The Introduction and Development of the Nursing Associate Role: Policymaker and Practitioner Perspectives

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Suggested citation:

Study webpage: [https://www.kcl.ac.uk/research/nursing-associates](https://www.kcl.ac.uk/research/nursing-associates)

**Acknowledgements and Disclaimer**

This research is funded by the National Institute for Health Research (NIHR) Policy Research Programme, through the Policy Research Unit in Health and Social Care Workforce, PR-PRU-1217-21002. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care. We are most grateful to all those who participated in this research and to members of the Unit’s Patient and Public Involvement and Engagement Advisory Group for their helpful comments.
The Introduction and Development of the Nursing Associate Role: Policymaker and Practitioner Perspectives

Contents

1. Introduction: 2

2. Approach: 3

3. The Development of the Nursing Associate Role: 5
   a. Drivers
   b. Numbers and Targets
   c. Care Setting
   d. Partnerships
   e. Career Progression
   f. Training

4. Establishing the Nursing Associate Role: 17
   a. Embedding
   b. Scope of Practice
   c. Skill Mix
   d. Outcomes

5. Summary and Conclusions: 27
1. Introduction

The Nursing Associate (NA) is a registered role at National Health Service (NHS) Pay Band 4, typically positioned between the care assistant and the registered nurse. It is a relatively new role, adopted by health and social care employers since 2017 when the first 2,000 Trainee Nursing Associates (TNAs) were taken on, completing their Level 5 qualification two years later. TNA cohorts have been recruited by employers in each of the subsequent years. At the time of writing (July 2021), there are around 4,000 registered NAs in post and 6,000 TNAs in training.

Since Spring 2019, researchers from the NIHR Policy Research Unit in Health and Social Care Workforce, have been evaluating the NA role, concentrating on its deployment, use, management, and impact. Two surveys of Nurse Directors in NHS Trusts (2019 and 2020) have been completed, along with two NHS Trust case studies. A series of interviews with experts from the health and social care system has also been undertaken. In 2019, the first set of such interviews was completed. By late 2020 it was felt that a repeat set of interviews would deepen our understanding of how the NA role was settling down, particularly in the context of the Covid-19 pandemic (henceforth Covid). This report presents the findings from this second set of interviews, initially presenting the methodological approach adopted, before moving on to explore the various substantive themes to emerge from the exercise.

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1 The NHS pay bands covered in the report relate to the pay and grading structure set out in the Agenda for Change agreement covering the NHS in England. The social care sector is not covered by this agreement.
2 The findings from the research work to date are published in various reports, all freely available on the Unit website: [www.kcl.ac.uk/research/nursing-associates](http://www.kcl.ac.uk/research/nursing-associates)
2. Approach

Conducted in early 2019, the first programme of expert interviews was designed to provide a policy context for the introduction and development of the NA role, and an appreciation of how it was viewed and being taken forward in the health and social care sectors. The interviews were centred on policymakers and practitioners with a stake in the role and positioned at different levels of the health and social care system – national, regional and organisational. They included stakeholders from, for example: representative bodies such as the Royal College of Nursing and Unison; regulatory bodies including the Nursing and Midwifery Council; higher education institutions (HEI) delivering TNA programmes; arm’s length bodies, for instance, Health Education England (HEE), and in social care the organisation Skills for Care (SfC); employer bodies such as NHS Employers and Care England; and health and social care patient/service user interest groups such as Age UK. As can be seen in Table 1 below a total of 36 interviews was completed at Time 1. We provide details of the role of interviewees but not other characteristics such as age, ethnicity or gender to maintain confidentiality.

The decision to repeat this set of interviews some 18 months later reflected an interest in exploring whether and how the NA programme had been impacted by Covid, both the new role itself and the related training. With more NAs qualifying and the role maturing, replicating the interviews also provided an opportunity to assess the degree to which views on and experiences of the role had developed. We were able to repeat most of the interviews (see Table 1 below), although in this second round we talked to a number of registered nurses working alongside NAs and TNAs, securing a further stakeholder perspective. It is important to note that with these second-round interviews conducted in late 2020/early 2021, the UK was entering its second wave of Covid. Our interviews were, therefore, picking up the effects of the first wave while impact of the second was still unfolding.

<table>
<thead>
<tr>
<th>Table 1: Interview Programmes</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
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<tr>
<td>Regulators</td>
<td>2</td>
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<tr>
<td>Arm’s-Length Body or sector skills councils</td>
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<td>11</td>
</tr>
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<td>Employers</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Patient/service user groups</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Educators</td>
<td>5</td>
<td>7</td>
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<tr>
<td>Union/Prof. Bodies</td>
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<td>1</td>
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<tr>
<td>Nurses</td>
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<td>Sector Stakeholders (others)</td>
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<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>38</strong></td>
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3 It is important to emphasise that the interviews were mainly with experts from representative organisations. Clearly missing are direct voices and experiences from the frontline of care: from the T/NAs themselves and from the patient/service users who engage with them. Future work on our evaluation will seek to capture these voices and experiences.

4 The findings from this first set of interviews were included in our Interim report, 2020 Evaluating the Introduction of the Nursing Associate Role in Health and Social Care: Interim Report - Research Portal, King’s College, London (kcl.ac.uk)
In repeating the interviews, we returned to the questions addressed in the first-round discussions with experts: why and how the role was being introduced; how the role was viewed and used by different stakeholders; and with what consequences for different outcomes. The cross-cutting impact of Covid on these matters provided a new and additional element to the discussion. In contrast to the first round, all interviews, lasting between 30-60 minutes, were conducted online or by telephone, not face-to-face, whilst again following a shared interview schedule, being recorded and transcribed. The three researchers undertaking the interviews coded their own transcripts producing lists of overlapping but also some complementary core themes. These themes are presented in Table 2 below, divided into two sets, dealing with the development and establishment of the NA role. Each set of themes is considered in turn, drilling down into the sub-themes, and combining them to create a narrative.

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<thead>
<tr>
<th>TABLE 2: CORE THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drivers</td>
</tr>
<tr>
<td>Numbers &amp; Targets</td>
</tr>
<tr>
<td>Care Setting</td>
</tr>
<tr>
<td>Partnerships</td>
</tr>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Career Pathways</td>
</tr>
<tr>
<td>Embedding</td>
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<td>Scope of Practice</td>
</tr>
<tr>
<td>Skill Mix</td>
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<tr>
<td>Outcomes</td>
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</tbody>
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Quotes used in the narrative below are labelled to reflect the interviewees’ position in the health and social care system – National= ‘N’; Regional= ‘R’; and Trust= ‘T’ – along with the individuals’ specific identifier number – 1, 2, 3 etc. So, for example, in the case of national interviewees, the unique reference codes for the individuals who expresses the view will read: N_1, N_2 and so on; for those at the regional level: R_1, R_2 and so on; and at Trust level: T_1, T_2 etc.
3. The Development of the Nursing Associate Role

The core themes from the expert interviews, with their associated sub-themes, can be organised around a development pathway (see Figure 1 below). As can be seen, this starts with those factors driving the NA role, moves through take-up of the role in different care settings and partnerships, to its use as a means of career progression and training. Cutting across these themes was the impact of Covid, with interviewees volunteering and encouraged to expand on the effect of the pandemic on the roll-out of the role. Each core theme and its sub themes are considered in turn.

Figure 1: Development Themes

a. Drivers

From the outset, the NA role has been viewed by policymakers as a vehicle for the pursuit of a variety of policy objectives. Thus, the NA has been presented as:

- A role of value in its own right as a bridge between the healthcare assistant (HCA) (NHS Pay Band 2-3) and registered nurse (RN) (NHS Pay Bands 5-7).
- A new career development opportunity for HCAs.
- A stepping-stone into pre-registration nurse training.
- A means of covering for nurse vacancies and controlling staffing costs.

In assessing the relative weight placed on these different objectives, an interest in developing a new bridging role, of value its own right, continues to inform the introduction of NAs at Trust level. As NAs have settled down within teams and their contribution to care has become clearer (see section 4.4 below), the weight given by Trusts to the value of the role has increased:

I know HEE (Health Education England) are keen to put a certain percentage through to the RN programme, but for us it was all about the NA role, that bridge between HCA and the RN was definitely where we saw it. (T_1)

Trusts are starting to see the departments pulling and saying, ‘I need a nursing associate to do this’, whereas before the conversation was, ‘if I have a nursing associate, what would they be doing’. They are coming to them now and saying, ‘I need a nursing associate in ITU’ (Intensive Treatment Unit), and ‘I need them here, I need them there’. They (Trusts) can see that they (NAs) come with a level of commitment, enthusiasm, drive, willingness, and they’re just performing at that level that they anticipate would be there but didn’t really know what it
would look like because they never had them before. So, that’s why it’s continuing, because they’re seeing the value on the ground, in wards, with patients; they’re seeing the interaction with the team and how they work with other colleagues. (R_2)

The NA role also continues to be viewed as a new career opportunity for long-serving and experienced HCAs:

Because these are our own most of the time, we’re growing them; there are very few Trusts that have gone out to external recruitment, they just see that they (NAs) have stepped up every single time and they have demonstrated commitment and enthusiasm and they’ve seen that growth of somebody who was a health care assistant, now developing over time and operating at a different level. (R_2)

This career opportunity for HCAs was often celebrated by RNs who have worked alongside them and who recognised that the TNA route offered a route for a more diverse cohort of trainees to progress into nursing, and to be recognised – with pay and status:

The fact that these people had been supported to go and do their nursing associate training, just felt really positive that organisations were recognising the value of these individuals and that they were probably working already slightly above their pay grade, and that they wanted to encourage them and give them the opportunity to develop and move up the bandings and widen their roles. So yeah, I just feel very positive about the role. (T_8)

The TNA thing, that was like a good alternative at the time, and continues to be so, so people who perhaps want to do their nurse training but didn’t have a way in because either they didn’t have the qualifications or couldn’t financially afford to do so or geographically it was too difficult for them to travel because they’ve got families, or whatever their circumstances, this has meant that they can actually do this. (T_9)

It was getting to a point where a lot of the experienced healthcare support workers are being asked to take on more and more roles, extended roles, medication, catheterisations, all sorts, and with being able to go forward and do their nursing associate training, gave them the background knowledge and information, plus the qualification, to allow them to take that forward, and it gave them the recognition. (T_10)

Since the first set of expert interviews, there has, however, been a slight shift of emphasis towards seeing the NA role as stepping-stone into pre-registration nurse training. In part this shift was being driven by the NAs themselves:

The desire to go on to (registered) nursing had come from the nursing associates rather than the Trust, because luckily, we’ve never really had a problem with recruiting nurses. (T_3)

As significant in prompting this shift had been the Government’s 50,000 registered nurse target, encouraging an emphasis on the NA role as a direct route into nursing. The NAs’ contribution to this nurse target should not be overstated: around 3,000 NAs in total were expected to contribute to the total by becoming RNs. But the increasing weight placed on the NA as a stepping-stone into nurse training was reflected in various interviewee comments:

It does feel there’s a real emphasis on trying to move them from people who want to be in that position and get to that position, to actually saying this is just a conduit into increasing our registered nursing numbers, and to potentially meet that target that’s been set by the government manifesto to get to 50,000 extra registered nurses. (R_3)

It (the NA programme) is now part of the 50,000 workstream; not necessarily TNAs in their own right, but certainly the nursing associate and assistant practitioner5 and RN programmes are an effective tool for the 50,000 and we’re looking between 3,000 to 4,000 to convert by

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5 The assistant practitioner is a non-registered band 4 role, resting on a Level 5 qualification which, through a top-up programme, might be used as a stepping-stone into registered nursing (see section 3.5 below)
the end of the programme time. (N_1)
The greatest emphasis is on how many of the nursing associates can we get onto the two-year programme to RN conversion; I think it’s about 3,000 we’re aiming to achieve towards that 50K, so it’s smallish numbers, but it is seen as very much part of that drive, and there is a hunger in organisations for that. (N_2)

A big part of what we’re doing is preparing that pipeline; we need to keep the pipeline going. The whole drive behind this 50,000 nurses target, so we’ve been doing some pipeline work, so we’ve worked with our OD (Organisational Development) team on that, we’re just at the final stages of agreeing. (T_4)

More prosaically, the practical and very immediate challenges of maintaining staff numbers given hard-to-fill registered nurse vacancies continued to drive approaches of the NA role. Thus, the NA was seen by some Trusts as an essential means of dealing with ongoing nurse shortages:

People will say, ‘we want registered nurses as well (as NAs)’, that’s fine, but ‘where do you think you’re going to find them?’ would be my question back. (R_4)

While stressing their Trust’s desire to develop NAs as RNs, another interviewee stressed the flexible use of NAs to deal with current nurse shortages in the organisation:

We’ve had a huge registered nurse gap; now that’s got better for us, it’s massively improved. But it has been a little bit of, okay, so we are where we are and how can we do things differently, so how can we make sure that our patients receive the quality of care that they need with the workforce that we’ve got while we’re still trying to attract registered nurses ...

Part of that solution has been this (NA) Band 4 role. (T_4)

b. Numbers and Targets

The drivers discussed were continuing to encourage take-up of the NA role in line with regionally set recruitment targets. Unsurprisingly, however, the first wave of Covid had disrupted this process, particularly reflected in its impact on the delivery of TNA programmes by some higher education institutions (HEIs). As noted by a national interviewee:

Covid has stopped a lot of education, and therefore there were delays in the training of a number of nursing associates and student nurses, during that period, and there have been delays to courses starting. So we won’t reach our (national TNA) target of 5,000 this year, but we will go full pelt next year. (N_2)

We deal with the impact of Covid on TNA training in more detail below (see section 3.6). However, at this point, it is worth distinguishing between the impact of Covid on the intake of new TNAs and the continuation of training for those TNAs already on their training programmes. In terms of the former, many HEIs and their partner health and social care employers have two intakes in TNAs per year – a Spring, March/April, and an Autumn, September/October, intake. The former coincided with the first UK lockdown (March, 2020), with our interviewees suggesting many HEIs deferred their Spring intake:

The figures we were looking at for 2019-20, our target ran from 31st March, things then did start to get difficult; we had a number of our March cohorts just paused; it was the week of Covid, the week we were about to go into shutdown, and there were cohorts planned that week, and they were just paused, and universities were sending their students home. (R_2)

While there was some uncertainty about the target setting period, the deferral of the March TNA intake by some HEIs created notional difficulties in meeting the 2019-20 target:

The programmes that were due to start in March, which would have swept up our Q(quarter)5 numbers and reached the 7,500 target was all delayed. So they generally start in the last
week of March, so we would have had those numbers; they were classed as deferred, ready to start again in August. (N_1)

In the case of those TNAs part way through their training, difficulties associated with the programme, especially related to placements (see below), were more likely to affect the number of TNAs qualifying. This was more of a concern for those in the second year of the programme, where the scope to complete and re-arrange placements was more limited than for those students with still over a year to complete their training.

As noteworthy as the impact of Covid on HEI programmes, the pandemic was also affecting the capacity of clinical units to take on new TNAs. An interviewee from one Trust noted:

There was push back by managers to take-on TNAs for March and April 2020. There’s a point of ‘busy-ness’ and March/April was where every service was under pressure and strain to deal with Covid and the situation, so I don’t think the time and the thought, the inclination was there to actually think about it. (T_5)

Perhaps more fundamentally, some Trust interviewees raised a broader point about a slow-down in the adoption of the role as certain teams reached a perceived limited on the number of NAs compatible with their skills mix:

Particularly for one of our inpatient wards, they’ve already got one nursing associate, they’ve got one about to qualify on our cohort three, but they’ve got two candidates who really want career development, want to go on, very efficient, very able. But the manager was, ‘I’ve not got that role in my team’; so I think it is a bit now have we got to the point that some of the teams haven’t got the budget or they haven’t got the role with it in their skill mix to have another NA, and that’s where we were for quite a few teams as well; they’d reached their skill mix point maybe with the NA role. (T_5)

c. Care Setting

With increasing numbers of T/NAs employed year on year, questions are raised about the distribution of postholders between care settings both within and beyond Trusts. In the case of Trusts, attention was drawn to an ongoing uneveness and variation in the organisational take-up of the role. Some Trusts were keener to run with the role than others:

We’ve got some areas in the region where TNAs have really taken off, and there’s some that really buy-into it, and then there’s other areas in the region where there seems to be a real reluctance to (buy-into it). (R_3)

Some Trusts have really large, large numbers and they really want to embed the role, and other Trusts that are large Trusts, they have four or five in a cohort and we have other Trusts that are having three or four training cohorts of 30 a year. It’s very different across the patch. (R_5)

In relation to Trust type, there were suggestions that community healthcare Trusts were more likely to have Band 3 HCAs in place, better able to transition to a new Band 4 role, than acute Trusts, where HCAs tended to be found in Band 2. A respondent commenting on Trusts in London noted:

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6 This should not detract from examples of TNA recruitment and NA deployment continuing throughout the period as reported by some: So certainly [Covid] hasn’t affected our recruitment into new nursing associate roles... We’re constantly feeding more new nursing associates into the system. (T_7)
Our community Trusts have been especially successful in recruiting to the (NA) role. There’s something about them having a lot of Band 3s in their organisations already; so for them to put the trainee nursing associate or the nursing associate apprenticeship into their organisation, they have a model that already has that pay band present, whereas a lot of acute Trusts have cut that out. (R_6)

Beyond secondary healthcare, primary and social care were raised as spaces opening not only to the development of the NA role as an established component of the workforce, but also to hosting placements for TNAs as part of their training programmes. In the case of primary care, this had been underpinned by the inclusion of the NA in the Additional Roles Reimbursement Scheme (ARRS), from October 2020, providing financial support the salary costs of T/NAs:7

When you look at the Additional Roles Reimbursement Scheme and the fact that it has now been made available to the trainee nursing associates, it is creating the feeling within primary care that this is a lot more doable, although they understand that there is still a lot of support required for the role, and that they will have to provide that support. (R_6)

One of the positive things that we have petitioned for is that the TNA role is now part of the ARRS programme through primary care, so they’re fully funded posts for primary care nursing to embrace, and we’re seeing quite a large amount of activity with primary care networks beginning to swoop and take these people up. (N_1)

One of the areas that we will see a dramatic increase in TNAs is in primary care because of the primary care Additional Roles Reimbursement Scheme that’s going forward. There’s going to be a massive increase because why would you not; they’re getting a fabulous deal there really, salary paid for two years, apprenticeship levy, HEE funding ... It’s an amazing role for primary care; somewhere that NAs will actually be able to maintain that generic oversight for the whole of their career, and there’s not many areas in health and social care where can say they’ll be able to do that. (R_4)

We’ve been working with primary care recently, very much along the lines of could they be a host placement for a nursing associate undertaking the UCAS route. So, they don’t have those employment issues, or needing to provide back-fill, but they are then able to start having nursing associates within their workforce as learners. (R_6)

The growing take-up of the NA role in primary care, and a sense of the scale involved, is reflected in the comment of a regional interviewee noting:

We have been really successful in primary care, we’ve had over 200 in primary care since the inception of the nursing associate and 500 plus out of hospital, so just building on that work really. (R_4)

The picture was somewhat different in relation to the development of the role in social care where despite some growth of interest in the role, take-up remained weak:

There is more interest in social care, but it is just the getting people over the line. Uptake has been slow and limited. (N_3)

Sensitivity to the low take-up of the role in social care had prompted steps by some local Integrated Care Systems (ICS) to encourage and support its developments:9

We’re going to have two project leads up in the (region) around social care linked to a couple of our ICS areas to really push the agenda in social care and develop those pathways and those flows and that information. (R_4)

7 See NHS England » Expanding our workforce
8 Universities and Colleges Admissions Service
9 Although see section 3.4 below for discussion of how ICS’ approaches to the NA role in social care and more broadly vary.
We’ve got a pilot running at the moment in the (region), TNAs in social care, because they’ve got the same issue as in primary care. They’re lots of small independent businesses, and they might be taking one or two trainees at best, and they’re finding the whole navigating the programme difficult. (R_2)

In some of the partnerships they have clinical educators from the Trusts supporting in social care. (N_3)

Such encouragement and support might come from other sources. In another stream of our NA evaluation, we are exploring how a local authority through its adult service department is brokering the development of the role in three care homes. This has involved bringing many care homes together to develop a self-supporting network, helping procure the necessary TNA training, providing financial support and a dedicated and full-time ‘placement development facilitator’ to support the TNA programme and its participants.

In the main, however, the interviewees highlighted challenges to introducing the NA role in social care. These challenges included:

- Understanding the role and how it might contribute to care.
- The costs of training, particularly in covering costs of staff backfill.
- The underdevelopment of the training infrastructure required to provide trainees with mentorship and supervision.
- Paying and retaining NAs once qualified.

These difficulties in social care, deepened by Covid pressures, were reflected in various interviewee comments:

- There is a low level of understanding around the role in social care. They (employers) want advice about whether they can or can’t do certain things, but there aren’t straightforward answers to that question. (N_3)

- The challenge for social care pre-Covid, it was hard enough, but what they’ve just gone through is a very, very difficult time and if you look at what’s happened in social care, their income is a lot less now, unfortunately. (T_6)

- It is fluid at the moment because the direction of travel has been so impacted by Covid activity, so we’re clearly conscious that pushing a whole load of stuff onto the (social care) sector at the moment is not appropriate in trying to push things forward. (N_3)

- Certainly social care is very tricky, because primary care are providing a lot of NHS-contracted services, so they can mesh in quite well, but in social care, there has been no infrastructure investment for a long time, they haven’t got the support mechanisms that are needed, the infrastructure that’s required to support learners, and again you’re asking small independent privately-owned companies in some cases, that don’t provide any NHS-contracted services, to consider taking on an apprentice. (R_6)

- It’s so expensive. I can understand absolutely why a care home owner, or a manager, would turn around and say, ‘where’s the benefit?’ It’s a huge cost. We, as big organisations, we’ve shared our levy quite a bit with smaller providers to allow TNAs on the programme, but that doesn’t cover the salary costs; half the time they’re not in work, so it’s a big hit they’re taking. (T_6)

- Underlying it all is the lack of a coherent infrastructure within social care that can support work-based training easily, so wherever it has been undertaken it has been that little bit harder and that little bit longer. (N_2)
d. Partnerships

From the outset of the programme in early 2017, place-based partnerships have been central to the development of the NA role. In general, these partnerships have included health and social care providers in given localities, including those from the private, voluntary or independent sectors, with a view to sharing and aligning resources and systems around the development of the new role. NA partnership and ICS models have, however, taken different forms, mapping on to local health and social care systems in various ways. Some NA partnerships have corresponded and been integral to the locality ICS (formerly working under Sustainability and Transformation Plans (STPs)); others have covered a discrete area within the ICS; while there are cases where the NA partnership has mirrored the ICS catchment area without being fully integrated into its governance structure. The relationship between the NA partnership and ICS has remained fluid, with a trend perhaps towards bringing the arrangements for the former into the infrastructure of the latter. The choice of model is important, with implications for the range of organisations involved in locality NA programmes and for the nature and levels of support provided for its implementation. An interviewee from a large city region noted:

Some ICs are inclusive (in NA terms), so (name of ICS a) and (name of ICS b) work very much as a collaborative with all the Trusts and primary care and social care in those areas coming together to support and provide the placement circuits that are needed for the role and to really support the learners in that. In contrast (name of ICS c) originally was a very acute-focused ICS, but has developed over the last year, two years, to include primary care within that collaborative and support primary care, and now this year they are planning to focus on supporting social care to get and to engage within that as well. (Name of ICS d) and (name of ICS e) are still a little bit more of a separated model. So we have the acute hospitals that work together as a partnership, and then we have the out of hospital collaboratives that work to support the role in those areas, but we are slowly linking them together. (R_6)

Working within the ICS infrastructure has also provided an opportunity for local health and social care systems to develop more strategic approaches to the NA programme, in some instances embracing the whole of the nursing workforce and examining how it might be structured in the future. In one city-based ICS, for example, an NA oversight board had been set up with work streams on: attraction/recruitment; workforce modelling; functional skills; training; and retention/career progression.

This broadening of the NA agenda is apparent in a comment from a regional interviewee:

One thing I’ve been really pleased with in (region name) is the partnerships sharing learning. So what we see now is each STP not just focusing on the TNA, but actually saying, the TNA is part of our nursing workforce, let’s develop our community of practice for TNAs so it is focused on the nursing workforce focus. (R_3)

Partly related, located within an ICS, there was scope for the NA role to become part of a systemwide process of workforce planning:

Those (partnerships) that have got embedded into their ICS, or STP are doing better, because it (the NA role) is part of the workforce issue and they can put pressure on the Trusts to start that workforce planning, not just against the bottom line, but against actually what you require in that space. (N_1)

These views were echoed by another interviewee stressing the scope for workforce planning at systems level increases with the growth in NA numbers:

The (NA) programme is driven by individual Trusts. It is still very much so in my area. But I suppose the STP picture comes in, in terms of broader workforce planning. So we’re trying to

10 For explanation of STPs see Sustainability and transformation plans (STPs) explained | The King’s Fund (kingsfund.org.uk)
get the STP doing their workforce plans and where does the nursing associate fit into those workforce plans, and it’s really only now that we’re able to get into those conversations because when you had 200 across three or four STPs, there just wasn’t the scale, and even within Trusts you say, you’ve got two over there in that department and there’s three over there, and it just wasn’t a conversation you could have. Now the conversation is we’re recruiting healthcare support workers, we’re trying to create a pipeline for them to progress, which is the nursing associate role; we’re then trying to get them to progress and fill nurse vacancies if that’s where they want to go, so where is your complete workforce plan that says you can support all of that infrastructure, so I think that’s where the STP comes in, and when you get that answer, it then would fall back to the individual Trusts. (R_2)

e. Career Progression

The implementation of the NA role is playing into a much broader agenda around the development of career pathways into nursing. It is noteworthy that in this round of expert interviews the topic generating the most extensive range of sub-themes centred on careers. The interviewees drew attention to steps being taken to promote the NA as a career option in its own right. Since our last programme of interviews, a Nursing Ambassadors role had been created, filled by current TNAs and NAs, and designed to publicise and encourage job seekers to take up an NA career. Ambassadors have been connecting with schools and encouraging young people into an NA role perhaps more accessible to some than the graduate registered nurse role:

The career pathways bit, we’ve been getting into schools, getting into colleges, talking to the BTEC students, making sure we increase that number of students that are coming our way. (T_4)

You’re probably looking at school-leavers and reflecting on my own career journey, I can remember being interviewed to be a registered nurse at 16 back in the early ’80s, and being told I could never be a staff nurse, but I could be an enrolled nurse; I didn’t care, I just wanted to be a nurse, so there’s an element of that with the trainee nursing associate, that if you’ve got those people who perhaps aren’t quite academic enough but they can see this as an opportunity, and the difference with the enrolled nurse and the trainee nursing associate is the nursing associate is a very definite routine stepping stone to RN whereas it wasn’t way back when, so there is definitely that element of actually this is a potential to get me where I want to go. (R_4)

It is around how can we look at other alternative streams in for the NA, whether that’s using further education colleges, or that could be their access to healthcare programmes and now the new T-Levels. (N_1)

These attempts to encourage young people direct from school onto TNA programmes raises interesting ‘downstream’ questions about the demographic NA workforce going forward, with the early waves of NA principally comprising experienced HCAs in their thirties and forties. Indeed, there are already signs of the relative orientation of more experienced and younger T/NAs. As one nurse working alongside T/NAs noted:

The ones (T/NAs) I’ve had dealings with have been very competent… they have been a healthcare assistant, so they’ve got the understanding and the principles … The younger ones come in and don’t always have the full understanding of what the NHS does, and aren’t always able to motivate themselves. (T_11)

The changing nature of the NA workforce is also signalled by the increasing engagement with the NA role by individuals external to the Trust, whether as self-funders on a TNA programme or as an externally recruited as a TNA apprentice. There were some differences between the regions in the scale of direct entrants. In one area this approach had yet to gain traction:

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11 Ambassadors to fly the flag for the Nursing Associate role | Health Education England (hee.nhs.uk)
In (region name), we haven’t got any major established direct entry cohorts. I think we had a few towards (town name) way, minimum numbers. (R_3_)

In another, it was taking-off and at scale:

I remember going to (city name) when they had just recruited at the start of the year, February time, and I was like, ‘oh, how’s the external recruitment going?’, because they were really nervous about bringing people in who’d had no care experience, and it’s just not going to work and they will leave after two months, and they were recruiting women from Thomas Cook (travel agency) who had just closed, and they were going... fabulous they’re absolutely amazing, so that’s an interesting one that, for me, would require follow-through because ultimately we can’t keep on just churning up our own people and pulling them through. (R_2)

An interviewee from another region noted:

The direct entry has come into the mix in the last 12 months and interestingly, personally from a (region name) perspective, I was really surprised that they recruited in September, I think it was 60-odd, that first cohort through direct entry. Across (region name) you probably had just over 100 direct entry TNAs that came in in September, and interestingly those people had applied for the trainee nursing associate programme; a lot of people thought they would apply for the RN, not meet the entry criteria and be directed to the TNA and that’s not what’s happened. People have applied directly for the trainee nursing associate programme as direct entry, rather than RN. (R_4)

This uneven engagement with external recruitment was reflected at Trust level. One Trust interviewee noted, ‘We’re looking to external next year’s cohort, but they’re internal at the minute’ (T_1). However, another Trust interviewee highlighted steps taken down this path as the number of current employees willing or able to move into TNA training began diminishing:

When we joined (the NA programme), we had about 75 percent internal and 25 percent external (candidates); that has flipped, and that’s the experience of a lot of people in our sector. You get to a saturation point, and it’s one of two things; it’s either functional skills, getting people through that takes a lot of time, or you are just targeting people who don’t have the aspiration to do it, and that’s why the external recruitment for us is now really important, because even our most recent round, where we wanted to support 20 places, we had a number come forward but only three successful. (T_6)

This reference to functional skills was raised by another of our interviewees who similarly stressed the challenges in acquiring them especially amongst aspiring HCAs as an ongoing problem, and a further reason for not meeting expected recruitment targets:

Where we have employers telling us they are going to recruit ‘x’ number to a programme and they are going to start ‘x’ number on a programme, the one thing that we always get back when we go to them and say, you said you were going to recruit this many, what happened, functional skills comes in there every single time. We’ve moved forward slightly. There is better pipeline support work in acute Trusts. We’ve now set up and supported the ICSs at that level to deliver and support their local communities to get those skills, but a lot of the time that’s still a stumbling block. (R_6)

Functional skills might become less pressing as NHS England and Improvement (NHSE/I) seeks to encourage the recruitment of healthcare support workers (HCSW) perhaps more formally qualified than the longer serving HCAs. An NHSE/I HCSW Programme,\textsuperscript{12} was designed to recruit to the HCSW role, so addressing longstanding vacancies. However, there were also suggestions that this was creating a new HCSW pathway into the NA role, with those becoming HCSWs then encouraged to move into NA training. As with the direct entry onto TNA programmes, this pathway and the generally

\textsuperscript{12} NHS England » Healthcare support worker programme
younger, more formally qualified cohort taking it, might well further contribute to the changing demographics of the NA workforce. An interviewee noted:

The healthcare support worker campaign has offered us a different perspective on the landscape…. Looking at the demographics of the people coming in, the level of education the majority of applicants have is a good-quality secondary school education, so we’ll be leaving with functional level maths and English, which will make transition into things like the NA programme or the nurse degree apprenticeship easier. \(N_1\)

They continued:

But some of them are graduates as well, so it’s how do we work with that demographic, going into healthcare support worker roles, how do we get them transitioning through a career pathway? So we’re now seeing you can come in as a healthcare support worker, you can do your Care Certificate, you can be talent-mapped into either nurse degree apprenticeship route and/or through the TNA process as well, dependent on where your ambitions lay, in the first instance, and it’s working with our provider organisations to be able to talent-map these people through. \(N_1\)

We have noted the increasing attention drawn to the NA role as a stepping-stone into \textit{pre-registration nursing training}. As a possible counter to this career pathway, it was noted that young people, with high formal qualifications might be tempted to move from schools or colleges directly on to Registered Nurse Apprenticeship (RNA). In other words, they might side-step the NA-RN route moving straight on to the RNA. As an interviewee at Trust level noted:

The RN Apprenticeship is better supported now, better funded as well, so for the first time we’ve done them separately in terms of our internal recruitment and adverts. In the past people came forward for the TNA and then separately for the RNA, whereas this time we put them out together. It was intentional and obviously we got a lot more apply for RNA than we did for TNA, and also the candidates who were of a high quality… healthcare assistants who were very good, who could access it, so there’s no point in putting them on a different programme for two years if their own goal is to be an RN anyway. I’d rather start them on the programme that they’re going to finish on, and they’re academically able, that’s clearly what they want to do, and so that’s also why we probably saw fewer internal people coming forward for TNA. \(T_6\)

Further weight was given to direct entry into the RNA by the suggestion that organisational support for personal development might be difficult to find immediately after NA qualification. There are various reasons why follow-up organisational support might be withheld, not least an interest in embedding the NA role and ensuring a return of the time and effort invested in the NA training. However, constraints on progression immediately following NA qualification risks causing frustration amongst these individuals and possibly encourages movement to employers prepared to offer support. As an interviewee at the regional level stressed:

What is slightly worrying, particularly within (region name), is that a lot of the organisations have been very focused on the initial TNA recruitment, recruiting into the NA role, but where they’ve had individuals who’ve qualified, who’ve wanted to go on towards registered nurse (status), they’ve not necessarily supported that because that’s not necessarily a priority for the organisation. So, particularly in (region name), there is movement of qualified NAs to different organisations, and I was on a call with (Trust name) and they’ve definitely seen a number from that first cohort qualifying move to another organisation who are supporting the RN top-up. \(R_3\)

The final career sub-theme relates to the interface between the unregistered Band 4 \textit{assistant practitioner (AP) role and the registered Band 4 nursing associate role}. In the first round of expert interviews the AP was principally viewed through the lens of tensions with the NA role. In the follow-up interviews the AP was viewed much more positively as a further potential route into registered
nursing (through a top-up programme\textsuperscript{13}) and a means of contributing to the target for 50k new nurses:

As time has gone on, I can only speak probably from (the region name) perspective, Trusts have had to respond to the existing AP workforce and reassure them, and with the emergence of the AP to RN top-up, now we’re seeing, in some respects, HEE, the government, Department of Health and Social Care are putting their money where their mouth is and saying ‘yes, as an AP we value your input’. (R\textunderscore 4)

Although uncommon, there were cases where APs keen to achieve registered status were prepared to train as NA without an ambition to become a registered nurse (progression from AP to RN status via the NA role would certainly be a long and costly route):

I’ve had some APs who have done a transition to nursing associates because they haven’t wanted to be a registered nurse but they’ve wanted to be registered and have that ability to develop a scope wider, so we have had a handful of assistant practitioners who’ve gone on and done year two of the nursing associate, and registered that way. (R\textunderscore 4)

\textbf{f. Training}

The subject of training has already been explored in the context of TNA and NA numbers and targets. It is, however, worth examining interviewee views on training in greater detail, particularly against the backdrop of Covid. As hinted at above, a distinction can be made between the pandemic’s impact on the start-up of new TNA programmes, and the operation of ‘live’ ones. With start-ups, Covid’s impact had been deferral of some programmes and the delayed engagement of participants. Where Trusts were taking two cohorts a year, this delay could be relatively brief. For example, in one region March 2020 programmes were often simply delayed until September 2020, although this did have knock-on effects with a new cohort due to start on that date as well: in some cases, this clearly inflated September 2020 participant numbers creating pressures which, in a few cases, led to the postponement of the September intake.

In the case of existing programmes, interviewees highlighted cases of programmes simply being suspended by Trusts:

In (region name) there was one particular organisation that paused every single one of their TNAs on every single cohort, regardless of where they were as a knee-jerk reaction at the beginning of Covid. Actually, there was two, but one of the organisations came back after about three weeks and said, ‘we’ve done the wrong thing, let’s just reinstate them’; whereas the other organisation has kept them on a break in learning for a substantial length of time. (R\textunderscore 5)

More specific Covid concerns impacted the three main elements of training-college (HEI) learning; placements away from the base placement and the base placement itself\textsuperscript{14} – slightly differently. College learning was largely able to move online, although this was not without its challenges, both in terms of internet access by TNAs and direct engagement with college tutors. The capacity for learning in the base placement was disrupted by the intensity of work in many clinical areas, and in some cases the redeployment of staff including TNA supervisors and mentors. However, most affected were the placements away from the base, with Covid limiting movement between care settings. This was especially problematic for TNAs in their second year; for first year participants placements could readily be scheduled for later in the programme; for second years there was less scope to do so:

\textsuperscript{13} This is not an unproblematic process, for example with HEIs adopting very different approaches to the Accreditation to Prior Education and Learning (APEL) and the extent which it counts to their RN training.

\textsuperscript{14} The most common training model is based on a core, base placement complemented by number of short placements in other care settings, often referred to as a ‘hub spoke’ model. There are, however, other arrangements, in particular, a not uncommon approach is one organised around a small number of rotations over the two years, again complemented by short placements elsewhere.
It’s addressing that placement capacity issue which is really challenging at the moment and it’s putting the emphasis on the second years who are due to qualify in Spring (2021) from the 2019 cohorts. (R_4)

However, several nurses reported problems with RN staff shortages leaving TNAs without mentors when on placements, which had pre-dated Covid:

Because of them requiring mentors on the ward … sometimes they’re having to work, go back to working as health care assistants when the numbers are short … they miss out on their trainee nursing associate time, really, that’s the problem …. They’re short-staffed in our Trust. (T_9)

There was also awareness from RNs of the wider impact Covid would have had on the TNA learning environment:

Covid’s had a huge impact and it’s definitely all hands on board. It must be really stressful coming into that environment and being part of a team going through something that had never happened to the Trust before, and it’s not having those learning opportunities, I suppose a lot of the training has been suspended in the hospitals and you can’t go to the dementia forums, you can’t go to these other services … In terms of wards around scrubs, so you can’t easily be identified because everyone looks the same so it’s harder to say ‘I don’t know, I’ve never done that before’. (T_13)

Generally, the responses to pressures on training were attempts to develop recovery plans and reconfigure programmes:

We’ve seen lots of universities front-loading theory into that first year component… if not all of them have front-loaded theory well up until Christmas, which is great because obviously, it’s addressing that placement capacity issue which is really challenging at the moment. (R_4)

Our students, including our nursing associates, can’t attend face-to-face teaching … so our universities [named HEIs] they’ve moved resources onsite to support the local learning offer on much more practice-based learning and more simulation...from a learning perspective, Covid has actually probably – I hate to say this, but – assisted in getting the learning much closer to the apprenticeship work-based offer. (T_7)

In terms of tangible consequences for training, there were some concerns about downstream pressures and blockages as deferred placements were becoming built later in the programme. While delays on the completion of programmes were around three or four months, at the same time the impact of Covid on TNAs should not be overstated. The ‘knee jerk’ response of the Trust noted above to suspend and then quickly reinstate TNA training is striking:

It was, ‘crikey, what’s going to happen with Covid, how many patients are we going to have, what capacity do we need, let’s just bring everybody back’, and as I say one organisation then realised that actually because we had student nurse deployment as well, we had stand down routine and services, actually they were inundated with staff, they had more staff than patients at some points, so they then reflected and said our TNAs can go back to that learning. (R_4)

A few years into the NA programme there was also a degree of resilience built into the training model in many NHS regions, not least in terms of building-up placement options:

It (Covid) was not as much of a challenge as you’d think, and because we’ve had this good solid three years of this in (region name), they’ve had real experience and appreciation of what placements could be, what opportunities could look like, and they’ve just scaled (up the number of placements), and they can go, okay, we can’t send you there, but we can send you there, and you can do two weeks there… they can really manoeuvre and flex things, whereas in the early days they were like, we’ve got three options here and that’s it, and now they’ve got ten options. (R_2)
4. Establishing the Nursing Associate Role

Having examined the themes related to the development of the NA role, this section explores the second set of themes derived from our expert interviews. These centre on the establishment of the role at the workplace level. The core themes and associated sub-themes are set out in Figure 2 below, which is designed to highlight the close link between them. Thus, the extent to which the NA has become embedded within the clinical team will be seen as closely related to the role’s scope of practice, which, in turn, has significant implications for skill mix. In other words, reviewing skill mix with the NA in the team is likely to be difficult until the role is integrated into service routines, and it is clear exactly what the postholder will be doing in terms of tasks and responsibilities. Despite the overlap between these themes each will be considered in turn.

![Figure 2: Establishment Themes](image)

a. Embedding

From the outset, the NA role has faced challenges embedding itself at the workplace level. In part these challenges have related to uncertainties about the nature of the role, to be explored below in relation to the scope of practice. They have also manifested in resistance from various stakeholder groups, who perceive themselves as threatened by the role. For example, an HCA might well view the NA role as a new career opportunity but, for those unsuccessful or not interested in taking this step, the NA role becomes a new and possibly unwelcome source of supervision and accountability. Higher profile resistance has been apparent from some registered nurses fearing substitution and a breach of traditional boundaries in terms of normatively protected tasks and responsibilities. This resistance from different parts of nursing workforce is reflected in an interviewee comment:

> It’s very hierarchical, nursing, and that’s quite debilitating. So I can only imagine what it’s like for some NAs out there, and having to manage the expectations of the RN, who would be delegating specific tasks, but then also having to manage healthcare assistants or, for example, an assistant practitioner who may feel, hold on a minute, we’re working to the same level here, but you’re regulated and I’m not, so they’re having to manage both ends. (N_4)
With the role becoming better known and understood, this resistance was beginning to weaken. As one interviewee noted, ‘It (resistance) has gone quiet on the horizon’ (R_2). In a similar vein another noted, ‘Two, three years ago there was a lot of resistance, maybe based on lack of understanding, threat, a whole lot of stuff. Most people have moved on from that now’ (T_6). An emphasis on familiarity with the role encouraging acceptance is reflected in a couple of further comments:

Just working with the nursing associates through the programme, they really do have a place and they’re so valued because of their experience before, and their motivation in this role is fab. And it’s been nice to see it working, especially with the bad press at first with... ‘are they the cheaper nurse?’ and stuff like that, but they really have got a place, they really are valued, and that goes from the feedback that we’ve had from staff as well, about when are you going to give us some nursing associates for a placement, and I was like, great, you can have more. (N_3)

The whole discussion with regards to replacement was an issue that the poor nursing associates that came through in wave one and wave two really felt impacted by because most of the nurses that they were work with, were going, ‘oh, they’re just trying to replace us, they’re trying to put in cheap labour’. But I always find that you would send a nursing associate into an area and just go, we’ll just have one for a placement, just see what they can do, and that would change their minds, because once they’ve worked with them, they would understand that actually you do fit in the team and this is where you fit in the team and this is what makes it work. (R_6)

However, there was a degree of residual concern about the NA role from various quarters. As one senior policy maker noted, ‘Absolutely, there are still a number of concerns around substitution’. Another national interviewee stressed:

The main challenge with the nursing associate role is actually with RNs and it’s actually the mindset within the registered workforce, not completely understanding and appreciating the role and its remit. (N_4)

This interviewee proceeded to cite the example of a particular task, cervical screening, traditionally performed by the registered nurse but possible being taken on by a NA:

Historically, it’s (cervical screening) always been RNs, practice nurses that have done this, and there’s this reservation in terms of, ‘oh, we need to be really careful here because of a, b or c’, but actually, with the right training, which is robust from a Public Health England perspective, from an NHS England Improvement perspective, the competencies, the training is very robust, but there is still that hesitancy from RNs because I don’t think they fully appreciate and understand the role yet, and that’s a mindset shift. (N_4)

More prosaically perhaps, embedding also touched on NA role take-up across the organisation, in particular whether and how it was being rolled out across clinical areas. Certainly, there was debate on whether to go broad in terms of NA role coverage or whether to build more of a critical mass of NA in certain wards and teams. One Trust had chosen the latter ‘critical mass’ approach, allowing NAs to become a self-supporting group and firmly established within a limited number of teams:

We’ve used wards that have got NAs in their establishment and we’ve then put TNAs in there so they could be supported and so that we can start to change that whole working culture really at ward level, so that people are used to having them in their workforce and working with them. (T_4)

Another noted:

We wanted to cohort them (TNAs); we didn’t want to just dot them out everywhere, because we just thought they’d get lost, so that’s why they chose two areas. And then for the October ’18 again it’s still fairly small numbers but we’ve tended to put them into groups of two, so again, we’ve got some in ED (Emergency Department), we’ve got some in surgery and medical
as well, so it’s spread out more now. (T_1)

Nonetheless, the former approach, introducing the NA more broadly and in range of specialist clinical teams, was also in evidence:

Endoscopy have had assistant practitioners for a very long time and they’ve really established and done well there, but they decided they want NAs, so they’ve taken NAs there, so that will be quite interesting and ITU is another area that they haven’t had them before and they’ve taken them. (T_4)

Another interviewee noted:

We’re seeing them (NAs) deployed more and more into really high-profile care spaces, so into critical care, into theatres, into HDUs (High Dependency Units) and rehabilitation wards as well, so I think that’s a really positive thing. And the NA role could come out of this (Covid) really quite well …. There are some cases (of NAs) working in critical care environments, and the amount of support they can offer, not just the nursing service, but also the families. (N_1)

Moreover, in some Trusts senior management was taking a more deliberate, considered approach to the clinical position of the role. This contrasts with an opportunistic, ‘bottom up’ approach to the location of earlier NA cohorts. As a Trust interviewee noted:

Initially it was all about getting the numbers in. People would be on programme and we would have to go out to areas and say do you want to have a TNA, and in the early days it was really hard because no-one knew what that meant or looked like and a lot of people didn’t want it; they were resistant so it was quite challenging and it was a bit of begging and lots of going out and about and trying to make a case. Now we’re in a position a few years on, where we know more about the role, what it does and what the training looks like, and also we can better see how it integrates into the wider nursing team. So there’s much more work now around having a clearer process for where TNAs are based, partly because we’ve now built up an establishment of those training posts, and they will just continue as training posts, and also then looking at the workforce, so we’ve recently done a whole lot of service change anyway, which would have happened without Covid, which included establishment reviews and a few areas put nursing associates into the establishment. (T_6)

This more considered approach to placing NAs in clinical areas is further reflected in the comments of a Trust interviewee noting the iterative nature of the search to find the ‘right place’ for the NA role:

We did keep in contact with the TNAs and look at their development, look at where their roles seemed to be benefiting the different areas, and then we had conversations obviously with our Deputy Director of Nursing at the time, who had conversations with the different services to see where the TNAs would be best placed, best deployed. So there was a lot of talk at the time about them being deployed into the community, not into In-Patients at first, because that’s where they thought the role would suit better because they were looking at those physical health targets in mental health services. However, initially the ward-based one was going to be on a community setting and it was going to be in a crisis home treatment team; however, once they’d started there, we recognised that it wasn’t working and we spoke to each other, and we don’t think the team was at that stage where the nursing associate role would be beneficial, so hence we had another conversation and moved them into the older persons’ ward, and actually it’s fitted in really well, where they weren’t thinking about In-Patient services at first. (T_3)

Approaches to the roll-out of the NA across and within healthcare organisation feed through to affect the scale of role take-up, the raw numbers being employed. Trusts are employing to the role with increasing alacrity. It is, however, important to place the 4,000 qualified NAs in context. There are over 300,000 registered nurses and over 160,000 healthcare assistants. In most Trusts NAs continue to be employed in relatively small numbers. As a national interviewee noted:
One of the problems is they’re still smallish in numbers... once you get a good mass of them into the service, that’s when I think the role will be much more appreciated, rather than ‘oh, you’re just the nursing associate, you’re like an add-on’. As the numbers grow and we clarify what the nursing associate can do, at that point it should tilt the other way. (N_2)

This view was echoed by a regional respondent stressing the need for enough NAs in a team to ensure their regular presence on shift:

If you’ve got ten NAs in a trust, how much impact are they going to have when you have maybe just one or two in a clinical area, when to actually have any meaning, you need about three or four in that area, so that when one’s on a long day, the other’s on a day off, one’s on annual leave, one’s on nights. (R_6)

b. Scope of Practice

Examining the NAs’ scope of practice is core to our evaluation. It centres on what NAs can do at the workplace both in terms of personal capability and institutional permissiveness, with significant implications for a range of stakeholders and for the NAs’ contribution to care delivery, and of course for the health and care outcomes of patients and service users. Given the regulatory arrangements underpinning the role, establishing the scope of practice emerges as an iterative process sensitive to a variety of factors. These regulatory arrangements establish some quite precise limits on the NAs’ scope of practice. For example, interviewees noted the fact that NA were not allowed to administer medication under a Patient Group Directive (PGD),15 limiting their discretion in certain respects:

If they (NAs) do a PGD, that’s prescribing by another name, really, and so I think there’ll be a lot of concern around that. So a nursing associate will not be able to prescribe, but they will continue to be able to administer. (N_2)

It was also stressed by one interviewee that NAs were ‘not allowed’ to undertake primary assessment of patients. Indeed, these very precise limits on NAs’ scope of practice were captured by one interviewee noting:

At the moment, the NMC (Nursing and Midwifery Council) are saying that the nursing associate cannot be the primary assessor, so the primary assessment needs to be undertaken by a more senior professional, and they can do the ongoing assessment. So I think there are subtleties (N_2).

However, more generally, the regulatory arrangements for NA role are quite broadly framed by the NMC. As for Registered Nurses, the NMC sets standards of proficiency for NAs’ generic areas of substantive responsibility. These are accompanied by indicative tasks which might fall within them, but healthcare employers retain considerable discretion as to how the role is used and the competencies they choose to develop in this part of their nursing workforce. Thus, Trusts have some flexibility as to how they develop the role to meet local circumstances and needs, leading the process of establishing the NAs’ scope of practice to be uncertain and uneven between and even within Trusts.

The distinction between uncertainty and unevenness is an important one. Uncertainty about the NAs’ scope of practice has been raised throughout our evaluation and, our expert interviewees suggested, a residual degree of uncertainty remained:

We’re still learning about what that looks like (the NA role), certainly in the organisation where we haven’t implemented it yet. (T_6)

Because the critical mass isn’t there in the majority of Trusts, people still question, what can

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15 Patient group directions (PGDs) are written instructions to administer medicines to patients, usually in planned circumstances. For more information of PGDs see Patient group directions: who can use them - GOV.UK (www.gov.uk)
you do (as an NA)? (N_1)

The (NA) role has been around for a number of years now, but I still don’t think there’s enough understanding and trust in the role and understanding what the role will look like and how it evolves and what these people actually can do and can’t do and what their capacity and capabilities are, amongst the nursing community, to be able to have fully embedded it and embraced it yet. (R_3)

There is a lack of awareness around the role. It seems what all the ward managers seem to ask me for, what they want is a list of what they can and can’t do. They want a tick box, they can do this, this and this, and they can’t do this, this and this, and actually when you try to explain that it’s not about what they can do, it’s who they can look after, and matching the skill mix that they have with the patient, that’s trying to change how you work on the ward and everything; there’s much more task allocation. (T_1)

This uncertainty about scope of practice was described by one RN as a source of frustration and vulnerability for some NAs and TNAs whom they worked alongside in an acute Trust:

There was a little bit of frustration from the nursing associates and the frustration that it wasn’t clearly set and I suppose they felt more vulnerable about what they could do and couldn’t do, it wasn’t always clearly put, and it is about other professionals knowing what their limitations are, not putting them in difficult situations where they might be asked to do something they couldn’t, and that can be quite challenging, especially newly-qualified. (T_13)

At the same time, and as stressed above, attention was also drawn to the role’s contribution to service delivery becoming clearer:

It’s evolving quite nicely really. At first with the nursing associate roles there was a lot of confusion between other staff that obviously weren’t involved in the roles about what they could actually do, and how it’s overlapped with the assistant practitioners as well and how it had a role in itself, it wasn’t a nurse, it wasn’t a qualified nurse, but it wasn’t a HCA. So I feel as though perhaps organically it’s started to evolve now and there’s a lot more clarity around those roles, which is really nice to see. (T_3)

I haven’t had that scope of practice question with Trusts in a long, long time; in the early days when we didn’t have qualified nursing associates it was quite a regular question. (R_2)

While uncertainty about the NA role can and is being overcome, unevenness in the scope of practices reflects more deliberate and enduring choices made by health and social care employers on how the role might be used and developed. This was partly reflected in debates on and variation in the inclusion of certain tasks in the NAs’ remit, most strikingly illustrated in the case of the administration of IV (intravenous) drugs, which fell beyond the NA scope of practices in many, but not all organisations:

What is happening in the (region name) and (another region name) is very different to what is happening down here. We have a very good communities of practice board and that board has agreed we don’t go near IV drugs ... We’ve already got this disparity happening where, in the (region name), they’ve said no, we’re going to train you to do IV drugs because that’s what we need you to do, because the nurses are doing this. So that’s fine, but this role is so... ambiguous at the moment, that we could do with a little bit of direction, and we’re not going to get that, so we’ll just sort it out ourselves. (T_4)

Another task subject to ongoing discussion is, as noted above, cervical screening, especially in primary care. It appears this can be undertaken by the NA under supervision by a nurse, but, as noted above, has traditionally been undertaken by registered nurses and for some this appeared to be the regulatory position:

There’s legislation around cervical screening, for example. I’ve forgotten the legislation, but
actually nursing associates aren’t on the register of recognised professionals to undertake cervical screening, but they can undertake the training, they can actually do the screening, as long as they’re supervised by a more senior registered professional. (N_3)

From a primary care perspective you’ve got to have development of the role around things like cervical cytology training because you have to be registered, you have to have a PIN number to undertake that training, so they did a lot of work in the early days with NHSEI, Public Health, HEE, to enable the nursing associates to be able to undertake that additional roles and responsibilities in training and they can extend their practice within their scope of practice in line with the NMC Code. (R_4)

The only scope of practice issues that we’ve come across have probably been in primary care, because I think that has been some specifics around can they do immunisations, can they do cervical cytology. (R_2)

At the same time, our interviewees highlighted unevenness in the scope of practice as a response to the specific needs and interests of different clinical areas. For example, in general surgical and medical wards the NA role was positioned to contribute to the routine delivery of higher quality ‘bedside’ care:

We would see this working as really well where we’ve got health care assistants who support really good fundamentals of care for the nursing team, the nursing associates who deliver a higher level of support to the patients who are stable and not overly complex or deteriorating and your RNs direct all of that care and are freed up to spend time with the more complex and sick patients. (T_6)

This quality ‘bedside’ care had been witnessed in practice by one RN, deployed under Covid to work alongside an NA in palliative care:

I was redeployed into palliative during the first lockdown, and working with the palliative team we were looking after a gentleman and one of the nursing associates was looking after him and the care that she (the NA) was providing was absolutely brilliant, and it wasn’t just clinical care, it was the more holistic care ... and the knowledge of that patient as well, not just clinically, but who they were, what they’re like, how they’ve been, what their family’s like was brilliant. (T_12)

In more specialist settings – for example the Emergency Department or ITU – the NA role was seen as resting on the development and application of a specific set of technical skills:

We’re trying to raise awareness about the standards of proficiency for NAs to be competent at when they qualify, but actually depending on what the patient need is. For example, potentially you could look at IV in ED, and ND (nasoduodenal) tubes in gastro wards and things like that, so it’s definitely something that we’re keen on. (T_1)

(Trust name) have employed nursing associates in their intensive care unit, and what they’ll do is they’ll have three patients, ventilation patients, critical care patients, with two RNs and a nursing associate, and they’ll work as a little team looking after those. Now, that would never have been considered at the beginning, but it’s working extremely well. (N_2)

As already implied, the uncertain and uneven development of the NAs’ scope of practices touches on a range of actors, raising dilemmas for them. For the NAs themselves the development of sophisticated clinical skills runs the risk of taking them way from their intended generic care role:

There is a mixed bag of understanding and desire around the role. The role itself is fundamentally to deliver patient centred care. If you put somebody into a drug room to draw up IV drugs, as many of them are now giving, are you taking them away from the fundamentals of the role? (T_4)

For the registered nurse, the passing-on of certain clinical tasks, often quite recently acquired from junior doctors, to the NAs, raises profound questions about the nature of the RN role:
When I was a nurse the junior doctor did the IV drugs and we did the patient centred care. That was then passed to us. Are we now passing that down? Are we deskilling ourselves or upskilling another part of the workforce? If we are handing that over what are we doing? (T_4)

Indeed, for the RN a similar dilemma arises as to whether the establishment of the NA institutionalises or reinforces their distance from the direct delivery of bedside care:

We don’t want to move away from the registered nurse being a carer as well, because that just diminishes the caring, because looking after somebody, washing somebody, you’re not only just washing somebody, you’re assessing their skin integrity, you’re looking at all sorts, and it can be quite complex and you need those assessment skills to be able to undertake that. (N_2)

c. Skill Mix

The issue of skill mix raises important questions about how the NA role is integrated into the team, and, more specifically, about the combination of registered and unregistered roles within a clinical team and on any given shift. It is a sensitive matter, touching on the interface between NAs and Registered Nurses and the use of the role as a potential source of substitution or skill mix dilution. One interviewee noted some concern and uncertainty amongst ‘Trusts with a large number of NAs’, about how CQC (Care Quality Commission) inspections might view the role in skill mix terms (R_7).

Another interviewee reported on a Trust sensitive to accusations of role substitution as the introduction of NAs provided scope to increase staffing levels in the context of RN vacancies:

There was a big decision made ... that we would look at the number of vacancies we had for Band 5 nurses.... and to pilot 65 specific nursing associate roles into 65 of those vacancies. We’re very mindful of role substitution, but we knew with the size of the workforce we could always make that up again if we felt it wasn’t appropriate ... We added 65 people to the workforce ... so we are firmly wedded [to] a skill mix that will include the nursing associates. (T_7)

In general, the expert interviewees were keen to view the introduction of the NA less in terms of narrow and precise staff ratios and more broadly in terms of the opportunity they provided for new ways of team working. In other words, the NA role was regarded less in terms of tightly argued debates about relative numbers of NAs and RNs and more in terms of how these two sets of registered professionals – NAs and RNs – might relate to one another through care delivery systems and routines. As one interviewee noted:

It’s about that service redesign and that skill mix: what can your NAs now do if they’re qualified? What services are they providing and how does that change the skill mix of what the registered nurse and your health care support worker provide? What does that complete team look like? And I don’t think we’re there yet; that’s where we definitely need to get to, because then it’s seen as a full standing role in itself. (R_2)

This view is also reflected in the case of the NA introduced in the ITU noted above:

It’s working extremely well at (Trust name), so that kind of model, that’s why I say more of a blended approach is probably the way that we can work it, and the nursing associate may do more of a caring element and the two RNs may do much more of the technical titration of the drugs and ventilation changes or the therapeutics. (N_2)

This is not to detract from the implications of the NA role for skill mix, however it was apparent that progress made by Trusts directly on this issue was limited. In part this slow progress reflected the still quite small number of NAs in any given Trust:

We’ve still got small numbers on the register and we’re on target for everything that everyone’s looking for. I’ve got a conversation this afternoon, actually, with one of the
regional chief nurses for NHS England around how do we invest in the nursing associate programme en masse to maybe get tens of thousands in, to support a different workforce skill mix and various other bits and pieces, and align new roles round things like critical care and outreach services and community services. (N_1)

It also related to the considerable range of pressures on service delivery and workforce recruitment and retention, not least in the context of Covid. In short this was not the ‘right’ time for systematic skill mix reviews:

At the moment, they’ve (healthcare providers) got huge pressures. They just need to manage their services day by day but, because of Covid, EU exit, we’ve now got winter pressures, we’ve got the three-headed beast, really, all nipping at them, and so I think what they’re trying to do is just trying to manage the caseloads that they have, and so they get to manage their patient safety correctly. Once things start to calm down again. Some organisations are really doing very well and really considering about the skill mixes, but the vast majority, not. (N_2)

In some, perhaps many, Trusts this combination of small numbers of NAs at present in post with intense service and workforce pressures, had led to an inevitably fluid, reactive and flexible approach to using and positioning the NA role within the team. It is worth quoting one Trust interviewee at length to acquire a sense of these processes in action at the workplace level:

Our (nurse) vacancy factor is the best it’s ever been, and you could say that’s a Covid factor, people haven’t moved because of Covid. But what we’ve been mindful of is, despite that, we now have new challenges; we have staff that are maybe not at work because of Covid or are self-isolating, so although we’ve had all these nurses come in, we’ve still got a problem and we still need to deliver quality care to our patients, so how do we do that? Part of that solution has been the Band 4 role. It may be that at times where there would have been four nurses on, there are three and an NA, but the next day it might be four. When you’ve got that scenario, because we haven’t got enough to have one on every shift, it’s a case of, okay, so how do you do your work differently today? What do you do today? Well, today I’m going to put the NA into the level zero bay where there are no IV drugs or actually the registered nurse will do my IV drugs and I’ll do all the care and I’ll report back to them. That’s been our challenge, to get the wards to see that different way, that different process of thinking, and I think one of our challenges is because they’re (NAs) not in our establishment in that way yet, people don’t see them that way yet. (T_4)

d. Outcomes

Assessing the impact of the NA role on workforce and clinical care outcomes remains challenging. Again, the relatively small numbers of NAs in post, along with the turbulence noted in the previous sub-section, make it difficult to isolate and control for the impact of the role on outcomes. This is not to detract from attempts being made to assess the NA role in outcome terms. An expert interviewee (T_4) described a regionally supported project in their Trust to evaluate the impact on the NA role. The details are provided in Table 3 below which highlight the introduction of a critical mass of NA/TNAs in three test wards with a view to measuring in a ‘before and after’ way their impact on various clinical outcomes including falls and clinical errors.
This was one of the few initiatives raised by our interviewees to evaluate the consequences of the NA role, with impact more generally being discussed in broader, more impressionistic terms. Clearly any evaluation of impact needs be sensitive to the policy goals informing the role, and we noted earlier in this report in setting out these drivers that there was a generally positive view in terms of contribution in these terms: as a bridging role, a career opportunity for HCAs and pipeline to address shortage in registered nurses. Often organisational value was perceived as intimately related to the personal characteristics of the NAs, initially having held experienced HCA roles within the Trust. As an interviewee noted:

The value (of the NA role) is down to the individuals that they’ve seen in it. I hear that time and time again. Because these are ‘our own’ most of the time. They just see that they have stepped up every single time and they have demonstrated commitment and enthusiasm and they’ve seen that growth of somebody who was a healthcare assistant, now developing over time and operating at a different level. (R_2).

They continued:

We need that level, we need that original conversation about shape of caring in terms of bridging the gap between healthcare assistant, they’re seeing that in real time, and during Covid as well, they have commented and remarked on the nursing associates and their flexibility and adaptability and just going with it and knowing that things are changing. (R_2)

The value of the NA role was also seen to lie in its registered status, allowing RNs to delegate to them with greater confidence and adding to the role’s legitimacy in the workplace:

Understanding what the role can actually do, deliver – not just the task orientation, but understanding the scope of the professional practice and how the individual is expected to conduct themselves because they are registered, is going to take the challenge out of it because people then start to embrace it. (R_1)

One of the stronger themes to emerge on impact related to the quality of care provided by the NA. In the absence of the direct patient voice in our interviews, clearly some caution is needed in reporting on service user perceptions of the NA role and its consequences for care quality. As the nursing workforce becomes more differentiated with the introduction of new roles, there are key issues for our evaluation to consider in terms of how patients and service users view and engage with the NA and indeed with the nursing workforce in general. Various interviewees did, however, note the NAs’ capacity to address both the physical and mental healthcare needs of patients as a contribution to improved care quality. One interviewee from a mental healthcare Trust gave no less than four care settings where the NA had been of value in these terms:

We’ve got one (NA) that’s in an early intervention team in mental health, and is working really well there; very much looking at the physical health needs of persons with a severe mental illness on their caseload, and making sure that all the physical health needs and all the targets around that in the early intervention team are being met, working really, really well.

Another lady was in a community mental health team, and again with the remit of physical health and mental health, and also supporting a lot of the clinics. So, a lot of the health and

Table 3: Trust Case: Assessing Outcomes

| Three Test of Change Wards: Care of the elderly; Surgical; Medical |
|-------------------------|-------------------------|
| Staffing: 3 TNAs; NA; No replacement of RNs |
| Metrics: Falls; Harm free; Pressure ulcers; Friends and family; Clinical errors |
| Measurement: Before and after |
| Timeline: Report July 2021 |
wellbeing clinics, and being supported by an advanced practitioner that was in that team.

We have a lady in **physical health district nurse team**, and again she had some great examples where her experience in mental health services and placements has become really handy in those services, and she also maintains a really good link with a mental health nurse that works with the team on a weekly basis, so she links in with her for clinical supervision.

We’ve got a gentleman in one of the **older patients’ in-patient** areas in mental health. Again, the role is perfect for that team, with a physical health and mental health focus, because the gap in the services there was very much at that level, the Band 4 level, to do with minor sort of physical health ailments, so they didn’t have to need to transfer a service user to an acute hospital, it could all be supported and dealt with in the environment.  (T_3)

An interviewee pointed to another clinical area, a gastro ward, where the NA had again contributed through the capacity to bridge physical and mental health needs:

On gastro ward where people come in with IV drug abuse, alcohol problems, they are adapting that role so they have a NA that has the generic training that has got the mental health side as well and using it to the full advantages. (R_7)

An interesting angle on the scope for the NA role to deliver a generic form of care was provided by an interviewee who not only noted the sharing of TNAs’ placements between an acute and a Mental Health Trust in a locality partnership but the tendency for NA qualification to sign up to the Banks (temporary staffing services) in the respective organisations:

It’s been fantastic having the partnership because what we’ve found, and again it’s happened organically, is we’ve had TNAs from the acute Trust coming to us and vice versa but, actually once they’ve qualified, they’ve remained on each other’s Bank services, so they can retain those skills in either of the organisations and the fields of nursing, but also we’ve seen the benefits of that background to them. So having the physical health expertise coming into a mental health environment on the Bank is fantastic, and vice versa. And it’s supported that parity of esteem, of mental health and physical health and the patient journey.  (T_3)

This connection to the ‘patient journey’ was further emphasised by a couple of our Trusts noting engagement with **patients and their representatives** in shaping the new NA role:

With those earlier TNA programmes, we had people with ‘lived experience’ (of mental health conditions) supporting NAs in our partnership, the nursing associates; so service users or ex-service users would work with the nursing associates individually to look at the issues that might come up and look at from a service user’s point of view, so they’ve really been a benefit to the local population. And, like I say, with those skills, those rounded skills that they have, it’s even better for the service users and patients.  (T_3)

One of the things we really wanted to do was involve our patients in what's happening, so there’s an NMC ‘ask’ around making sure patients are involved in interviews with TNAs which we’ve done. We were going to look at friends and family data (from the Patient Survey), but obviously it’s not really specific around do you know who the nurse was that looked after you, were they an NA or a TNA. So we’re planning to involve our Patient Council, so this is going to be a little bit more qualitatively done, I suppose, facts and figures. We’ve got a small group of Patient Council representatives and then doing a bit of chatting with patients, seeing what they think... what their experience has been like, and would they even know there was any difference apart from the uniform, so that kind of stuff.  (T_4)
5. Summary and Conclusions

With the continued roll-out of the Nursing Associate programme, now entering its fourth year, a repeat set of interviews was conducted with close to 40 experts positioned at different levels of the health and social care system. Carried out in late 2020 and early 2021, some 18 months after the first-round interviews, these repeat interviews were seen as particularly timely given the possible impact of Covid on the management, use and consequences of T/NA. We were able to capture the views of most of those participating in the earlier set of interviews, and, in processing the interview transcripts, generated two sets of themes.

The first set of themes centred on the ongoing development of the NA role, with the following key points emerging:

- The NA role continues to be driven by a variety of policy and practitioner objectives, including establishing a new bridging post between HCAs and RNs and creating a new career opportunity for HCAs. However, with a national policy goal of generating 50,000 additional registered nurses by the end of this Parliament, there had been shift in emphasis towards the NA role as helping to meet this target by providing a stepping-stone into pre-registered nurse training.

- With the uncertainty around the nature and contribution of the role dissipating, healthcare and some social care employer commitment to employing NAs had deepened. Certainly, progress towards meeting the 2020-21 target to recruit 50,000 new nurses had been slowed by pauses in the commencement of TNA programmes. However, with many employers taking-on more than one TNA cohort per academic year, this slow-down had proved temporary. In the main starts-up had simply been deferred.

- Notwithstanding a deepening employer commitment, take-up of the role varied both within and between care setting. While some NHS Trusts had taken up the NA role with alacrity, others were slower to participate in the programme at scale. Since our first-round interviews, there was much greater enthusiasm for the role in primary care, in large part related to the provision of financial support for its introduction, under the government’s Additional Roles Reimbursement Scheme. However, engagement with the NA role in social care remained limited, with the pressures faced during Covid deepening the challenges faced in taking it forward.

- Place-based partnerships of health and social care employers, providing mutual guidance and support, continued to be important in the developing of the NA role. The design of these partnerships did, however, vary in terms of their inclusiveness and integration into the governance of the locality ICS, with implications for the nature and coverage of the NA programme. Where NA partnerships were closely aligned with the ICS, there was greater scope to include NAs in workforce planning at systems level. With such alignment, in some cases the new NA role had also stimulated a wider system review of the structure and management of nursing workforce.

- In many Trusts, the NA role was becoming an essential stepping-stone on a career pathway through from HCA to Registered Nurse. It was a pathway increasingly being made available, not only to Trust-experienced HCAs, but also to those external to the organisation, for example school leavers and those without previous health and social care work experience. Moreover, the NA role itself was being made more accessible to candidates external to the Trust, particular self-funders on TNA programmes. The increasing accessibility of the NA role, whether through direct entry route or as part of a more extended career pathway via a HCA post, was reflected in the emergence of the NA Ambassador, promoting these career options. Such developments raised interesting questions about the future demographics of the NA workforce as the long-serving and trusted HCAs taking up the role during the earlier waves of recruitment, gave way to younger postholders, perhaps with higher formal qualifications but
with fewer life experiences and less previous engagement with ward or clinical teams and patients.

- Where TNA programmes had (re-)started, the different elements of training have been impacted by Covid in various ways. The College component had typically moved online creating problems for those without easy internet access, inhibiting close relations with tutors but ensuring continuity of teaching. Base placements continued although in some cases the scope for on-the-job learning was reduced by the pressures of dealing with Covid. Most adversely affected were outside placements, with the pandemic ruling out movement between workplaces. This was a particular problem for second-year TNAs less able than first year trainees to re-arrange the timing of their placements. The resilience of TNA programmes should not, however, be understated: over the years many NA partnerships had build-up an extensive stock of placements, allowing alternatives and providing options even in difficult times.

The second set of themes to emerge from our expert interviews centred on whether and how the NA role was embedding itself at the workplace level, with the following points emerging:

- While a residual degree of resistance to the role continued, particularly amongst registered nurses, this was dissipating as more became known about the nature of the role and its scope of practice. Resistance was also weakening with the roll-out of the role to a wider range of clinical areas. Thus, the NA role was not only settling down in general medical and surgical wards, but also being introduced into more specialist clinical settings such as EDs and ITUs. Indeed, some Trusts were taking a more considered, strategic approach to the organisational positioning of NAs, so ensuring the full value of the role could be realised.

- There were important constraints of the NAs’ scope of practice, for example precluding the administration of Patient Group Directives (PGDs) and the undertaking of primary patient assessments. There were also tasks at the outer limits of NA practice which continued to generate considerable debate, such as the administration of IV drugs and cervical screenings. However, even within these limits there was continued uncertainty and unevenness in the development of NAs’ scope of practice. Such uncertainty was perhaps an inevitable consequence of introducing a new role into well-established care delivery routines and, as stressed, was reducing as the nature and value of the NA role became clearer. By contrast, unevenness in the NAs’ scope of practice was often a consequence of Trusts moulding the role and developing competences to meet the needs of its different care settings, giving rise to more enduring differences in its shape.

- With the NAs’ scope of practice still uncertain, the organisational capacity to review skill mix remained limited. The difficulty in reviewing skill mix with the introduction of the NA role was further inhibited by the small number of NAs employed in many Trusts as well as by the immediate and possible longer-term disruption to established working arrangements caused by Covid.

- With the number of qualified NAs in post still relatively low, assessing in statistically robust ways the outcomes associated with the role remained difficult. At the same time, most of our interviewees, especially at Trust level, presented the NA role as positively impacting on care delivery. In part, this was reflected in the capacity of registered nurses in a variety of care settings to confidently delegate the care of patients with less complex conditions to the NA. This created a ‘win-win’ situation whereby the NA could devote more time to the less complex patient, freeing up the registered nurse to deal with the more complex patient. There were also suggestions that the NAs’ capacity to deliver a generic form of care straddling mental and physical conditions was being effectively utilised in several care settings.