Whilst mainly aligned with the STP footprint, (T)NA partnerships varied in how closely they were connected to the STP infrastructure. This connection appeared to be tightening as the government set local targets for the recruitment of wave 3 and 4 TNAs, although in this report we do not explore in detail the (T)NA partnership-STP relationship.

[5] https://www.gov.uk/government/news/health-secretary-announces-nursing-workforce-reforms

[6] https://www.hee.nhs.uk/sites/default/files/documents/Phase%201%20OPM%20Evaluation%20Report%20%28002%29.pdf

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2019[7] (covering year 2 training). Following-on from the Traverse work, we were requested to evaluate the deployment of these 2,000 TNAs by NHS and social care employers, as they qualified in early to mid-2019.

In broad terms, our evaluation was designed to examine:

- the objectives underpinning the introduction of the NA role;
- whether and how employing organisations in different health and social care settings were seeking to realise these objectives; and
- how NAs were viewed and used by various actors with a stake in the role including the NAs themselves, their co-workers, particularly care assistants and registered nurses, team or ward managers, and people who use health and/or care services including carers.

In short, underpinning our evaluation was an interest in the NA role's ability to achieve certain policy objectives, and if so whether this capacity was sensitive to various situational factors and contingent on the perspective of different stakeholders.

The evaluation was conceived as tracking the NA role as it developed over several years. By mid 2020 the following elements of the study had been completed. This part of the study received ethical approval from King's College London on 29 March 2019 [8]:

- ***A review of primary and secondary literature***. With the NA so new, there were very few primary studies of the role. We have, however, explored primary research literature on more established support roles in health and social care. The secondary literature reviewed mainly took the form of policy documents and commentaries by various organisations related to the development of the NA role.
- ***A series of expert interviews***. Thirty-nine expert interviews were carried out during the Spring and Summer, 2019. The experts included policy makers, employers, practitioners, patient and care user representatives or advocates, and researchers with a stake or interest in the NA role. (A list of organisations covered is included in Appendix 1 of this report.) These policy makers and practitioners were positioned at different levels of the health and social care system: national, regional and workplace.
- **A survey of Chief Nurses in English NHS Trusts**. This survey was administered in autumn 2019. Around 100 responses were received including 47 from Trusts employing a qualified

[7] https://www.hee.nhs.uk/sites/default/files/documents/15.1%20-%20Trainee%20Nursing%20Associate%20Year%202%20Evaluation%20Report_0.pdf

[8] Reference number: MRA-18/19-11438

NA, in other words, from the first two waves. With around 120 health and social care employers involved in the first wave pilots, this 47 represent 40% of these organisations. The survey data are yet to be fully processed but we present basic frequencies in this report. Given our focus, we use those frequencies drawn from the 47 organisations employing qualified NAs. (The breakdown on these respondents by healthcare setting is set out in Appendix 2.)

In addition, a project infrastructure was established. This included a project advisory group comprising experts from various stakeholder organisations including public and patient representatives, and convened for a meeting in July 2019 (with the second taking place mid-January 2020). Moreover, the project has engaged with the Unit's Public and Patient Advisory Group, presenting to and discussing with its members, the project proposal, and seeking feedback and input into the design of various research instruments, for example, the Chief Nurse survey questionnaire. Plans for a survey of 2000 NAs from the first two cohorts had to be set on hold as the Coronavirus pandemic took hold in early 2020 as were the planned 6-8 case study sites in-depth exploration of the NAs in practice. However, data from visits to two case study sites were successfully obtained just before lockdown and findings are reported separately.

In this interim report the findings from the literature review, the expert interviews and the Chief Nurse survey are presented in the form of an integrated narrative covering:

- **Nursing Associates in context**: exploring the emergence of the NA role, particularly in terms of national policy.
- **The objectives of the NA programme**: examining the aims underpinning the introduction of the NA role, viewed from both the national and local perspectives.
- **The NA role in practice**: providing an early assessment of how the role is being deployed and settling down at the organisational level, with a focus on benefits and challenges associated with it.

Each of these themes is considered in turn, with a final section summarising and concluding.

2. CONTEXT

2.1 The NA Role and the Structure of the Nursing Workforce

The emergence and future deployment of the NA role in NHS England and social care relate to longstanding debate and changing practice on the structure of the nursing workforce. The failure of the nurse profession to secure full occupational closure on the creation of the nurse register in 1919[9] has provided ongoing scope for a range of occupations to contribute to the delivery of nursing care[10]. This includes a strata of support workers routinely assisting registered nurses and becoming an established part of the health and social care workforce. In the context of fragile occupational boundaries[11], the development of different nursing support roles has created periodic tensions, often centred on job territories and jurisdictions[12]. For example, whilst a longstanding part of the health workforce, healthcare assistants were not accepted as full members of the Royal College of Nursing (RCN) until 2011.

Three policy junctures have been significant in configuring the relationship between registered nurses and support workers, and are essential to framing an evaluation of the NA role:

- The first was the establishment of a regulated second tier of nursing with the emergence of the registered **State Enrolled Nurse** (SEN) in 1940. The SEN was principally a response to wartime shortages of registered nurses[13], although a regulated second tier of nursing is a common feature of nursing workforces internationally. [14]
- The second policy juncture was a major reform of nurse education following a report from the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting in 1986, **Project 2000[15]**. Government implementation of the report's key recommendations in the 1990s saw nurse education transformed from a largely on-the-job training model delivered through hospital schools of nursing, to one based on a university or college

[9] Abel-Smith, B. (1982) A History of the Nursing Profession, London: Heinemann

[10] Kessler, I. Heron, P. and Dopson, S. (2015) Professionalization and Expertise in Care Work, The Hoarding and Discarding of Nursing Tasks, *Human Resource Management, 54(5):737-52*

[11] Nancarrow, S. and Borthwick, A. (2005) Dynamic professional boundaries in the healthcare workforce, *Sociology of Health and Illness*, 27,7, 897-919.

[12] Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labour*. Chicago: University of Chicago Press.

[13] Seccombe, I. Smith, G. Buchan, J. and Ball, J. (1997) Enrolled Nurses: A study for the UKCC, Brighton: IES.

[14] Kessler, I., Heron, P. and Dopson, S. (2012) *The Modernisation of the Nursing Workforce: Valuing the Healthcare Assistant*: Oxford: Oxford University Press.

[15] Bradshaw, A. (2001) The Project 2000 Nurse, Oxford: Wiley-Blackwell.

taught diploma and later degree level qualification. As part of the process, programmes to create new SENs were phased out, and with the student nurse's time now evenly split between learning in education and practice settings, the long-established nursing auxiliary developed into the healthcare assistant (HCA), explicitly seen by policy makers as the principal source of support for registered nurses in the delivery of frontline care[16].

- The third significant policy juncture saw the emergence of the ***assistant practitioner*** (AP), initially developed by the NHS Modernisation Agency in the early 2000s as one of several new health and social care work roles[17]. Conceived as a senior support worker role with the scope to undertake more clinically complex tasks, the AP remained an unregistered role, requiring a level 5 qualification, typically graded at AfC pay band 4, and positioned not only as a nursing role but also to assist a range of allied health professionals (such as occupational therapists).

Despite its growing importance to care delivery, the evidence base on the health and social care support workforce has been patchy[18]. Nonetheless, in general terms it suggests the following:

- **Workforce numbers:** The growth of the nursing support workforce has been relatively significant over the last decade. The most recently available timeline from September 2009 to July 2019 indicates that while the number of nurses (and midwives) increased from 278,470 to 288,205, the number of nursing support workers rose at a proportionally faster rate from 134,153 to 158,181[19]. More specifically, while the take-up of APs has been uneven across health and social care providers, it remains a resilient part of the workforce[20] [21].

- **The nature of support roles**: Nursing support roles have assumed a variety of forms, ranging from the performance of routine ancillary tasks to more clinically complex ones.

[16] Grimshaw, D. (1999) Changes and skill mix and pay determination amongst the nursing workforce in the UK, Work, Employment and Society, 15(2)

[17] Department of Health (2000). *A Health Service of all the Talents: Developing the NHS Workforce*. London: DH.

[18] Manthorpe J and Martineau S (2008)
https://www.kcl.ac.uk/scwru/pubs/2008/manthorpeandmartineau2008support.pdf

[19] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/july-2019

[20] Kessler, I. and Nath, V. (2019) Re-evaluating the Assistant Practitioner role in NHS England: Survey Findings, *Journal of Nursing Management*, 27(3): 625-632.

[21] Buchan, J. et al (2019) Falling: The NHS Workforce Challenge, London: The Health Foundation.
https://www.health.org.uk/publications/reports/falling-short-the-nhs-workforce-challenge

In general, however, such support roles have extended over the years to undertake an increasingly wide range of frontline care tasks[22].

- **The management of support roles**: Whilst acknowledging different organisational approaches, the management of nursing support roles has often been under-developed. Career opportunities have been limited, while pay has become disconnected from the size of the role and the capabilities acquired through accredited training[23]. These shortcomings were acknowledged by the Cavendish Review[24], which prompted, in turn, the introduction of the Care Certificate, founded on a more thorough (if short and not mandatory) induction for support workers in health and social care, and the formulation of the first national strategic framework for training and development of such workers, Talent for Care[25].

- **The consequences of support roles**: The evidence base on the consequences of support workers, particularly for clinical outcomes, has been varied in character and far from conclusive. Qualitative findings have highlighted the positive impact of support workers on people who use health services. For example, APs in bespoke roles with specialist capabilities, have improved service user/patient well-being in several ways and in various contexts[26][27][28]. More generally, healthcare assistants, with more time for bedside contact than registered nurses, and drawing on often well-developed tacit caring skills[29], have been able to provide service users/patients with emotional and pastoral support, especially in acute care settings[30].

  By contrast, quantitative research findings have suggested a less clear-cut picture on the relationship between service users/patients and support workers. Thus, the dilution of skill mix, in particular, has been presented as negatively related to certain clinical

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[22] Kessler, I., Heron, P., Dopson, S. (2013) Indeterminacy and task allocation: The shape of support roles in healthcare. *British Journal of Industrial Relations,* 51:2, 310-322*.*

[23] Kessler, I. Heron, P. and Dopson, S. (2012). The Modernisation of the Nursing Workforce: Valuing Healthcare Assistant. Oxford: Oxford University Press.

[24] Cavendish, C. (2013) The Cavendish Review, London: HMSO

[25] HEE (2015) Talent for Care, Cambridge: HEE

[26] *Harrison, D. and Virden, F. (2011). Assistants practitioners lead the way. British Journal of Healthcare Assistants, 5(8), 409.*

[27] Miller L, Williams J, Marvell R, Tassinari A (2015*). Assistant practitioners in the NHS in England.* Bristol: Skills for Health.

[28] Kessler, I. and Nolan, R. (2018) Constructing an assistant practitioner role in a children's community tram. *British Journal of Health Care Assistants*, 12(9): 398-404.

[29] Thornley, C. (1997). *The Invisible Workers: An Investigation into the Pay and Conditions of Healthcare Assistants in the NHS.* London: Unison

[30] Kessler, I. Heron, P. and Dopson, S. (2015) Managing patient emotions and being one of us, *Work, Employment and Society*,29(5): 775-791.

outcomes. This research, however, needs to be treated with some caution. Most quantitative studies have been undertaken in acute health care settings, often in overseas healthcare systems, for instance in the United States (US)[31]. Typically, these studies have weakly theorised the relationship between support workers and a narrowly conceived clinical outcome, usually mortality[32]. Moreover, given the newness of the role and relatively small numbers in post, researchers have not as yet extended this statistical approach to the introduction of the NA role.

The latter limitation is an important one given that the NA role has been presented by policy makers and practitioners as distinctive from previous support roles. The NA's distinctiveness has been seen to rest on the following:

- **Generic** : In contrast to the AP role, which, as implied, often developed as a specialist role in particular care settings, the NA has been conceived as a generic role with the capacity to provide holistic care sensitive to overlapping physical, mental health and social care needs. As HEE, in defining the NA role, stated:

  > The nursing associate is a new support role in England that bridges the gap between healthcare support workers and registered nurses to deliver hands-on, *person-centred care* as part of the nursing team[33].

  Similarly, NHS Employers in guidance on the role noted:

  > The nursing associate is a new generic nursing role in England that bridges the gap between healthcare support workers and registered nurses, to deliver hands-on, *person centred care* as part of the nursing team.

  This emphasis on generic care is reflected in the curriculum for NA training which covers the different branches of nursing - adult, children, mental health and learning disability - and in the availability of training placements in various settings - in hospital, at home and close to home. As the NHS England Interim People Plan noted:

  > They (NAs) are educated to work with people of all ages and in a variety of settings across health and social care, including in hospices, in community nursing teams and nursing homes, and in acute inpatient, mental health, learning disability and offender health services.[34]

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[31] For example: Aiken LH, Clarke SP, Sloane DM, *et al* (2002) Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA **288**:1987–93

[32] For example: Ball, J et al (2018) Post-operative mortality, missed care and nurse staffing: a nine country cross sectional study, International Journal of Nursing, 78:10-15
[33] https://www.hee.nhs.uk/our-work/nursing-associates

[34] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

- **Developmental**: The NA role has also been designed to provide development opportunities, particularly supporting career progression into pre-registration nurse training. This contrasts with the SEN role, which, as our lay members of our advisory group and others commented, was often seen as a 'dead-end' in career terms and discriminatory:

  > The thing we really wanted to guard against was reinventing the state enrolled nurse, because it was a complete career cul-de-sac and exploitative. (Expert Interviewee)

- **Registered**: In contrast to the AP, the NA is a registered role. Indeed, with a separate section on the Nursing and Midwifery Council register, the NA has been presented as a 'new profession', with its own occupational identity albeit covered by the same of Code of Practice[35] as registered nurses and midwives:

  > By virtue of having their own part of the register, they (NAs) are a professional because they have done the training needed to get onto that part of the register. (Expert Interviewee)

Whilst distinctive, the NA role remains connected to the history of the nursing support roles in health and to a more limited extent in social care. Thus, despite differences in their registered status, the NA has features in common with the AP role: both require a level 5 qualification, and both are notionally positioned in NHS England at Agenda for Change (AfC) pay band 4. It is also important to note that the distinctiveness of the NA role was evolving in policy terms even as the first two cohorts of (T)NAs were being recruited and as they progressed through their two years of training.

2.2 Policy Developments

The evolution of the NA role in parallel with the launch of the first and second wave pilot sites, is an important backdrop to our evaluation of the deployment of qualified NAs. Those employers participating in the 2017 pilot sites were in effect committing[36] to a new role if not 'blindfolded' then certainly with a limited appreciation of the form it would eventually take. The scope for the role to evolve in uncertain ways following its launch in 2017 was apparent in two senses.

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[35] https://www.nmc.org.uk/standards/code/

[36] It was indeed a commitment because as part of the application process pilot partners largely undertook to provide substantive post for NAs on qualification. This was another difference with the development of the AP role, where it is was not uncommon for workers on completing their AP training to find that there were no substantive AP posts for them to fill. This rendered them 'overqualified' HCAs, frustrated in their inability to progress in career terms and to fully use the skills they had developed.

First, the policy making process underpinning the NAs' introduction had not been completed when the pilot sites were launched. HEE, a non-departmental, arms-length public body established under the Care Act 2014, had undertaken a nationwide consultation between January and March 2016[37], revealing support from the sector's practitioners for such a role. The 35 selected pilots were aware that the NA role would be registered with the NMC.[38] This was confirmed in November 2016 when the NMC was formally asked to regulate the role. The NMC, in turn launched its own consultation on NA regulation in January 2018[39], becoming the role's legal regulator in July 2018. The most striking consequence of this rolling process of policy development was the need for HEE to formulate a (T)NA framework curriculum[40] before the NMC had developed its own, underpinned by NA standards of proficiency. However, the HEE worked closely with the NMC in the development of the NA framework curriculum, and in the meantime quality assured the training programmes adopted by the NA pilot sites. These programmes were all approved by NMC subsequently. The statutory instrument opening the NMC register to NAs made specific reference to those completing the HEE designed and assured programme as being qualified to join the register[41], although before registering these NAs were assessed against the NMC's standards of proficiency, so reducing the risk to public safety.

Second, the evolution of the NA was the inevitable consequence of a new healthcare role 'hitting' the workplace and seeking to integrate itself into health but also social care contexts governed by often long-established procedures and ways of working[42] [43]. These evolutionary challenges were particularly significant for a generic role explicitly designed to be taken-up in diverse care settings. Indeed, it is noteworthy that the national oversight group set up to

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[37] https://www.rcr.ac.uk/sites/default/files/hee_final_response.pdf

[38] Applications to become a pilot site closed on 10 August 2016
https://www.contractsfinder.service.gov.uk/Notice/f3d7efb2-3c47-4360-93fa-8f963cf2f12f

[39] https://www.nmc.org.uk/news/news-and-updates/nmc-response-to-hee-nursing-associate-consultation-findings/

[40] https://www.hee.nhs.uk/sites/default/files/documents/Nursing%20Associate%20Curriculum%20Framework_1.pdf

[41]
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703838/Regulation_of_Nursing_Associates_in_England_-_government_response.pdf

[42] Reay, T., Golden-Biddle, K. and Germann, K. (2006) Legitimizing a new role: Small wins and micro processes of change. *Academy of Management Journal*, 49, 977-998.

[43] Kessler, I. Heron, P. and Spilsbury, K. (2017) Human resource management innovation in health care: the institutionalisation of new support roles, Human Resource Management Journal, 27(2):228-245

support the implementation of the NA role and comprising representatives from various organisations (including RCN, Unison, the NMC and NHS Employers) decided not to develop a national NA job description[44] [45]. Instead it issued a guidance note setting out a series of key questions to be asked by employers in drafting their job descriptions and person specifications for the role. As this guidance noted:

> The nursing associate role will be deployed in a wide range of settings and services across health and social care in England. For this reason, there can be no prescriptive 'national' job description for nursing associates[46]

More generally, a range of documents and statements was produced by influential bodies to inform and guide health and social care organisations as they deployed the NA role, for example:

- National Quality Board (NQB) (2018), An improvement resource for the deployment of nursing associates in secondary care[47].
- HEE (Feb.2018), Advisory Guidance: Administration of medicines by nursing associates.[48]
- Care Quality Commission (CQC) (Jan. 2019), Briefing for providers: Nursing associates.[49]
- NHS Employers (Feb. 2019), Employer guide to nursing associates.[50]

These documents assumed significance not only as useful advice, but as an influence on how employers viewed and used the NA role. This material was influential in two domains. The first related to safe staffing, directing employers to the use of highly robust systems and procedures in deploying the NA role. Both the NQB and CQC documents provided guidance on how the NA should be managed and developed to ensure safe staffing levels and an appropriate skill mix in different care settings. It was suggested, for example, that the introduction of the NA in any care setting be predicated on a quality impact assessment alongside the use of a recognised skill mix tool.

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[44] This group did produce a job description for the TNA role

[45] It is worth noting that for very similar reasons there is no national job description for the registered nurse role in NHS England.

[46]https://www.hee.nhs.uk/sites/default/files/documents/Nursing%20Associate%20Job%20Description%20Guidance%20.pdf99

[47] https://improvement.nhs.uk/documents/3649/Nursing_associates_in_secondary_care_.pdf

[48] https://www.hee.nhs.uk/sites/default/files/documents/Advisory%20guidance%20-%20administration%20of%20medicines%20by%20nursing%20associates_0.pdf

[49] https://www.cqc.org.uk/news/providers/briefing-providers-nursing-associates

[50] https://www.nhsemployers.org/nursingassociates

A second domain centred on the administration of medicines, as reflected in the advice provided by the HEE following the deliberations of an expert working group. As an activity, medicine administration gave a hint of the NA's potential to contribute to service delivery, whilst at the same time highlighting the residual discretion available to employers on how they used and shaped the role. Employers retained a choice as to whether NAs would administer medicines, a decision contingent on their willingness to manage local clinical governance issues and develop the necessary organisational protocols and or policies. As the NQB noted:

> Like other registered professionals. NAs can develop extra skill and knowledge before and after registration, and their practices is not limited to their initial competencies.

More prosaically, the deployment of the NA was supported in several other ways by various agencies:

- HEE set up a NA website[51] which included several short case study reports on how the NA role has been used and developed in various organisations.
- NHS I/E ran a series of webinars including presentations for NHS Trusts on their experiences with the role and maintains a site comprising useful material on the role.
- HEE's seven regions organised NA deployment workshops including two in HEE London, three in HEE Kent, Surrey and Sussex, and one in the South West.
- The NMC placed several illustrations of personal NA experiences on their website.[52]

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[51] https://www.hee.nhs.uk/our-work/nursing-associates

[52] https://www.nmc.org.uk/standards/nursing-associates/na-case-studies/

3. OBJECTIVES

In broad terms, the key objective underpinning the introduction of the NA role was to provide 'a bridge' between health and care assistants and registered nurses. However, a review of policy and practitioner documents and statements indicates that the role was informed by a variety of aims. There is value in unpacking and exploring the nature of and relative weight placed on these different aims by national and local stakeholders. Indeed, moving forward with our study, the stated objectives become an important means, if not the only one, of evaluating the implementation of the new role.

3.1 The National Perspective

The review of the national policy literature and the expert interviews, revealed the following closely related, but distinctive, objectives for the NA role:

- **To Create a New Senior Support Role**

    Best reflecting the intention to establish a new 'bridging role', this objective presented a new registered senior nursing support role positioned between care assistant and registered nurse, as valuable in its right[53], contributing to improved generic care[54]:

    > I see the role as a support role for registered nurses; I see it as a role that will improve patient care and the delivery of hands-on care; I see the role as an important role in its own right, in that it will support patient care and improve patient experience. (Expert Interviewee)

    > What the nursing associate is bringing is knowledge across the four fields and the lifespan; that's what person-centred is, and then looking at the person in front of you, not just the bit of them that your service looks after. (Expert Interviewee)

    > You couldn't just keep layering things onto care assistants. You needed a role that had a standardised level of education and training; that fitted between the two; but a role that also had more generic knowledge across the field, that was much more person-centred. (Expert Interviewee)

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[53] Indeed, it was the House of Common Health Committee which in a recent report on the nursing workforce described the NA as a 'role in its own right'.

https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

[54] There are examples of 'bridging' senior support roles being developed alongside other professional groups: for example, the higher-level teaching assistant in education and the paralegal in the legal profession.

For the NQB, the NA was a role 'bridging the skills gap between care support workers and more senior registered professionals'. While the latter would continue to be the primary assessors and prescribers of care, 'the NAs (could) deliver and adapted care contributing assessment within agreed parameters'. The NQB presented these differences in the scope of practice between NAs and RN by contrasting the platforms for the NMC standards of proficiency[55]. The NQB table, reproduced below, indicates shared platforms, for example an accountable professional, but also important differences: thus, the NA monitors, while the RN assesses needs, plans and evaluates care; the NA works in a team while the RN leads and manages care.

Table 1: NA and RN Standards of Proficiency Compared (*Differences*); source NQB

Platform	Nursing associate (NA)	Platform	Registered nurse (RN)
1	Be an accountable professional	1	Be an accountable professional
2	Promoting health and preventing ill health	2	Promoting health and preventing ill health
3	*Provide and monitor care*	3	*Assessing needs and planning care*
		4	*Providing and evaluating care*
4	*Working in teams*	5	*Leading and managing nursing care and working in team*
5	Improving safety	6	Improving safety
6	*Contributing to integrated care*	7	*Co-ordinating care*

- **To support new forms of service delivery**

In part related to the development of a generic role to support the provision of holistic care, the NA was more broadly seen to support delivery of integrated care. As the NQB stressed in framing the NA role:

> The NHS is striving to develop new models of delivery that are more patient-centred and enable treatment and care to be provided at home and closer to home.

The NA role aligned with the more integrated delivery in terms of its generic quality:

> For the employer, what they (NAs) bring to the table, with health and social care integration, is a person who's trained across all those areas, and it's the ultimate flexible worker, because they've been health care, they've been social care, they've been mental health, community, GP, they've seen it all. (Expert Interviewee)

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[55] These are the standards of proficiency the NA must meet to register. There remain opportunities for the NA to develop their scope of practice once registered and in post.

The role also aligned with integrated care delivery in terms of how it was developed and supported. It has already been observed that the NA partnership sites typically matched the STP/ICS footprints. The DHSC mandate to HEE 2018-19 also noted:

> The partnership sites for the new Nursing Associate role will see trainees being offered experience across a range of health and social care settings. This will help provide the preconditions for integrating health and social care by 2020. [56]

- **To provide additional support for registered nurses**

The establishment of the NA was seen to have positive 'knock-on' consequences for registered nurses. Given the long history of inter-occupational tensions in the NHS workforce, it is unsurprising that the NA, as it acquired tasks and responsibilities, was viewed with caution by the Royal College of Nursing (RCN). However, in taking on these very tasks and responsibilities, the role was conceived by national policy makers as generating benefits for the registered nurse profession. These benefits have been framed in different ways, for example:

- *Releasing registered nurse time* to focus on key tasks, as suggested by the then Chief Nursing Officer for NHS England:

> The new role has clear benefits for registered nurses, providing additional support and releasing time to provide the assessment and care they are trained to do, as well as undertake more advanced tasks. This will ensure we use the right skills in the right place and at the right time.[57]

- *Freeing-up nurses*, as highlighted by a recent report on the nursing workforce by the House of Commons Health Committee:

> Nursing Associates are intended to supplement nurses rather than replace them but may ease pressure by freeing up registered nurses' time for tasks that require their degree-level skills[58].

- *Allowing nurses to work to the full extent of the licence,* as stressed by the NQB*:*

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[56]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/781757/DHSC_mandate_to_Health_Education_England_-_April_2018_to_March_2019.pdf

[57]
https://www.hee.nhs.uk/sites/default/files/documents/Nursing%20associate%20%20key%20stats%20and%20fact%20(1).pdf

[58] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

NA skills and proficiencies not only help to meet patient/clients but frees up more senior professionals to work to the full extent of their licence.

As an expert interviewee noted, in outlining the purpose of the NA role:

> If you look at every staff nurse's tasks they'll be things in there that don't require a registered general nurse to do, and because they (RNs) are at such a premium and there's such a shortage of them, it's better if we focus them on doing what only an registered nurses can do and that other people who are properly trained and supported can take on some of those other tasks.

- **Lowering nurse turnover**

Underlying the objective of freeing-up nurses to undertake more advanced tasks was the desire to reduce workplace 'burdens' and stresses, so improving nurses' quality of working life and encouraging them to remain within their employer and the NHS:

> By introducing this (NA) role to support other qualified practitioners you make a working environment that's more conducive to retaining staff and so you're less likely to have vacancies. (Expert Interviewee)

More explicitly, addressing the problems of nurse recruitment and retention, was the use of the NA role as a stepping-stone into registered nursing training.

- **To support career progression into registered nursing**

'Grow-your-own' has been established employer approach to developing a 'pipeline' of registered nurses for some years[59], although its capacity to deal with nurse shortages should be viewed with caution: given the length of nurse training, it has never been a 'quick fix'; funding to support seconded or part-time nurse training had been limited; and with HCAs often graded at AfC pay band 2 with at best a level 2 or 3 qualification[60] the leap to a degree level band 5 RN role has typically been a large one. The NA has been seen as providing a new and more accessible career stepping-stone, particularly for existing HCAs, into nurse training, in the process refreshing and boosting the supply of registered nurses. As the Interim NHS People Plan noted:

> Our ambition must be to drive towards a supply balance for nursing that meets the demands of health and care services, centred on a domestically grown workforce. This will require a focus on (*inter alia*) (added): providing clear pathways into the profession and further developing additional entry routes through the nursing

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[59] Malhorta, G. (2006) Grow Your Own, London: The King's Fund
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/grow-your-own-creating-conditions-sustainable-workforce-development-gita-malhotra-kings-fund-3-august-207706.pdf

[60] Kessler, I. Heron, P. and Dopson, S. (2012). The Modernisation of the Nursing Workforce: Valuing Healthcare Assistants. Oxford: Oxford University Press.

associate qualification and apprenticeships …(and) expanding the pilot programme for nursing associates wishing to continue their studies to registered nurse level[61].

This aim was further reflected in the comments of the then Secretary of State for Health:

> This new (NA) role will enhance patient care and open-up a career in nursing for thousands of people, as well as providing opportunities for existing staff who want to progress to become registered nurses.[62]

Indeed, the Nursing Times reported the DHSC Chief Nursing Officer as saying:

> By asking the NMC to regulate the role, the secretary of state is establishing a clear pathway for aspiring nurses, through education and training, supported by regulation that can give confidence to patients and employers that this will be an important role in our NHS workforce of the future [63].

It was a view echoed by an expert interviewee:

> Because of the strong link with nursing and, in particular, the policy remit aspect of it, which was 'we want it to be a progression route to nursing', if it was the NMC then it could design the standards so they fitted together well, and it was easier for HEIs (higher education institutions) to create progression routes.

- **To widen participation in health and social care workforce**

The NHS has long sought to widen participation in the NHS workforce, in recent years explicitly driven by the NHS Constitution which commits to a workforce that reflects the community it serves. This aim is reflected in HEE's Widening Participation strategy published in 2014[64]. More recently, the HEE mandate 2018-19 noted:

> HEE will build on their programme of work for improving social mobility and widening participation to further increase opportunities for people from disadvantaged backgrounds to gain a career in the NHS.

Open to and mainly taken up by healthcare assistants[65] already working mainly in NHS and some social care organisations, the NA role aims to be of value in its right by providing a new

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[61] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

[62] https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2017-19/Government-response-to-nursing-workforce-report-17-19-Cm-9669.pdf

[63] Nursing Times 30 Nov. 2016 https://www.nursingtimes.net/news/professional-regulation/jeremy-hunt-asks-nmc-to-regulate-new-nursing-associate-role-30-11-2016/

[64] https://www.hee.nhs.uk/sites/default/files/documents/Widening%20Participation%20it%20Matters_0.pdf

[65] The Traverse Report revealed that most of the two waves of TNAs were taken-up by internal trust employee, typically HCAs. Over time, the external labour market for qualified NAs looks set to develop, providing health and social care employers with the scope to recruit them.

and viable career pathway to individuals often denied life chances and development opportunities:

> There was a huge cohort of health care support workers that were hungry for more development, but just didn't have a pathway into registered nurse training, and now they have that. (Expert Interviewee)

> We hadn't got a really formal career structure for our healthcare assistants and we wanted to grow one, we'd need to retain the staff we've got and develop them, to keep them in the region. (Expert Interviewee)

From diverse, typically lower socio-economic backgrounds, sometimes let down by the education system in their younger days, HCAs are likely to be deeply embedded in the local community, and experienced, highly valued members of their organisation's workforce[66]. The scope for the NA role to support career development of employees was hinted at by a former health minister:

> This new (NA) role, and the opportunity it offers for those who want to progress to a registered nurse, will open up a career in nursing for thousands of **people from all backgrounds**[67]. (Ben Gummer MP, Emphasis added).

It was also emphasised in the House of Commons Health Committee's report on the nursing workforce:

> We welcome the new role of Nursing Associate…. which adds diversity to the workforce as a route onwards for aspiring nurses for whom the traditional undergraduate route is not an option…..It will enable Healthcare Assistants, who previously had few career progression options or opportunities for further training to become Nursing Associates.[68]

As an expert interviewee noted:

> If you look at the widening participation debate, it's (the NA programme) probably one of the best models of widening participation we'll ever see…. We've been talking for years about trying to open up pathways into the professions and getting past 'A' levels and utilising skills and experience; the nursing associate, that foundation degree, does that because it recognises people's skill experience gained at the workplace, takes it into an academic setting and delivers something that's measurable in academic terms.

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[66] Kessler, I. Heron, P. and Dopson, S. (2012). The Modernisation of the Nursing Workforce: Valuing Healthcare Assistant. Oxford: Oxford University Press

[67] https://recipeforworkforceplanning.hee.nhs.uk/Portals/0/HEWM_LinksAndResources/Response%20to%20Nursing%20Associate%20consultation%2026%20May%202016.pdf?ver=2016-06-29-110005-797

[68] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

While the various objectives for the NA have been clearly articulated by national policy makers and practitioners, for individual health and social care employers the capacity to establish a clear predictive rationale for the role has been less straightforward. For those employers in the pilot sites, establishing how a new role might further and support organisational ends was difficult while uncertainty remained about the nature of that role. For example, piloting a role before its standards of proficiency were formally established made it difficult to assess how effectively the role could bridge the gap between HCAs and registered nurses. Indeed, it might be argued that local aims for the NA role were emergent rather than predictive or planned, developing gradually on completion of the policy-making process and as the role's scope and potential became fully apparent in practice. Notwithstanding these concerns about local objective-setting, our Chief Nurse survey asked about the objectives informing the introduction of the NA role. Survey respondents were asked how much importance (on a five-point scale from considerable importance to no importance at all) they attached to different objectives, and then requested to select the three most important of these objectives. Indeed, in asking Chief Nurses about objectives for the role, we were tapping views on how they felt the role would benefit their Trust.

Tables 2 and 3 below present the findings from those 47 respondents employing NAs from the wave 1 and 2 sites and indicate the following:

- Trusts adopted the NA role for multiple reasons, implicitly viewing the role as generating a number of organisational benefits. Thus, many of the reasons listed were seen of 'considerable' or 'some importance' by a substantial proportion of respondents. The one reason not seen as being of importance was adopting the NA role to address financial pressures: around two-thirds of respondents attached little or no importance to this reason. In short, cost saving was not to the fore in the decision to take-up the NA role.
- While adopted for a range of reasons, there were differences of emphasis placed on the different listed objectives. A high proportion of respondents attached 'considerable importance' to the NA as a bridging role (63.8%), in other words as an end in its own right:

    The main driver for the ongoing development (of the NA) within our organisation was working to make the roles meaningful in their own right, and linked to

workforce planning, rather than a stepping-stone to registration. (Survey Respondent 50363353[69])

- More typically, emphasis was placed on using the NA role as a mean to end. Thus, over three-quarters of respondents attached 'considerable importance' to: using the NA role to grow their own nurses (76.6%); freeing -up their nurses (78.7%); and providing career opportunities for their HCAs (78.7%).

- Asked to prioritise objectives, the NAs' interface with registered nurses emerged as particularly important. Thus, by far the most important objective, selected by almost half of the respondents (46.8%), was using the NA role as a career pathway into registered nursing. A quarter (25.5%) saw freeing up nurses as the most important objective, with fewer (14.9%) viewing the development of career opportunities for HCAs as the top priority.

- It is unsurprising that few respondents saw the achievement of (T)NA target as key reasons for introducing the role: such targets have been used more in relation to waves 3 and 4 (T)NAs. More striking is the relative lack of support for service re-design as an objective for the role, possibly indicative of the role still bedding-in and finding a place at the workplace level.

Table 2: How much importance do you attach to the following as reasons for the introduction of a nursing associate role in your organisation?

	% (N=47)					
TO:	Considerable Importance	Some Importance	Little importance	No Importance	Don't know	No answer
Grow our own 'registered nurses'	76.6	19.2	4.3	0	0	0
Free up registered nurses to perform other, more complex/specialist tasks	78.7	17.0	4.3	0	0	0
Retain healthcare support assistants by providing them with new career progression opportunities	78.7	21.3	0	0	0	0
Reduce labour costs through changes to skill mix	10.6	19.2	46.8	19.2	4.3	0

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[69] This number of is the unique respondent identifier

Create a bridging role between healthcare assistants and registered nurses	63.8	27.67	6.4	0	0	2.1
Facilitate service re-design	40.4	40.4	12.8	0	4.3	2.1
Meet STP (or other) targets for the recruitment of nursing associates	12.8	31.9	31.9	12.8	8.5	2.1

Tale 3: Which of the reasons listed do you think are the three most important in your organisation?

	% (N=47)		
	Most important	**Second most important**	**Third most important**
To grow our own 'registered nurses'	46.8 (22)	10.6 (5)	19.2 (9)
To free up registered nurses to perform other, more complex/ specialist tasks	25.5 (12)	29.8 (14)	14.9 (7)
To retain healthcare support assistants by providing them with new career progression opportunities	14.9 (7)	27.7 (13)	29.8 (14)
To reduce labour costs through changes to skill mix	2.1 (1)	0 (0)	4.3 (2)
To create a bridging role between healthcare assistants and registered nurses	8.5 (4)	17.0 (8)	19.5 (9)
To facilitate service re-design	2.1 (1)	8.5 (4)	6.38 (3)
To meet STP targets recruitment of nursing associates	0 (0)	2.1 (1)	4.3 (2)

A more nuanced and detailed sense of the objectives shaping the introduction of the NA role was provided by expert interviews with senior nurse managers from four NHS Trusts.[70] The Trusts included as part of our expert interviews were drawn from different healthcare settings: two were acute Trusts; another was a mental health Trust; and two were community healthcare Trusts. Moreover, they came from a variety of English regions - two from the north, one respectively from the midlands and the south. They also varied in the number of (T)NAs they had taken, ranging from a two Trusts taking on only around half-a-dozen NAs in these early waves to another taking on close to 50 at this time.

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[70] Six senior nurse managers were involved in the interviews covering these four Trusts.

In general, the Trusts' nurse managers shared an interest in the NA role as part of a broader desire to re-structure their nursing workforces. In other words, the NA was viewed not solely as a new role to be slotted in the nursing team, but as the basis for a more radical review and re-distribution of tasks and responsibilities within that team. However, the Trusts came to this point in different ways:

- **Trust 1 (Acute) (40 NAs): A strategic engagement with the NA role.**

In Trust 1 the re-organisation of the nursing workforce had been a long-term project, pre-dating the introduction of the NA, and partly in response to recruitment and retention pressures which suggested 'we were not going to have enough clinical staff available to provide care'. It was a challenge which prompted this Trust to consider the role to be played by 'the 21st century registered nurses':

> We needed to be thinking differently on two tracks: one, what the registrant (nurse) was going to do, but two, what the other roles were going to do in order to support the registrant in order to free up the registrant to provide still high-quality care, but maybe using their skills differently.

In these circumstances the NA role proved to be a timely and welcome policy initiative, connecting well with and a response to longstanding concerns and projected workforce reforms.

- **Trust 2 (Community) (6 NAs): An opportunistic engagement with NA role**

In this community healthcare Trust, the NA role was taken up on a much more tentative, exploratory basis:

> We felt that it would be good to be involved in the (NA) pilots, so we could help shape what this looks like, and also assess whether this role has a place in the community. So, we were part of the pilots in really small numbers; we were dipping our toe in the water and getting an idea of what works and what doesn't work.

This is not to detract from the significant challenges faced by this Trust, particularly associated with the supply of registered nurses. However, in contrast to Trust 1, the NA role fed in less to an ongoing organisational debate on the structure and organisation of the nursing workforce, acting more as stimulus to such debate and policy development. Thus, subsequent to taking on TNAs, Trust 2 did develop a new clinical workforce strategy, a strategy which now places an emphasis on the NA as part of a 'grow-your-own' approach to nurse recruitment. As its strategy states:

> It is expected that upon successful completion of the nursing associate training, staff can progress towards a registered nurse qualification if they wish.

- **Trust 3 (Mental Health) (8NAs): Filling a gap**

The mental health Trust placed particular weight on the NA role as filling a gap between the healthcare assistant and the registered nurse: the bridging objective highlighted above. This Trust saw the potential value of a registered support worker, allowing nurses to delegate with greater assurance and confidence:

> The band fours weren't working as band fours because they hadn't got that clarity of the difference between a band three and a band four, and because the registered nurse didn't feel that they could fully delegate to them, because they weren't regulated.

The Trust was also attracted by a generic role, able to provide holistic care in a flexible way, especially in the context of more an integrated care service delivery model:

> We've got gaps in mental health care in terms of physical health... Also the difficulty that we've had as we're coming into integration is that we don't have posts that are very portable, so we wanted to develop a post that would be portable that we could rotate across organisations, but also that would give us a lot more flexibility in health and social care, working across those boundaries.

- **Trust 4 (Acute) (39 NAs): Filling a gap**

The significance of the role in a filling a gap was echoed in the second of the acute Trusts:

> I think (the NA) is a workforce solution. There is a definite gap and I think we have to fill that gap somehow and this is the best way of doing it.

At the time, attention was drawn to the scope the NA role provided for career progression into nursing, explicitly seen to differentiate it from the older SEN role:

> The challenge back then was that (the SEN) couldn't proceed any further their career, there was a real glass ceiling for that role. This time round, I think the role has lost that glass ceiling; you can actually progress on to becoming a registered nurse and this has made the (NA) role much more practical and attractive to this day and age.

4. THE NURSING ASSOCIATE ROLE IN PRACTICE

As we commenced our data collection, the first 2,000 NAs were only just qualifying, with health and social care employers still in the early stages of accommodating the new role. However, 'catching' the qualified NAs as they entered the workforce was important to our evaluation in generating benchmark data and as a point of departure for mapping changes in the nature and impact of the role over time. There were also grounds for expecting deployment issues to arise even at this early stage. The NAs had been with their employers as trainees for two years (albeit some of the time on placements), and by the time we conducted our Chief Nurse survey many had been in post as qualified NAs for several months.

This section of the report explores NAs in practice at the workplace in three main parts: the first draws attention to the benefits already being generated by the NA role; the second provides an *overview* of the perceived challenges faced by employers in introducing the NA role, mainly drawing on the survey data; the second sets out the key themes on the deployment of the NA role. These themes emerged inductively from the expert interviews and from the free text comments provided by survey respondents. (Appendix 3 sets out these survey respondent comments in full.) The general survey data also allow us to provide some underpinning evidence on these themes.

4.1 Benefits

The benefits being generated by the NA role have, in part, been touched on in presenting the importance attached by Chief Nurses in our survey to the range of objectives underpinning the introduction of the NA role. However, these benefits are worth drawing out and restating. They include:

- ***Creating accessible career development pathways for HCAs, including into registered nursing***:

    From the outset we decided that this role was to support the registered workforce across all care setting and to develop a career that could have the nursing associate as the peak of their career or take them further through a range of clinical opportunities not just nursing. (Survey Respondent 5044122)

    It is important to develop staff members so they can also progress professionally (Survey Respondent 5044101)

The (NA) role is proving very popular for those who do not want to embark on a university course. It has also provided a gateway for the more experienced HCA's who would like a career pathway

- ***Helping to retain HCAs in the healthcare workforce by providing such opportunities***:
  This is a new nursing role which we are very keen to support, it aids with development and retention of our HCSW workforce, which is very important to us (Survey Respondent 5045307)

  The nursing associate programme provides the ideal opportunity for development of Band 2-4 staff into pre-registration nursing education. This aids retention of very experienced HCAs (5044120)

- ***Freeing*** up nurses to concentrate on more complex and advanced clinical tasks:
  It (the new role) gives the NAs autonomy to do skills and for nurses to focus on more complex cases (Survey Respondent 50444118).

- ***Supporting and giving effect to partnership working at systems level:***
  The (TNA) pilot has provided a valuable opportunity for partners across health and social care to work in collaboration and has created a strong foundation on which other STP and workforce projects can develop (Survey Respondent 5030539).

- ***Helping attract people to work in the NHS***:
  This is a positive development which will help us attract new people into health and care careers. (Survey Respondent 5044110)

- ***Developing an intrinsically valuable and distinctive second tier nursing role***:
  For the majority staff and patients this has been a welcome addition to the clinical team (Survey Respondent 5030456)

4.2 Challenges

The Chief Nurse survey asked respondents to indicate the importance they attached to a given list of challenges potentially faced in introducing the NA role. A follow-up question asked respondents to list the three most important of these challenges. Tables 4 and 5 below, setting out the findings, indicate the following:

- Employers were facing a wide range of challenges in introducing the NA role: thus, none of the challenges listed was seen as being of 'no importance';

- There were, however, differences of emphasis placed on these challenges. In particular, a significant majority, close to three-quarters of respondents (74.5%) attached 'considerable importance' to the challenge of integrating the NA role into established routines and ways of working and, closely related, nearly two-thirds (61.7%) placed 'considerable importance' on finding a distinctive role for the NA to play;

- The NAs' interface with different stakeholders appeared less challenging: barely a quarter of respondents (25.5%) viewed NAs gaining acceptance by service users/patients as a challenge of 'considerable importance'; with under half (46.8%) attaching 'considerable importance' to the challenge of NAs gaining acceptance by HCAs.

- Greater weight was placed on the challenge of NAs gaining acceptance by registered nurses: this challenge was viewed of 'considerable importance' by well over half of the respondents (59.6%).

- The data on the three 'most important' challenges reinforced this picture. By far the most important challenge was 'fitting the NA role into established routines and ways of working', which was the 'most important' challenge for close to half the respondents (46.8%). The only other challenge seen as being the 'most important' by a quarter of respondents (25.5%) was related, finding a distinctive role for the NA.

- Only a small proportion of respondents (12.8%) selected gaining acceptance from RN as their 'most important challenge', although it is noteworthy that around half of the respondents placed this challenge in their top three.

Table 4: Importance attached to the challenges faced by the organisation in introducing the nursing associate role

% (N=47)						
	Considerable importance	Some importance	Little importance	No importance	Don't know	No answer
Finding a distinctive role for the nursing associate to play	61.7	29.8	6.4	0	0	2.1
Gaining acceptance of the nursing associate role by healthcare assistants	46.8	44.7	6.4	2.1	0	0
Integrating the nursing associate role into established team/ward routines and ways of working	74.5	17.0	2.1	0	0	4.3

Gaining acceptance of the nursing associate role by registered nurses	59.6	29.8	8.5	2.1	0	0
Finding a sufficient number of permanent nursing associate posts in the organisation	34.0	44.7	10.6	6.4	0	4.3
Ensuring registered nurses are prepared to delegate tasks to nursing associates	46.9	36.2	10.6	2.1	0	6.4
Gaining acceptance of the nursing associate role from patients and other service users	25.5	36.2	25.5	2.1	4.3	6.4

Table 5: Three most important challenges in your organisation

	% (n=47)		
	Most important	Second most important	Third most important
Finding a distinctive role for the nursing associate to play	25.5 (12)	14.9 (7)	14.9 (7)
Gaining acceptance of the nursing associate role by healthcare assistants	2.1 (1)	8.5 (4)	8.5 (4)
Integrating the nursing associate role into established team/ward routines and ways of working	46.8 (22)	19.2 (9)	14.9 (7)
Gaining acceptance of the nursing associate role by registered nurses	12.8 (6)	21.3 (10)	12.8 (6)
Finding a sufficient number of permanent nursing associate posts in the organisation	6.4 (3)	12.8 (6)	2.1 (1)
Ensuring registered nurses are prepared to delegate tasks to nursing associates	2.1 (1)	12.8 (6)	31.9 (15)
Gaining acceptance of the nursing associate role from patients and other service users	2.1 (1)	4.3 (2)	8.5 (4)

4.3 DEPLOYMENT AT THE WORKPLACE

There were expressions of support for the new NA role, reflected in comments from several survey respondents:

> There have been highs and lows but for the majority staff and patients this has been a welcome addition to the clinical team. (504412)

This is a vital role and is reflected in our workforce plans. (5046800)

Such views should not detract from some residual concerns about the role:

I am finding it increasingly difficult to justify the NAs' place in nursing. It has bought about a lot of confusion and it is difficult to help the workforce to understand it. (5053869)

In general, however, the picture to emerge was one caution and care in the deployment of qualified NAs by employers. As various survey respondents commented:

This role has great potential and although we are at the beginning of the journey of integrating them into practice, we can see the great benefit they are likely to bring. (5044317)

This role is very much part of our future planning, but we have a long way to go and in very early talks to understand the role and what is needed to support it and how it fits into the teams we have. (5113986)

More specifically, the following related but distinctive substantive themes were evident as the deployment of NA unfolded, each in turn worthy of consideration:

- Partnership working

- Work organisation

- Substantive posts

- Other stakeholders

- Progression and support.

4.3.1 Partnership working

In process terms, a key feature of the NA programme was the decision to pitch the development of the new role at the level of local health and social care system, notionally aligned with the STP, and requiring the establishment of NA partnerships comprising the locality's health and social care providers. A few partnerships, particularly smaller ones, did not align with the STP at all. Moreover, where aligned, there was variation in the degree to which the partnership connected to the STP infrastructure and decision-making machinery. Some partnerships simply mirrored the STP catchment area without being formally integrated into decision-making infrastructure. Others were more firmly embedded in the STP's governance structure. Notwithstanding these differences, many of the NA partnerships had proved resilient and continued to support the development of the role:

Partnerships working within an STP footprint (around the NA role) were one of the first workforce things where you saw a tangible STP type of approach. (Expert Interviewee)

The (name) TNA pilot has provided a valuable opportunity for partners across health and social care to work in collaboration and has created a strong foundation on which other STP and workforce projects can develop. (Survey Respondent 5030539)

More tangibly, the partnerships continued to fulfil several functions:

- Providing the basis for a **community of practice** by bringing employers together to share experience and practice around the NA role:

  I have a community of practice, which is each of the leads from those seven sites. We meet quarterly and I suppose it's just an opportunity for them to share learning and best practice and also to talk about things from a more strategic point of view and how things have been going. (Expert Interviewee)

Indeed, some NA partnerships had broadened their focus to deliberate on nursing-related issues across a given catchment area:

  Some of the partnerships have morphed and they use it as a platform for lots of other nursing conversations around workforce. (Expert Interviewee)

- Developing a nascent regulated **labour markets** for NAs, with employers agreeing not to 'poach' each other's qualified NAs:

  There have been gentlemen's agreements within partnerships that they won't poach each other's staff. I guess that will change over time but because there has been such close partnership working that they want to support those NAs through that transition into their new role and see how they impact on the workforce. (Expert Interviewee)

- Allowing the NA to become a **system resource**. Drawing upon the generic capabilities acquired during their training, agreement had been reached in one partnership for the NA to rotate between a mental health and acute Trust. Employed by the acute Trust one NA was nonetheless to be seconded to the mental health Trust for half the year:

  Trainees (NAs) spend such a long time in mental health, they're helping us to break down barriers and challenge stigma, so there's one nursing associate in particular who was trained by an acute trust who's desperate to work in our learning disability services, so rather than see acute trust lose her completely, we're working with the acute trust to do a rotating post. She's going to spend six months working in outpatients in the acute trust, and six months working on our community learning disability service. (Expert Interviewee)

4.3.2   Work Organisation

The most significant of the deployment themes to emerge, in terms of its centrality in determining the NAs role in the future nursing workforce and more generally in the delivery of care, related to the issue of work organisation. This was hinted at in the

survey which presented integrating the NA role into care delivery and finding a distinctive role for it in established ways of working, as major organisational challenges. The implications of the NA role for work organisation assumed several forms:

- **Scale**

Currently the number of qualified NA employed in any given employer remains small. In October 2019, there were 1,482 registered NAs (at end 2019, the latest figure available), a reduction on the original 2,000 accounted for largely by attrition during the training programme and those qualified NAs who chose to move straight into their pre-registration training (see below). As can be from Table 6 below, 40 percent of our respondents employed five or fewer NAs, with close to three-quarters employing 10 or fewer.

Table 6: Number of NAs Employed	
Number of Qualifed Nursing Associated	**% (N=47)**
1-5	40.4
6-10	29.8
11-15	23.4
16-20	17.0
21-30	12.8

The limited scale of take-up suggests that even with a small or medium sized organisation, the number of NAs was likely to be 'spread fairly thin', as yet having only a limited impact on work organisation:

> The areas that have got a nursing associate have only got one, so it's quite difficult when there's only one person that's got a new role in that whole ward or whatever, to really make a radical change to either the workforce or patient care because they're on their own. (Expert Interviewee)

The capacity of employers to scale-up the employment of NAs remains an open question. Clearly subsequent cohorts provide a new pipeline of TNAs and indeed many of those on the third of cohort of TNAs, which started training in early 2018, have now qualified as NAs. However, survey respondents did raise concern about of the costs of supporting such a programme going forward:

> Utilising the Nursing Associate pathway as a "feeder" into professional training creates additional and unnecessary expense. (5097298)

> In our own team we would like a TNA however we have no money to employ one and the current support workers do not want to even apply for this opportunity. (5030434)

> The biggest challenge is funding to drive further expansion of the role. (5030523)

There were specific employer concerns about the full-time of employment of TNAs who then spent a considerable part of their training period working in other organisations on their placement. More pointedly, with the TNAs now being developed through the apprenticeship route, new challenges were arising. The additional costs associated with the apprenticeship route that were not funded by the apprenticeship levy, were becoming significant[71]. Indeed, one of the unintended consequences of the TNA programme might be for the role to draw disproportionately from apprenticeship levy, depleting funds available for other forms of apprenticeship training.[72]

At the same time, organisations responding to our survey did appear to be taking on TNAs from subsequent waves at a significant scale. As indicated in Table 7 below, over a quarter (27.7%) of the organisations with qualified NAs employed more than 40 TNA, with close to half employing more than 30 TNAs. This suggests that employers taking on the new NA role in perhaps a speculative way have become more convinced of its value[73]. Certainly, this was the case in the community Trust covered in our expert interviews, where an initial intake of barely half a dozen of TNAs was 'ramped-up' to 60 on the third wave and a further 60 on the fourth.

Table 7: Number of TNAs Employed
(N=47)

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[71] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/720320/NHSPRB_2018_report_Web_Accessible.pdf

[72] The funding band for a two year NA apprenticeship is a maximum £15,000. Assuming organisation pay this maximum, NA apprenticeships will take £187.5 million from levy. It has been calculated that the levy will cost the NHS around £200 million a year. On the basis of this crude calculation wave 3 and 4 training is consuming half of the NHS apprenticeship levy funds.

[73] Such an interpretation should be viewed as provisional. Increasing numbers of TNAs in Trusts with qualified NAs might also be related to the greater of use of targets for the take up of TNAs in waves 2/3. Most of our survey respondents attached some importance to achieving targets as a reason for employing NAs, although very few put it as one of their top three objectives.

Number of Traineee Nursing Associates	% N=47
1-5	8.5
6-10	4.3
11-15	12.8
16-20	19.2
21-30	10.6
31-40	14.9
More than 40	27.7

- **Distribution**

The issue of distribution centres on the spread of the NA role across ***different types of healthcare setting*** – acute, mental health and community (leaving social care aside for the moment). There were suggestions from our expert interviews that the NA role might be settling into certain healthcare settings more easily than others. For example, the community healthcare Trust (see above) ramping up its number of TNA had found a niche for the role in helping to administer insulin to people living with diabetes in their homes. On the other hand, some survey respondents suggested that the role faced challenges in a mental health care setting:

> There are significant concerns about the deployment of NAs in mental health settings (with particular regard to mental health legislation and accountability). Nationally, there has been insufficient clarity from NMC or NHSI/E. This is provoking some anxiety with the deployment of this role. (5106128)

Such views need to be placed alongside those from an expert interview in a mental healthcare Trust where the NA role had been taken up with alacrity and enthusiasm. Future analysis of the survey data will allow us to develop a clearer picture of the relationship between the qualified NAs and Trust type or care setting.

In a more precise sense distribution relates to the ***internal choices*** made by employing organisations as to where NAs might be located. An expert interviewee noted that:

> The soft intelligence is very much that the role is being deployed in a very broad range of areas, and that that has occurred successfully.

Our survey findings provide support for this view, with Table 8 below highlighting the variety of clinical areas and teams chosen by employers for their qualified NAs. Indeed, one of the more striking features of the Table is the fact that any given employer seems to have placed their NAs in several clinical areas: on average about three.

Most surveyed employers, around 60 percent, were placing their qualified NAs in surgical and medical wards, likely reflecting the fact that overwhelming majority of our survey respondents provided acute services. However, significant proportions of employers are deploying NAs in other acute services areas, such as operating theatres, outpatients and to a lesser extent in intensive care, while a third of employers have NAs in their community teams.

Table 8: Distribution of NAs by Clinical Areas/Team	
Clinical Area	**%** **(N=47)**
Surgical ward	61.7
Medical ward	59.6
Care of the Elderly/ Older People (in-patient ward)	59.6
Accident and Emergency	38.3
Community team	34.0
Children's wards	23.4
Mental healthcare (in-patient ward)	17.0
Outpatients	14.9
Theatres	14.9
Intensive Care	10.6
Maternity	2.1
Others • Children's Respite Care (LD) • Dementia Team • Inpatient learning disability service • In-patient neuro rehab unit • Learning Disability • Oncology ward • Rehabilitation • Renal and neonates • Vascular team	19.2

- **Workforce Structure**

One of the central deployment issues facing employers centred on how NA role fitted into the nursing team. It was an issue which generated a configuration of related matters: the appropriate distribution of nursing tasks and responsibilities across the team; the future role of other team members, particularly registered nurses and HCAs; and skill-mix ratios, rostering patterns and staff establishment levels, especially with a view to ensuring safe staffing. It was a configuration of issues encouraging some employers to view the deployment of the NA role as only meaningful within the context of a broader and more profound review of work organisation and the structure of the nursing workforce. As a Director of Nursing in one urban STP argued:

> Focusing on the nursing associate role in isolation is not helpful…It fails to maximize the contribution the role can make to safety, quality and efficiency…It stifles flexible and creative thinking in terms of deployment.

A similar point was made by another expert interviewee, who went on to stress an important wider point: that any attempt to re-organise the nursing workforce needed to ensure that different departments - nursing, HR and finance - worked in a more co-coordinated way:

> Rather than looking at one role in isolation, we need to look at the teams or the workforce establishment as a whole and see how it can integrate and where it can add the most value. This (broader thinking) is dependent on the relationship within the trust between the HR department, the finance department and the nursing and midwifery department which is where nursing associate role sits at the moment. Dependent on how well these departments work together, we can see a big difference in how well the role is taken into the organisation. When they work as silos, then there are real challenges.

At this stage of the evaluation we have limited data on how organisations have addressed these detailed issues associated with work organisation. However, the following general points can be made:

- **Workforce planning**: The number of qualified NAs currently appears too small to meaningfully feed through into workforce planning process:

> The reduction of labour costs through changes to skill mix has not been a primary consideration and it would be too early to tell as our first cohort have just qualified and we need to evaluate its impact which will inform workforce planning and skill mix. (Survey Respondent 5032177)

The first cohort of Nursing Associates qualified in April 2019 and it is too soon to measure impact on skill mix although this is an integral component of the evaluation process. (Survey Respondent 5036353)

Certainly, Table 9 below suggests that many organisations were still working through the nature of the impact role on work organisation and especially skills mix. It can be seen that over half of the survey respondent indicated that they were still reviewing or thinking about reviewing skill-mix in clinical areas with NAs, while as yet only a third had revised skill mix in some or all of their clinical areas with the introduction of the NA role.

Table 9: How has the introduction of the nursing associate role impacted on skill mix in your organisation? (N=47)	
	%
Skill mix revised in *all* clinical/social care areas with nursing associates	12.8
Skill mix revised in *some* clinical/social care areas with nursing associates	19.2
Reviewing skill mix in some or all of the workplaces with nursing associates	44.5
Thinking about reviewing skill mix in some or all of the workplaces with nursing associates	10.6
No impact on skill mix	6.4
No answer	6.4

- **Supportive tools**. New tools (alongside established safe staffing tools) were being developed to help organisations re-profile nursing teams, for example by systematically reviewing the tasks performed within the team. There were also 'good practice' cases widely available, on how organisations had introduced the NAs into specialist clinical areas, for instance into A&E and intensive care departments.

- **Safety.** At the same time and at this early stage, there is a caution in the use of the NA within different clinical areas and teams, not least associated with the need ensure safe practice:

    There is some hesitancy because of the safer staffing guidance and concern about

CQC will say, and what is it that the nursing associate can do and can't do; so I think there is currently a mixture of feelings about (the NA role). (Expert Interviewee)

We think the two main problems are ensuring the NAs are being used safely and also being used to their full potential. (Survey Respondent 50359049).

- **Nursing Workforce Strategies**. Trusts and indeed some STPs were developing nursing workforce strategies sensitive to and often prompted by the introduction of the NA role. It is, however, noteworthy that such strategies were only now being formulated. For example, one London STP, employing over 50 TNAs across half its Trusts[74] in the first wave, was only at the early stages of devising such strategy. Indeed, as a regional expert interviewee noted:

  Our next phase around workforce modelling will really be around how we grow the nursing associate role at scale, so that it becomes more of a predictive type demand, if that makes sense, looking at two years to five years where will they make the most impact on our service redesign.

  Similarly, another expert interviewee working in a Trust remarked:

  We have done things round the wrong way, but I don't think we're alone. So we are now revising our safer staffing modelling to incorporate the nursing associate role. Usually (you start) with a workforce plan. This hasn't happened. It has been nursing associate first and now we're looking at our workforce plan with them being part of it.

- **Local Contingencies**. How the NA role affects future work organisation might well depend on a range of local factors, for example recruitment and retention pressures in the labour market catchment area. As one interviewee from a mental health Trust noted:

  We don't particularly have a recruitment and retention problem, whereas the acute trusts did, so we've not had the debates raging in our organisation about substitution, because we know that we're doing it because it's the right thing to do for the skill mix, not because we're trying to fix something, whereas acute trusts were in a different place.

- **Positive Impact**. Some examples were given of where the NA role was already beginning to positively impact on work organisation:

  We've had some wonderful feedback from the placements, and the most joyful one that I got was from a ward manager in an acute Trust who said to the trainee - who'd got a mental health background; after she'd been on placement she said, now I can see what you can bring to the team, I'm going to reorganise the way that I deliver care on this ward. So, she'd actually seen the opportunities of that different skill mix. (Expert Interviewee)

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[74] Interesting this STP area contains several specialist Trusts which are yet to employ any TNAs, suggesting the limits of the role in such contexts.

Indeed, this impact sometimes emerged in unexpected ways:

> One of the things that has been a real bonus that nobody predicted was that they've really lifted morale across services, just because they're fresh, they're bringing something different, they're showing progression, so the NHS is progressing. And once people started seeing that, it just gained its own momentum, and now we've got teams asking if they can have a nursing associate. (Expert Interviewee)

4.3.3 Substantive Posts

In the overwhelming proportion of organisations (87%) responding to our survey qualifying TNAs had moved straight into a substantive NA post. With pilot sites required to give assurances on the availability such a post as part of the application process, this finding is not surprising. It is, however, still worth noting given that in the past HCAs preparing to become APs had sometimes been frustrated in failing to find an AP role to move into on completion their training. Indeed, while clearly not a major issue with (T) NAs, it still lingered as a concern, reflected in the comment above about the need to ensure that NAs work to their 'full potential'.

Notwithstanding this residual concern, the establishment of substantive NA posts generated a couple of noteworthy issues. The first centred on the identification of clinical areas or teams which might benefit from the introduction of an NA role[75]. This process varied between employers, particularly in terms of the balance between a central, top down approach and a more organic bottom up approach. Illustrating a top down approach, one interviewee noted:

> We focused on safety, but we also focused on where they'll add most value and would be able to use their skills to the hilt. (Expert Interviewee)

Reflecting the latter, more voluntary approach, another interviewee noted:

> We said to our staff 'right, this is an opportunity'. You need to identify in your areas if you can support this role, at least in principle at this stage, because nobody knew what one was, and they will sit within your band two vacancies because we've got to pay for them while they do the job as they were salaried we said, if you put your hand up for one of these, you will absolutely get a training nursing associate on placements. (Expert Interviewee)

The second issue related to the relative value of TNAs returning to their original department or team on qualifying. In several of the Trusts responding, the substantive NA post was established in the

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[75] It is important distinguish between a clinical area/team which might provide a placement for a TNA and one which might represent the final destination for a qualified NA. The former does not necessarily lead to the latter, although it might serve as an opportunity to test-out the suitability of a NA role in the future.

trainees' original place of work: in other words, on qualifying the NAs returned to their original work teams. There is an evidence base for such a practice: studies[76] suggest that new healthcare roles are more likely to embed where they are performed by individuals known and trusted by the team. However, there were differences of practice between Trusts in this respect. For example, one Trust had chosen to re-locate qualified NAs in a new clinical area, allowing the NA to establish a new workplace identity unencumbered by colleagues' perceptions of them in another work role, typically as an HCA:

> We wanted to make sure that they had the opportunity to establish themselves in their new role; that they didn't have the baggage of the old role and people's expectations of them in the old role. …Most of our trainees didn't want to go back to where they started because they've got all these new skills and they wanted to branch out and try something different.

It is interesting that this Trust still ensured that (T)NAs undertook their last placement before qualifying in their future place of work allowing them to hopefully develop the necessary rapport with other members of the team.

4.3.4   Other stakeholders

A key dimension of our evaluation is how the NA is viewed by and impacts on various actors with a stake in the role: for example, service users/patients, registered nurses and co-support workers. At this stage our data on this issue remain 'second hand', with the different stakeholders themselves yet to be asked for their views, an element to be taken forward in the next phase of the research. However, some early impressions on how the role has been perceived by stakeholders emerged from our interview and survey findings:

- **Patients.** Our Chief Nurses' survey presented patient acceptance of the NA role as a relatively low-level challenge:

> We don't think there will be a problem with service user acceptance. (Survey Respondent 5036353)

However, this view was not universal amongst our survey respondents:

> I do not think the general public, service users or our families will understand the NA role. There needs to be a national campaign to highlight the new role. Patients and

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[76] Kessler, I. Heron, P. and Spilsbury, K. (2017) Human resource management innovation in health care: the institutionalisation of new support roles, Human Resource Management Journal, 27(2):228-245

families will always expect fully trained personnel to deliver care. The NA role will cause confusion. (Survey Respondent 5104331)

It was perhaps too early for the qualified NA to have impacted on service delivery, although examples were cited of the role promoting more generic ways of working:

> There was one nursing associate on a surgical ward and he said, six months ago, or even two years ago, a patient would say, I feel sick following an operation, he would have to go and find a registered nurse to give them an injection, it would take maybe up to half an hour to 45 minutes to sort that out, he can now do that himself. So he feels he made a massive difference by just some of those small things that he can now do as a registrant and they're the sorts of examples that we're getting more of, to say that even though there might be only one person on that ward, when they're on duty they are making a small difference to that overall workload and patient experience. (Expert Interviewee)

- ***Registered nurses.*** According to the Chief Nurse survey responses, gaining acceptance of the NA role from registered nurses was a more challenging prospect. Thus it was noteworthy that close to half of Chief Nurses (46.9%) viewed ensuring that RNs delegated to NAs as 'a considerable challenge' (See Table 4 above) and around half also perceived it as one their top three challenges (See Table 5 above) despite the registered status of the NA:

> There has been some professional tribalism with regards to NAs giving medications which has been a challenge to manage. (Survey Respondent 5042272)

Where there were concerns amongst registered nurses, they had typically taken the form of 'anxiety about the role', derived from uncertainty or misunderstanding about it rather than from any feeling of 'threat'. As various expert interviewees noted:

> Nothing has come back to us that people are feeling threatened. I think they're just anxious that they don't allow them (NAs) to do something that they shouldn't do, but we've not heard anything about (NAs) being seen as taking people's jobs.

> There have been real challenges in the rest of the team understanding what the role is and what they are capable of doing and what it's within their professional scope to do, so the integration and the cultural shift is still something that needs to be worked on in detail. And that's understanding across the board, so this isn't just nurses, this is also the medical team, how do they work with... and AHPs (Allied Health Professionals), how do they work with and make the most of every member of the team?

These residual uncertainties, misunderstandings and anxieties should not detract from ways in which the NA role was beginning to positively impact on the working lives of registered nurses. Thus, in one mental healthcare Trust the role already appeared to be freeing-up nurse time:

> What the team leaders are talking about is how the nursing associate is freeing the degree nurse to work more on the technical things that you want the degree nurses working on. In the CMHTs (Community Mental Health Teams) it's about how they're bringing the physical health profile, and in the district nursing team it's how they're

bringing the mental health focus. (Expert Interviewee)

Where there were residual concerns amongst registered nurses, and indeed other stakeholders, it was often put down to the recognised shortcomings in organisational preparation, particularly communication:

> In some areas, there was resistant (to the (T)NA role) but what that told us is that we hadn't done the preparation right in that area. So, some of the feedback that we got from trainees was variable in terms of how well received they were, but by the third placement that was sorted, because we knew how to prepare the teams by then.

- **Support workers.** The impact of the NA on other support workers needs to be treated with nuance and caution. For *the HCA*, the role had been presented as a career development opportunity, with several survey respondents highlighting the value of the role in these terms:

> It (the NA role) aids with development and retention of our healthcare support workforce; which is very important to us. (5043442)

> The NA Programme provides the ideal opportunity for development of Band 2-4 staff into pre-registration nursing education. This aids retention of very experienced HCAs. (5037761)

Indeed, as an expert interviewee noted:

> For healthcare assistants, it's given them a lot of inspiration that they want to become a trainee or eventually become a nursing associate. So, we have had a lot more enquiries around how do they get into that position, how do they develop into a nursing associate?

Such views need to be qualified for some HCAs for whom progression along this pathway has been complicated by the challenge of acquiring the necessary functional skills and entry qualifications needed to embark on a level 5 qualification.

For *assistant practitioners (APs),* engagement with the NA role has raised a number of issues. There were indications that organisations with experience of introducing new roles, including the AP, might have better equipped to introduce the NA role. As different survey respondents noted:

> Because we had got experience of developing new roles that we'd learnt from, and we headed off some issues. (50359049)

> We already had a strong history of AP development which we have dovetailed the implementation of the NA role into. (5075594)

However, where organisations had heavily invested in the AP, questions emerged on how the new NA role interfaced with it: As one survey respondent noted:

> As an organisation we have always trained APs and have a well-established AP workforce. We are examining how we can introduce the NA into this workforce and as yet have not introduced the role but are working to do so next year.

The Chief Nurse survey suggested that the number of APs employed in organisations with qualified NAs should not be overstated. However, it can be seen from Table 10 below that about a third of our respondents' organisations employed 31 or more APs.

Table 10: Approximately how many assistant practitioners does your organisation currently employ? (N=47)	
Number (band)	%
None	**6.4**
1-5	**4.3**
6-10	**6.4**
11-15	**25.5**
16-20	**6.4**
21-30	**6.4**
31-40	**14.9**
More than 40	**17.0**
Don't know	**14.9**
No answer	**2.1**

Of wider significance were the implications of the NA role for the continued development of the AP role. The provision of AP training was indicator of organisational policy on this issue. Around half of our survey respondents' organisations (42.6%) did not provide AP training. It was unclear whether these organisations had discontinued such training with the introduction of the NA role or indeed had never trained APs. However, the discontinuation of such training for APs in non-nursing roles might be an unintended consequence of the NA programme.

Alongside these institutional factors, the NA role was reported to have created some personal uncertainties for existing AP postholders:

> As an organisation we needed to reassure the APs that they were still valued. (Survey Respondent 50422726)

4.3.5 Progression and Support

The final deployment theme relates to NA career progressions, related to the support provided by employers for the further development of those in the new role. The use of the NA role as a stepping-stone into registered nursing has been highlighted as an important policy objective. However, there were suggestions that this aim might be in tension with other policy aims, in particular the development of a bridging role of value in its own right. It is noteworthy (see Table 11 below) that over half of our Chief Nurse respondents (53.2%) had introduced a nursing degree apprenticeship, a possible route into registered nursing for the NA. Whether or not this route was being used, there were indications that some NAs were quite quickly moving into pre-registration nurse training, causing employers, who had heavily invested in their NAs' training, some concern. This progression through to registered nurse training varied by employer and by partnership. However, in one quite large partnership of around 60 qualified NAs, almost half (29) had moved straight into nurse training. Indeed, for one employer this concern was leading to a 'golden handcuff' requirement for (T)NAs to sign an agreement to stay in their post for at least two years following qualification.[77]

Table 11: Does you organisation have……		
	% (N=47)	
	An NA preceptorship	A Nursing Degree Apprenticeship
Yes	89.4	53.2
No, but we are planning to introduce one	8.5	29.2
No, and we are not planning to introduce one	0	12.8
Don't know	0	4.3

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[77] Despite such an agreement not being legally enforceable.

Indeed, several expert interviewees from Trusts placed considerable weight on retaining their TNAs in post after qualification, seeking to further develop and embed the NAs in their role and work team. One expert interviewee was particularly critical of the publicity given to the 'race for the first NA to become a registered nurses', achieved in October 2019[78]. Commenting on an NA who had moved straight to nurse training, another interviewee noted:

> I don't want to put out people's fireworks and it was great that that individual got on a programme, but actually they didn't consolidate anything that they learned, and I don't get that, and I don't understand why there's so much pressure for us as organisations, for universities, to get nursing associates onto a nurse programme. I don't get that, because that wasn't the original intention… The majority of nursing associates that will have qualified won't even have completed their preceptorship. So why have we done that? Why couldn't we wait 12 months and then do something? We've got to demonstrate the value of the role to practitioners on the shop floor … We've got to get the value out of the role and get them to understand what their role needs.

An interest in consolidating newly qualified NAs in their new role is reflected in the fact that the overwhelming majority of Chief Nurse respondents (89.4%) reported the introduction of an NA preceptorship programme in their organisation (see Table 11). This consolidatory approach was reflected in the comments of a regional expert interviewee:

> There's a little bit of, 'yes, I do want to do this (nurse training) in the future' but right now they are thinking 'I've just come off a two-year foundation degree, I just want to settle into my role as a nursing associate and then think about taking that next step when I'm ready for it personally'. There's a lot of support out there from Trusts for any candidate that wants to do that (nurse training), but I'm not seeing huge numbers at the moment; that might change in six months' time.

Whether this contrast in the emphasis placed on NAs moving quickly through to registered nurse training or consolidating within their new roles is locally contingent on recruitment and retention pressures or different policy choices made by employers is worthy of further consideration in our detailed follow-up work.

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[78] https://nursingnotes.co.uk/first-nursing-associate-makes-leap-registered-nurse/

5. Summary and Conclusions

Following-on from the Traverse review of the two-year training programme undertaken by the first 2,000 trainee nursing associates, our evaluation focuses on how these TNAs, qualifying in early 2019, have now been deployed by NHS and social care employers. In general, our evaluation explores whether and how the national policy objectives underpinning the introduction of NAs are being met, and the extent to which the consequences of the role are sensitive to the interests of various stakeholders – NAs, their colleagues and services users/patients - and different contingencies such as care setting or locality. In the first year of the evaluation, we have: reviewed the primary and secondary literature on support roles in health and social care; conducted close to 40 expert interviews; and administered a survey of Chief Nurses in NHS England. In this interim report, we have presented initial findings in three substantive sections: context, objectives and the NA role in practice.

In contextual terms, the NA role feeds into a long history of nursing support roles. It has, however, been presented by national policy makers as a new and distinctive role: registered and designed to deliver generic care while at the same time providing development opportunities for the individual postholder. With the regulatory arrangements for the role taking some time to complete, the 35 pilots were launched with considerable speed. These pilots were aware the NA would be registered with the NMC, but with the TNA framework curriculum still being developed there was a degree of uncertainty about the nature of the role, leading in turn to organisational caution and incrementalism in deployment of the NAs.

For national policy makers and practitioners, the principle objective of the role was to act as a 'bridge' between the care assistant and the registered nurse. However, reviewing the policy literature a sub-set of more refined aims was revealed:

- Supporting new care delivery models, particularly based on integrated, generic care and reflected in the generic quality of the new role;
- Freeing registered nurses to work in more advanced ways and on clinically complex issues;
- Providing a new, more accessible stepping-stone into registered nurse training;
- Widening participation into the healthcare and social care workforce by establishing new career opportunities especially for those often denied them in the past.

Our evaluation found that for health and social care employers [79] the adoption of the NA role was

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[79] The latter are few at the time of writing.

informed by a combination of these objectives, albeit with an emphasis on its capacity to provide a stepping-stone into registered nurse training. More detailed analysis suggested that employer objectives in engaging with the new role were context-specific , often being rooted in local circumstances and needs: for example in some cases the NA role was a timely opportunity to address a long run interest in re-structuring the nursing workforce; in others it was a unexpected opportunity to tentatively explore new ways of delivering care.

In fulfilling national and local objectives, employers were revealed as facing several challenges. In part these centred on securing stakeholder acceptance of the NA, particularly amongst registered nurses who often remained uncertain about the nature of the role and particularly about its scope of practice. It was striking, for example, that despite the NA being a registered role, a significant proportion of Chief Nurses still saw nurse delegation of tasks to NAs as a significant challenge. More telling as perceived challenges were finding a distinctive role for the NA and ensuring its integration into established ways of working.

The importance of these latter challenges more fully emerged in a range of themes highlighted in examining the NA role in practice:

- **Partnership working**: Based on networks of healthcare and social care provider organisations, the pilot sites had stimulated resilient forms of partnership working, and in some instances were said to be the first tangible example of the STP/ICS working in a meaningful way.
- **Work organisation**: The NA role was impacting on work organisation in a variety of ways:
- *Scale*: the number of qualified NAs in any given employer organisation remained low, limiting the role's impact to date on service delivery and the value of including them in workforce planning. Notwithstanding the pipeline of third and fourth wave TNAs, in some organisations the scope to scale-up the number of NAs remained uncertain, raising broader questions about the organisation's training capacity and the level and distribution of training funds.
- *Distribution*: NAs had been allocated to a wide range of clinical areas, albeit with a concentration on medical and surgical wards.
- *Workforce structure:* Amongst some employers and more strikingly at local systems level in STPs, the NA role had prompted a strategic review of nursing workforces. These were often emergent strategies, with the introduction of the qualified NA not so much being driven by a workforce strategy as leading to the development of one. This strategy-making was

underpinned by a considerable amount of detailed work on how the NA role safely fitted into different clinical areas, with implications for skills mix and establishment levels.

- **Substantive posts**: Almost all TNAs appeared to have found substantive posts on qualifying although there were residual concerns about whether those in the role would be working to their full potential.

- **Other stakeholders**: Views varied on how the NA role was being perceived by service users/patients and carers. However, there was a significant level of consensus on the negative implications of the NA role for one stakeholder: the assistant practitioner (AP). In part, concerns centred on the personal consequences for individual APs, whose value, worth and morale were being challenged by the introduction of the NA role. There were, additionally, broader institutional concerns about the NA role amongst organisations that had heavily invested in the AP as means of developing their workforce.

- **Progression and support.** There appeared to be some tension between the development of the NA as a role valued in its own right and the use of the role as a stepping- stone into registered nurse training. There was some unevenness across organisations and regions in the speed with which qualified NAs were moving into registered nurse training. However, in the general, organisations appeared keener on supporting qualified NAs bed-down in their new role and on helping them consolidate their skills, reflected not least in the widespread development of NA preceptorship programmes. There were, nonetheless, cases where qualified NAs had moved rapidly into registered nurse training causing some consternation amongst employers who had devoted considerable time, energy and resource to their NA training.

Moving forward with the evaluation, the interim findings presented in this report suggest the value of exploring:

- How the scope and nature of the NA role develops in practice: The regulatory arrangements underpinning the NA role now provide the basis for employer choices on how they use and deploy it. It is early days and there are presently signs of caution, not least reflecting matters of safety. However, whether and how the NA role develops in substantive terms and contributes to care delivery in different clinical and care areas remain central to our future analysis, which will of course need to take account of the COVID-19 context.

- Whether and how the development of the role is sensitive to care setting: The interim findings were unclear on this issue. Questions were raised about the use of role in some settings such as mental health services, and yet there were high-profile examples where the

role had been adopted with alacrity in such a setting. Whether such factors as leadership and organisational culture 'trump' care setting in this context remain to be seen.

- How the potential for the NA role to widen participation and reduce inequalities is being played out in practice, both in terms of the work but also in respect of responding to possible accommodations in continuing professional development and other employment opportunities.

- How the role impacts on different stakeholders: Again, this issue has been touched on but in a 'second hand' way. We need to engage directly with such stakeholders and examine whether and how the NA role tangibly impacts on different outcomes. In particular, the role of managers and supervisory staff may be key to NAs flourishing, and to safeguard NAs from problems of bullying and burnout that challenge policy ambitions for the NHS to be 'the best place to work'.

- How and whether social care employers are employing NAs, promoting the training opportunities to their staff, and how care home nurses, in particular, perceive the potential of NA working. In our in-depth case studies, we plan to address the care sector's experiences and perspectives and to consider the risks that NAs working in social care may then be attractive to local NHS employers with their generally higher remuneration packages.

- The broader organisational and local system consequences of the NA role: While the focus of our evaluation is ostensibly on the deployment of the 2,000 qualified, pilot site NAs, the role's 'ripple effect' cannot be ignored. Most obviously initial experience of the NA role has informed organisational decision-making on the future use and take up the role. We have also seen how the role has stimulated a much wider review and possibly re-structuring of the local nursing workforce. Indeed, where such reviews have been pitched at the level of the STP/ICS, questions are raised about whether and with what consequence the NA role presages moves to workforce organisation, planning and management at the level of the local health and social care system.

Appendix 1: Expert Interviews – Organisations Involved

Age UK
Alzheimer's Society
Care England
Care Quality Commission
Dementia UK
Health Education England (8 interviews including 4 at regional level)
Hospice
NHS Employers
NHSI
Nursing and Midwifery Council (NMC)
Nursing Home (care home with nursing)
Orders of St John Care Trust
Queen's Nursing Institute
Royal College of Midwives
Royal College of Nursing (RCN)
Skills for Care
Skills for Health
NHS Trusts (7)
Unison
Universities providing nurse education (4)

Appendix 2: Survey Respondents by Health and care Setting/Trust (Pease not that respondents were asked to tick as many health and care settings/Trust as appropriate)

Acute 87.2%

Community 42.6%

Mental health 29.8%

Primary healthcare 14.9%

Social care 10.6%

Appendix 3: Chief Nurse Survey Comments by Theme

Concerns	Positive contribution	Recruitment & Retention	Skill mix	Finance/ Resourcing
We are currently evaluating the role and despite pressure to put more staff on the course I am not doing this at the current time	Having been part of the work with the legacy cohort and the Trust having a long positive track record with safe care delivered by AP we are more than happy with the role	The main reason we are supporting high numbers of NA apprentices is because we know we cannot fill all our Band 5 vacancies	The reduction of labour costs through changes to skill mix has not been a primary consideration and it would be too early to tell as our first cohort have just qualified and we need to evaluate its impact which will inform workforce planning and skill mix Whilst it is too soon to see the potential impact of this new role on service re-design it is expected to play a part in skill based workforce planning	A key component of our nursing strategy is to create capacity, capability and flexibility to work across traditional boundaries and take on new roles. As a Trust we have co-produced and implemented a Degree Level Apprenticeship which is our identified route into professional training and a key component of our "grow our own" strategy. Utilising the Nursing Associate pathway as a "feeder" into professional training creates additional and unnecessary expense. We would wish to focus on the development of the Nursing Associate role as an alternative career option
It isn't always easy to have a good understanding of what the wider agenda is at exec level for Nursing Associates	This is a new nursing role which we are very keen to support, it aids with development and retention of our HCSW workforce; which is very important to us	Whilst there may be some workforce efficiencies gained through the wider adoption of NAs, overall it is anticipated that this will provide at best a cushioning of the overall increased investment required in nursing numbers.	The first cohort of Nursing Associates qualified in April 2019 and it is too soon to measure impact on skill mix although this is an integral component of the evaluation process	In our own team we would like a TNA however we have no money to employ one and the current support workers do not want to even apply for this opportunity
There are significant concerns about the deployment of NAs in mental health settings (with particular regard to mental health legislation and accountability). Nationally, there has been insufficient clarity from NMC or NHSI/E. This is provoking some anxiety with the deployment of this role.	From the outset we decided that this role was to support the registered workforce across all care setting and to develop a career that could have the NA as the peak of their career or take them further through a range of clinical opportunities not just nursing	The most important reason is that we feel we will have no choice in the future but to use NAs where we have previously used registered nurses because we won't be able to recruit RNs.	We have requested all areas to review their skill mix to see how the nursing associate role can be embedded in their area in the future.	Acceptance to both the TNA & qualified NA's has been very good particularly from patients. The biggest challenge is however funding to drive further expansion of the role.
The role is difficult for community services as our Healthcare Assistants are very highly skilled	This is a vital role and is reflected in our workforce plans			The biggest challenge is the financial modelling to support this programme and the NA programme in the medium and longer term to make it affordable

We don't think there will be a problem with service user acceptance. We think the two main problems are ensuring the NAs are being used safely and also being used to their full potential.	It is important to develop staff members so they can also progress professionally and be Staff Nurses someday. In addition, it gives the NAs autonomy to do skills and for Nurses to focus on more complex cases.			Supporting my staff to complete the training has had an impact on my team as the staff member is on placement quite frequently and she has a lot of training days which allows very little time for patient contact within her substantive post. We also have TNAs on placement as well as other student nurses and it can be quite demanding of the team to host 2 students at a time.
There has been some professional Tribalism with regards to NA's giving medications which has been a challenge to manage	Nursing Associates will be a valued part of the workforce as were 'second level nurses' or ENs in a previous. APs remain a valid option for senior HCAs who do not want to become NA's but wish to concentrate on a more specific specialist role with a smaller scope			
It has often been the process that was challenging rather than the introduction of the role. For example it is important to keep patients and the NA safe and therefore it has been challenging to ensure that we have prepared our registered workforce appropriately	The NA Programme provides the ideal opportunity for development of Band 2-4 staff into pre-registration nursing education. This aid retention of very experienced HCAs.			
I do not think the general public, service users or our families will understand the NA role. There needs to be a national campaign to highlight the new role. Patients and families will always expect fully trained personnel to deliver care. The NA role will cause confusion.	The role has been accepted more easily in those areas who already have band 4 roles. The NA is an enhanced and valued role within the ward team			
As far as I can see most have returned to the placement that supported/applied	The role has been well supported by registered nurses and majority of staff			

for their training but now in a different role . I think that is difficult as there is a potential to slip back to the previous role				
I am finding it increasingly difficult to justify the NAs' place in Nursing. I think it hasbought about a lot of confusion and it is difficult to help the workforce to understand it. I am yet to be truly convinced of its' worth and expense to introduce it. I am a little dubious that it will last. Most of the TNA's we have Are doing it as a stepping stone into Registered Nursing as they are unable to afford the tuition fees for pre-reg Nursing training at University in the traditional route. I think that the introduction of these fees has prompted a lot of interest in apprenticeships into Nursing routes, if it isn't for that then I don't thinkit would be very popular.	Invaluable role and helps with vacancy levels			
Real concern about the role of the NA in mental health, and how to safely deploy and utilize	The ()TNA Pilot has provided a valuable opportunity for partners across health and social care to work in collaboration and has created a strong foundations on which other STP and workforce projects can develop.			
	The role is proving very popular for those who do not want to embark on a university course. It has also provided a gateway for the more experienced HCA's who would like a career pathway			

56

57	This is a very important role in nursing due to the lack of nurses from the traditional route. It has taken some time for people to understand the importance of this role as we continue to develop and expand the scope of practice in different areas of the Trust			
	There have been highs and lows but for the majority staff and patients this has been a welcome addition to the clinical team. We have examples of excellent NA who will no doubt pursue a career as a registered nurse in the future and many who will strive for excellence In their role			
	This role has great potential and although we are at the beginning of the journey of integrating them into practice, we can see the great benefit they are likely to bring.			
	This is a positive development which will help us attract new people into health and care careers.			
	This role is very much part of our future planning but we have a long way to go and in very early talks to understand the role and what is needed to support it and how it fits into the teams we have.			