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Evaluating the Introduction of the Nursing Associate Role: The Cambridgeshire and Peterborough NHS Foundation Trust Case Study

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1. Introduction

The NHS People Plan (NHS England, 2020)[1] sets out ambitions for the supply and support of staff working in the NHS. Among these are commitments to increasing the numbers of nurses and to retain valued staff within the NHS. One element of career development opportunities in recent years has been the creation of new roles among which is the Nursing Associate (NA).

Researchers at the Health and Social Care Workforce Research Unit (HSCWRU), King's College London, have been commissioned by the National Institute of Health Research to evaluate the introduction and deployment of the Nursing Associate (NA) role in the NHS and social care in England. The NA is a new registered nursing role at pay band 4[2], typically positioned between the healthcare assistant (HCA) (in terms of NHS banding) and the registered nurse. Our evaluation is principally focused on the first two waves of NAs, that is those 2,000 Trainee Nursing Associates (TNAs) who began their training in 2017 and have now qualified and, in the main, registered as NAs. More specifically, the evaluation is examining the organisational deployment of these initial waves of NAs, albeit with some interest in subsequent cohorts as the role extends within and across health and social care provider organisations. The core questions underpinning the evaluation are:

- How and why the NA role was introduced;

- How it is being managed and used and

- With what consequences for key stakeholders including the NAs themselves, their co-workers, managers and patients/services users.

Following a series of interviews with national policy makers and practitioners reported in our Interim Report on the NA project[3] , HSCWRU researchers intended to carry out a small number of organisational case studies, with a view to addressing the above questions. Prior to the COVID-19 pandemic, these case studies were just starting. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) was to be

[1]NHS England (2020) NHS People Plan, London: NHS England
[2] The pay bands referred to throughout the report are NHS Agenda for Change pay bands
[3] Kessler et al (2020) NA Project: Interim Report, Kings College, London

the second of these case studies, providing a similar range of largely community-based services but in another part of England with a different demographic profile, to our first case study (as reported REF Link needed). While our pre-COVID-19 case studies are now limited to these two sites, we hope that they will assist in holding service context constant in exploring similarities and differences in organisational approaches to the implementation of the NA role between these two Trusts. In this report, however, we concentrate on presenting the findings from the single CPFT case study[4]. The report comprises the following sections:

- Background
- Methods
- Findings

2. Background

2.1 The Trust

Established as a Foundation Trust in 2008, CPFT provides health and social care services to over 900,000 people in the Cambridgeshire and Peterborough area, with mental and physical health conditions, as well as to those with learning disabilities. This care is delivered across over 50 different sites, by a workforce of around 4,000 including some 1,800 registered nurses and 900 allied health professionals. In 2019-20 CPFT had a budget of £225 million and in 2018-19 a financial surplus of £4.1 million.

Indicative of the services provided, CPFT is organised in three directorates:

- Older People's and Adult Community Services
- Adult and Specialist Mental Health Services
- Children's and Young People's and Family Services.

Many CPFT services are delivered in the community but the Trust does have 315 in-patient beds across 24 wards. These are mainly adult mental health beds (211), with

[4] A future paper will compare developments across the different sites.

the others beds in rehabilitation and in children's and young people's mental health services.

A more detailed list of services provided by CPFT includes:

- Mental health services:

  Child and adolescent mental health wards

  Community mental health services for people with learning disabilities and autism

  Community-based mental health services for adults of working age

  Community-based mental health services for older people

  Forensic/secure wards

  Long stay/rehabilitation mental health wards for working age adults

  Specialist community mental health services for children and young people

  Wards for older people with mental health problems

  Wards for people with learning disabilities and autism

- Community health services:

  Community health services for adults

  Community health services for children, young people and families

  Urgent and emergency care

  Community health in patient wards.[5]

[5] This background information on the Trust is drawn mainly from the Care Quality Commission (CQC) CPFT Inspection Report, 2019 (the Trust was rated overall 'good')
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ3939.pdf
and from the Trust's website https://www.cpft.nhs.uk/

2.2 Qualified Nursing Associates

In late 2016, CPFT was accepted as a first wave nursing associate (NA) pilot site. This was in partnership with four other Trusts in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) catchment area. In total the Cambridgeshire and Peterborough NA partnership recruited 40 Trainee Nursing Associates (TNAs). Twelve of these TNAs were employed at CPFT and mainly drawn from and based in mental health in-patient wards and teams. At the beginning of 2019, 10 of the 12 TNAs qualified and registered as NAs. Of these 10, seven enrolled on a bridging programme as a step into registered nurse training, although they continued to perform in their NA role until progressing into nurse training.

In this study we mainly focus on CPFT's 10 first wave qualified NAs. It is, however, noteworthy that the Trust has continued to recruit TNAs. With intakes in September and December of each year, in early 2020 the Trust had recruited a total of seven TNA cohorts, with between half a dozen and a dozen on each cohort. To date those individuals taken onto the CPFT NA programme have all been internal recruits, typically existing HCAs, in other words drawn from the Trust's current workforce.

3. Methods

Conducted over two full days in mid-February 2020 - one day on a site in Peterborough, the other on a site in Cambridge - the fieldwork comprised interviewees with various stakeholders. Details of these interviewees are presented in Table 1 below. Mainly one-to-one interviews, but with a couple of group interviews, a total of 14 individuals were spoken to during the visit. This number included those responsible for managing the Trust's NA programme and four of the Trust's 10 qualified first wave NAs. Reflecting the concentration of the NAs in in-patient mental health wards, the four NA interviewees were located in the following units/teams:

- An adult mental health recovery unit
- A crisis home treatment team
- A female personality disorder ward

- A mixed acute mental health assessment unit.

In the latter three units/teams, it was also possible to interview stakeholders including unit/ward managers and co-workers, working alongside the NA. The colour coding in the Table below indicates working area and the interviewees drawn from the same team.

Table 1: Interviews Carried Out[6]	
Participant	**Format**
Learning and Development Manager and Nursing Associate Lead.	One to One
Head of professional nursing	One to One
Clinical Education Lead for Nursing Associates	One to One
NA Recovery Ward	One to One
CPD and Nursing Associate Co-Ordinator	One to One
NA Crisis Resolution Home Treatment Team (Mental Health)	Joint Interview
NA Personality Disorders Ward A (Female)	
Ward Manager Personality Disorders Ward A (Female)	
Team Manager Crisis Resolution Home Treatment Team	One to One
Deputy Ward Manager Personality Disorders Ward A (Female) and NA supervisor	One to One
NA Acute Mental Health Assessment Unit A for Adults (18-65)	One to One
Clinical Nurse Specialist Acute Mental Health Assessment Unit A	One to One
Band HCA Acute Mental Health Assessment Unit	Joint Interview
Registered Mental Nurse Band 5 Acute Mental Health Assessment Unit A	

It is worth noting that while we were able to interview those managers directly responsible for coordinating and organising with the Trust's NA programme, few of the Trust's most senior Trust managers (director and deputy director level) were interviewed. Moreover, those managers interviewed were not all in post when the NA

[6] For the purpose of referencing/coding the quotes in the report, the following identifiers are used: Senior Managers (SM): these are managers above team/ward level; Managers (M): these are managers at ward/team level; Nursing Associates (NA), Registered Nurse (RN); and Healthcare Assistant (HCA)

pilot commenced at the Trust. This pattern of interviews did limit the scope to explore initial Trust engagement with the NA programme, particularly at Board level, although our interviewees were able to reflect on this process.

A draft of the final case study report was sent to CPFT for comments and particularly to ensure that there were no factual mistakes or major errors of interpretation in our write-up. CPFT confirmed the report provided a clear and accurate picture of developments for which we are most grateful.

4. Findings

The presentation of the CPFT case study findings is structured around the following themes, linked to our key research questions:

- ***Rationale: Introduction of the NA role.***
- ***Process: Implementation and management.***
- ***Consequences: Impact on various outcomes.***

4.1 Rationale

The rationale for the introduction of the NA role at CPFT can be considered through two lenses. The first views the take-up of the role as the pursuit of specific organisational objectives. Thus, the NA role has been widely seen by policy makers and practitioners as:

- an end in its right as a new 'bridging' role between the HCA and the registered nurse;
- a way of providing a career development opportunity for new, but more particularly existing staff, typically HCAs; and
- overlapping with this latter aim, a means of establishing career pathways into shortage professions, especially registered nursing.

Clearly these are not mutually exclusive aims - an organisation might pursue one or more - although there may be differences of emphasis between them.

The second lens centres on strategic intent. An organisational strategy will naturally have a clearly articulated set of aims, but strategic intent encourages an interest in whether the organisation has a formal and structured plan in place to manage and take these aims forward.

In terms of the first lens, aims, CPTF was most obviously keen to provide a career development opportunity particularly to the Trust's existing support workers. In part this opportunity was framed as a ***retrospective*** acknowledgment of the extended nature of the support worker role at the Trust, and the (considerable) experience and skills of those practitioners performing it. The Trust already employed a few support workers at Band 4, for example the Support, Time and Recovery (STR) worker in mental health, as well as a sizeable swathe of Band 2 and 3 healthcare assistants (HCAs), many in extended roles. However, the value of this Band 4 NA career opportunity, both for the individual employees and the Trust, was seen to lie in its registered status: a formal means of recognising the status and capability of its support worker and providing a more secure platform for the delegation of tasks to them:

> We have healthcare assistants doing very, very complex work, particularly in community and district nursing teams; they're doing all sorts of very complex work, and we wanted people doing those tasks to have a registerable qualification….I think lots of us felt that it would be good to have that other level of nursing because people are accountable in the same way that registered nurses are accountable. (SM_1)

> It's really incredibly supportive for them (HCAs) when they hear about the nursing associate role. I've had feedback from individuals who've worked in the community as a healthcare assistant for six years, had no career progression or no support. They've joined this Trust, when they are here, they've been offered or given the opportunity to become a nursing associate, so they can develop their skills. So, from that point of view I think it's such an opportunity for individuals that they didn't have before. (SM_2)

> Those people that have gone into the nursing associate course have been around for a long time and have a lot of experience as healthcare assistants, why wouldn't we, if we had the opportunity to develop people? (SM_3)

The NA role was also seen by some at the Trust as a means of establishing a career pathway for the Trust's support workers into registered nursing: a way of flexibly addressing the Trust's staffing challenges, while at the same time helping to further the personal aspirations of the individual support workers:

> We could see that it (the NA programme) was a pipeline, because we were anticipating that a programme would be developed and it would be a step-on, step-off approach, so you could then step off and stay as a nursing associate or you could carry on and do your registered nurse training. People had the foresight at the time to see that that was potentially a way of solving our vacancy issues and challenges. (SM_1)

> There's something about development of staff. Staff that are healthcare assistants who are doing a really good job, but actually can only get to a certain level and then there's no development for them. I also think there's something about, particularly with mental health; there is the national picture of shortage of nurses anyway. (M_1)

> It's really important that we embrace nursing associates and their development and that we have pathways within the Trust where people can come in at different levels and we can grow our own staff, really, and develop those staff to then go on to be registered nurses. (M_2)

Indeed, another interviewee placed the development of the NA role at the Trust as a 'grow-your-own' responses to nurse shortages:

> At first, people were put forward to it (the NA programme) because there was a reduction in the number of nurses that were going through training to the Band 5 level and obviously, there's a culture of grow you own within the Trust. (M_3)

In terms of the second lens, the ***strategic*** **intent** behind CPFT's engagement with the NA programme, the picture was less clear cut. Certainly, in the absence of interviews with senior Trust managers some caution is needed in drawing conclusions about the

formal planning underpinning the NA programme. Moreover, the speed with which the first NA cohort was recruited to meet the deadline for the national programme mitigated against considered organisational planning. However, there were several signs of an *ad hoc*, perhaps opportunistic, Trust approach to early NA cohorts.

Thus, TNA recruitment to the initial CPFT cohorts was principally 'bottom-up', an open call being made to those teams/wards and individuals keen to participate in the programme. As one manager noted:

> I think initially it was definitely whoever wanted to put their name forward (for the NA programme). (M_3)

This 'bottom-up' call was not necessarily inimitable to a considered strategic approach, arguably encouraging self-selection by those most enthusiastic about and strongly committed to the NA programme. However, in practice this call prompted a process, largely centred on individual employees and their personal training needs, rather than on the organisation's broader service delivery and design needs. As one team manager at CPFT noted:

> It (the NA programme) was about developing our staff so that they have a route into advancing their skill profile, and I think specifically with (name of NA), that was a particularly good route for (him/her) in terms of building confidence, in terms of getting back into training and education. There wasn't a specific thought process about what the nursing associate role would look like in (name of team) at the end of the process, which in reflection I think would have been of benefit. (M_2)

As a ward manager noted:

> It was driven by (NA's name) herself; she wanted to do something new and go up the food chain and clearly had more experience and education and knowledge, so I think we just went, yeah, that's fine. I think she drove it, rather than it coming from anywhere else. We were all just like, yeah, you have the time to do it, off you go, no problem. (M_1)

It was the bottom up, self-selecting nature of the approach which generated an initial concentration of NAs in mental health, seen by some within the organisation as not

necessarily ‘the best place’ to launch such a role. As one senior manager noted:

> I probably would have targeted district nursing because I can see how the role fits in really nicely into a district nursing team, whereas in mental health services, we have struggled a bit for people to understand the difference between an STR (Support Time and Recovery) worker and a NA. (SM_1)

Another senior manager noted that perhaps there was scope for the Trust to be a little more ‘top down’ or directive in encouraging teams or unit to consider the NA role:

> We probably needed to get a bit more proactive; being able to go in and say, have you ever thought of... because I know there are areas where there could be nursing associates, but there aren't at the moment, and sometimes that's about people thinking about how would that work for us.(SM_2)

The patchiness of strategic intent was also reflected in the fact that the Trust only now seemed to be exploring whether and in what sense the NA role had wider implications for the structure of the nursing workforce. Certainly, these wider implications were recognised. As one senior manager noted in commenting on the NA role:

> We're good at change, aren't we, in the NHS, but we're also a little bit worried about things like ‘does that mean?’, ‘what about my role?’, and I think we've got to make brave decisions, we've got to think differently about how we do things and think about the nursing profession and the nursing role. (SM_1)

However, asked ‘whether the Trust had sat down and worked through a strategy around the structure of the nursing workforce?’, another management respondent noted that ‘that's a work in progress’. Indeed, it was striking that with seven cohorts of NAs/TNAs now recruited at CPFT, the Trust was still seeking to fully map the precise location of these workers within the Trust’s wide range of services.

4.2 Process

The process of developing and deploying the NA role at CPFT comprised several dimensions:

- Establishing a supportive infrastructure;

- Developing NAs; and
- Providing ongoing support for qualified NAs.

Each is considered in turn.

4.2.1 Infrastructure

The infrastructure for the NA role can be found at both system and organisational level. At the ***system level,*** the Trusts in the Cambridgeshire and Peterborough area had for some years been working closely in the delivery of support worker training, in the main using one provider, Anglia Ruskin University, and meeting fairly regularly in, for example, a quality assurance education group. From this well-established collaboration, the Cambridgeshire and Peterborough (C&P) Nursing Associate Partnership emerged, becoming the main vehicle for progressing the NA role in Trusts and other health and social care providers across the area. The C&P NA Partnership agreed governance arrangements. Initially meeting face-to face on a monthly basis, the Partnership now convenes bi-monthly although members remain in regular contact with another. The partnership initially comprised the five pilot site Trusts and one Higher Education Institution (HEI) but has since expanded to include a GP Practice, social care providers and hospices, and two additional HEIs.

The NA partnership essentially mirrored the Cambridgeshire and Peterborough STP and formally connected to the STP infrastructure. The C&P Nursing Associate Partnership reports into the STP Supply and Education Group feeding into the STP's workforce strategic delivery group, and in turn the STP's Local Workforce Advisory Board.

The C&P Nursing Associate Partnership has sought to develop a shared identity amongst NAs, with the Partnership Trusts developing shared job descriptions for the TNA and NA, and adopting a common approach to TNA and NA uniforms:

> Across the Partnership we organised job descriptions and we've shared those; we've tried to have consistency across the Partnership, so there's a uniform that's consistent because we felt that was really important to provide people with an identity. (SM_2)

For the early cohorts, there was also a shared approach to pay, with TNAs being

paid at Band 3, with those trainees already on Band 4 retaining this rate during the programme. The Trusts have since adopted slightly different approaches to trainee pay, for example, some moving closer to Agenda for Change Annex 21 (setting pay at a proportion of the pay scale maxima). There have also been more recent differences between Trusts in approaches to the recruitment of TNAs: while CPFT has continued to recruit experienced internal candidates internally, at least one other Trust in the C&P NA partnership has begun to take on young people from the external labour market. There were additionally some importance differences between Partnership Trusts in how they counted TNAs in their staff numbers: at CPFT TNAs were supernumerary while on placement but included in the numbers back at the Trust in their base placement; at least one other Trust in the C&P NA Partnership treated their TNA as supernumerary throughout the training programme.

At the ***organisational level***, the most striking development in support of the NA programme was CPFT's appointment of a clinical education lead for nursing associates. This post was taken up in December 2019 by an individual who had been at the Trust since May 2019 as a practice educator. Sitting above the practice educators to be found within different clinical areas at CPFT and reporting to the Trust's NA lead, the Learning and Development Manager, the post had various responsibilities. It helped organise TNA placements and indeed prepared placement sites for a role with which they were not necessarily familiar. The postholder also helped manage the interface between the Trust and its HEIs, ensuring a consistency in the delivery of the TNA programmes. Finally, the role involved supporting the TNAs themselves, dealing with the personal challenges, preparing them for placements in unfamiliar clinical settings and generally helping them through the programme. Clearly, however, the clinical education lead for NAs was a very recent role, not in place when the early TNA cohorts were progressing through the programme.

4.2.2 Developing Nursing Associates

In general, the qualified NA interviewees at CPFT viewed their two-year training programme as challenging but rewarding, with team colleagues and managers providing them with strong support. Assuming various forms, the challenges largely

centred on the academic aspects of the programme and the interface with the college. As the first CPFT cohort and with the national standards of proficiency and training requirements still being worked through by the Nursing and Midwifery Council (NMC), there were some uncertainties about the programme, and short notice changes. Such changes could confuse and disrupt, particularly in terms of workplace commitments:

> You have to be adaptable because they (the training arrangements) were constantly changing. So we went in December and we were told that we were accepted and all of this was going to be happening and our start date was the 30th January and I think by February we'd got altered timetables already because things were already changing, and then communication sometimes was a bit difficult between the university and your work because, although you've got your commitments to the university you've also got commitments to your manager and your ward and the team that you're working with, and it's very difficult having to be at uni(versity) one day and then come back to your ward the next day and say, actually, they've said we're now doing this on this date, can you please change my rota? (N_1)

> It was challenging at times because it (the training programme) was brought in a little bit early. We started the course before everything had been finalised. We started the course expecting to have to do a certain level of placements, and then Health Education England said that we actually had to increase our hours of placement, which then directly impacted on the wards because they were expecting me to be returning to the ward and I was still on placement, and vice versa. So it was quite difficult at times. (NA_2)

Other challenges were more reflective of personal circumstances: for example, individuals who had been out of formal education for some time and or needed to adjust to a university level and style of education:

> For me it (the TNA programme) was challenging. It was a big ask for me. I wasn't initially, as a young person in my teens, wonderful academically, sitting at computers and laptops, so I found it hard. (NA_3)

The placements were seen by the NAs as particularly rewarding. With four

placements, varying in length from one to three months, the NAs were provided with experience of varied and very different care settings.

> I had a paediatric surgical unit and I really enjoyed that placement, then I had a stroke rehab unit. It was challenging because it was completely taking me out of my comfort zone, but I have to say it was good to have that experience and have done that. (NA_4)

> I enjoyed mine on the day surgery unit as well. The opportunities to go into theatres and recovery and learn lots of different things that I would never experience otherwise. (NA_1)

> With the nursing associate role being more generic, it was nice to get experience in other areas. So I worked in other hospitals and physical health and things like that, so that was good. (NA_2)

Back in their base placements, there could be tensions. Three of the four NA interviewees had worked in their base placement as support workers before joining the TNA training programme. As noted above, the TNAs continued to be counted in the unregistered staff numbers, rather than being supernumerary. It was an arrangement which risked team colleagues continuing to view TNAs as HCAs rather than trainees:

> It was confusing because people would say, 'what are you today?' They couldn't get the grasping that I'm actually a student, full time…Because they knew me here, and I slipped straight back into here, I was an HCA, to them; in their eyes I was an HCA. (NA_3)

> I was wearing two hats throughout my placements on the wards really, which at times was difficult, but you just find a way. (NA_4)

Given the first wave TNAs were experienced HCAs, there was also perhaps a tendency in some areas to question what more the TNAs had to learn:

> It was quite difficult because I'd been in that team for so long, there wasn't much I hadn't been on or had done, so for me, learning opportunities in my team were limited. (NA_3)

Generally, however, work colleagues in the TNAs' base placements were supportive,

with dedicated learning opportunities for TNAs often being found during a shift:

> I had a good team support behind me. Even though I was in the numbers, they would make a concerted effort to make sure that I was doing medications with the nurses, and that I was doing more of the assessment stuff with patients that came in, and I was doing the care plans and things like that behind the admissions that were happening, despite the fact that I was also having to cook the dinner and make the beds and things like that. (NA_2)

> In the base placements, we were in numbers. Not always, though. Not always, because when (ward manager's name) could manage it, I had proper student days at work as well. (NA_1)

> I was doing HCA stuff (while a TNA), but the ward was aware that I was also doing the training, so they did make concerted efforts to help me to do the learning experiences as well. (NA_4)

4.2.3 Ongoing Support

The ongoing support for NAs following their qualification and registration principally took the form of a preceptorship. For the initial NA cohorts at CPFT, this was a six-month period of follow-up in-house support and training. More recently, and in response to (T) NA feedback, this preceptorship programme has been increased to nine months. The preceptorship includes a one 'mandatory day' a month, where NAs are required to attend a session; they need to attend at least of six of these nine sessions. In the main, however, the preceptorship period allows the NAs to complete and sign off their competencies:

> The preceptorship is broken down into achieving the competencies, the standards, so that they have been signed off as completing the in-house learning to support where they work, as well as the standards they've achieve in their two years' training, that they can practise as a qualified NA. (SM_2)

The NA preceptorship at CPFT also provided the early NA cohorts with some discretion to develop their interests, and in doing so, helped shape their new role going forward. A manager noted the example of the first NA cohort's interest in smoking cessation, and a keenness to become champions for this initiative in their

teams/units:

> In the preceptorship they identify things that they're interested in and skills that they'd like to develop and expand upon during the preceptorship period. So the first (NA) cohort was very interested in smoking cessation, and they all took that off and became champions in their own areas, which in mental health is particularly a problem; obviously it's not good for people's health for them to smoke, so all of them took on that role of being a smoking cessation champion in their workplace. (SM_1)

The other form of support for qualified NAs is a six-month bridging programme, which prepares the individual for progression into registered nurse training. As noted above, the majority of CPFT's first wave NAs had taken this module, although completing it did not necessarily mean the NA had finally decided to move into nurse training: for example, one NA had completed the module but remained uncertain whether to progress.

4.3 Impact

In this section we explore the impact of the NA role at CPFT on:

- The NAs themselves
- The distribution of nursing tasks
- Co-workers and care outcomes

4.3.1 Nursing Associates

For the NAs themselves, the consequences of taking up and performing the new role need to be placed in the broader context of their career trajectories:

- What path had their career taken to the point where they decided to become TNAs?
- Why had they joined the TNA programme? And
- Closely related, what were their career ambitions going forward, which may (or may not) have developed since they started on the TNA programme.

From an organisational perspective these are also important questions: if the NA role was seen by the Trust as a career opportunity and pathway, particularly for existing support staff, how did the (T) NAs view and use this chance and with what consequences for the future of the NA role and for the broader shape of the Trust's workforce?

Table 2 below tracks the career pathways taken by qualified CPFT NA interviewees. It can be seen that:

- Three of the NAs (1, 2 and 4) had quite extended and varied work experiences before joining CPFT. These involved a period of employment in a non-care role, but also work in at least one social care role before joining CPFT.
- While NA1 had worked in several settings in CPFT, the others had remained in the same ward/team since joining the Trust.
- Indeed, all four NAs had worked for the Trust for a considerable period time: in two instances ten or more years (NAs 1 and 2). This is very much in line with the Trust's intention of providing a career opportunity for its existing, experienced support workers.
- The interviewees had, however, joined the TNA programme from different pay bands: two from pay Band 2, one from pay Band three and other from pay Band 4.

NA	Since Leaving Schools →							Years at CPFT
1	Retail	Dental Technician	Doctor Receptionist	Community Drug Team (CPFT)	Pharmacy Dispensing	Psychiatric Intensive Care Unit	Mental Health Recovery Ward (Band 2 HCA)	13
2	Forensic Psychiatry (CPFT)	Crisis Team (Band 4 STR worker)						10
3	Veterinary Surgery	Own Children	Food industry	Learning Disabilities	Personality Disorder Unit (CPFT) (Band3 HCA)			8

4	Insurance	Retail	University: Teaching qualification	Residential Home: Young adults with disabilities	Acute assessment unit for adults (CPFT) (Band2 HCA)			6

Table 3 below sets out the reasons why the NA interviewees were attracted to the role and the career ambitions informing their decisions. It is clear that all four NAs were keen to move on to become registered nurses, with three of them (NAs 1, 2 and 3) already taking the bridging module. However, this NA desire to progress straight into nurse training needs to be qualified in several ways:

- First, given uncertainty about the nature of the NA role as this pilot cohort embarked on their training in 2107, it is perhaps unsurprising that at the outset none of them viewed moving into and performing the NA role as an end in its own right. Arguably it is difficult to view taking up a new role as an option if there is uncertainty about what the role looks like:

  > There was no kind of job description for a nursing associate in (my) team. They didn't really know what I was going to be used for. (NA_3)

  > We were on the pilot course, so there was a lot of unknowns about the role, I guess. (NA_1)

- Second, while all four interviewed NAs were keen to become registered nurses, there were important differences in the development of this aspiration. There were NAs (2 and 4) keen from the outset to move into registered nursing, viewing the NA programme as a stepping stone to this goal. In one of these cases, the nurse aspiration was linked to pay:

  > I thought it (becoming an NA) was a good opportunity for me then to progress to then become a nurse, and it seemed like a nice way to do it. (NA_2)

In another case the aspiration was linked in more practical terms to the value of a earn-as-you-learn approach to career progression:

> I saw it as an opportunity to develop skills. I have always had the intention to top-up to the mental health nursing and that was a step route into it, but without having to become a student again because obviously financial commitment, mortgages and life got in the way, as it does. (NA_4)

The other NAs were less certain about becoming a registered nurse at the outset of their training, with this goal only emerging during the training programme:

> I sort of considered it (becoming a registered nurse), and spoke to the matron about it at that time and I also thought that I was perhaps a little bit too old to be doing that kind of thing; I was assured that I certainly was not, and at points throughout doing the nursing associate training and the study level and how difficult it could be at times, there were definite points that I was never going to go further, so I actually finished, and then decided, actually, yeah, I do want to go further. (NA_1)

- Third, there remained ongoing challenges for a number of the NAs in pursuing their registered nurse aspiration. In the case of NA2, for example, the absence of Band 5 nurses in this NA's team, left it open as to whether a nurse role would be available for them in the future (although it was hoped to create a Band 5 nurse position for this individual).

  In the case of NA4, progression into registration had come to a pause following qualification as an NA. In part this NA's team manager felt that this NA would benefit from consolidating her NA skills:

  > I think she (the NA) needs a period of embedding the role, feeling comfortable with that role before going off and doing her

training. (M_4)

Limited training funds within this team had also put on a break on further career development for this NA, who had yet to take the bridging module.

Another of the NAs (NA1) had completed her bridging module, but there was a reluctance to immediately move into the further intense period of training required to become a registered nurse:

> I just think, another 22 months (training to become a registered nurse), I think that's a lot to ask, to... I think it's going to be to repeat a lot of things, to repeat placements. We've done four placements as a trainee nursing associate and now we'll just re-do them in different areas, and I just think it's just repeating itself. (NA_2)

Table 3: NA Career Intentions

NA	Attraction to the (T)NA Programme	Ambition/Future	Illustrative quote
1	Personal development	Nurse (emergent/uncertain) Bridging Module: Yes	I thought that's (the NA programme) a good chance of me improving myself, improving my skills, and being the more mature HCA. I thought that would be good for me, for my own personal development,
2	Career stepping stone and pay progression	Nurse (planned) Bridging Module: Yes	I was told do this course; we'll look at your banding once you've completed it …. It'll be about a year's top-up to do your nurse training. I thought it was a really good way of, one, going up potentially a banding, because I was already at the ceiling of my current banding, but also a good opportunity for me then to progress to then become a nurse.
3	Deepen knowledge and skill	Nurse (emergent) Bridging Module: Yes	I always want to know more and learn more and I want to do better; so not just for myself, for the people that I work with.
4	Develop skills and career stepping stone	Nurse (planned) Bridging Module: No	I saw it as an opportunity to develop skills. I have always had the intention to top-up to the mental health nursing and that was a step route into it

4.3.2 The Distribution of Tasks and Responsibilities

Given our interest in the deployment of qualified NAs, the (re-) distribution of nursing tasks and responsibilities following the introduction of the new role is central to the evaluation. Originally conceived as a 'bridging role' sitting between the HCA and the registered nurse, questions are raised about the NA's scope of practice, which might be viewed as extending from where the NA takes on tasks and responsibilities beyond the remit of the HCA, to where nursing tasks and responsibilities remain the preserve of the registered nurses:

- How was this scope of practice established at CPFT?
- What substantive tasks and responsibilities fall within it?
- Are there any remaining limitations and uncertainties at the Trust about the boundaries of the NA role?

Each of these questions is considered in turn:

- **Establishing the NA's scope of practice**

Even within the context of the NMC's NA Standards of Proficiency[7], and particularly Annex A and B which respectively provide more detail on the kinds of communication and procedural activities postholders might be perform, the process of embedding the new NA role and establishing its scope of practice at CPFT remained an open and challenging process. The process was not made easier by the NMC NA Standards of Proficiency which many at CPFT felt were not sensitive enough to the mental health care setting. If we are, however, to track the process of embedding the NA role at CPFT, in the main we need to focus on the team and granular workplace developments designed to shape and accommodate it within the local and particular systems of service delivery.

Certainly, at the Trust level, steps were taken to help establish the NAs' scope of practice. The Trust's operational policies were amended to acknowledge the NA as a member of the 'nursing family'. More recently, regular meeting of teams and unit managers had been convened to discuss the NA role and its possible contribution in

[7] https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/nursing-associates-proficiency-standards.pdf

different settings. The Directorate Heads of Nursing also now regularly discussed the NA role and its contribution to service delivery. Most striking, and a means of addressing uncertainty, the Trust had drafted a document, described by one interviewee as an 'aide memoire', explicitly setting out the range of tasks and responsibilities an NA could and could not perform[8].

However, located in diverse care settings, the process of shaping and establishing the NA role was principally played-out unevenly within different teams and often in the context of considerable uncertainty about role boundaries. As a team manager noted:

> At the time we were a bit ambivalent about what that (the NA role) would look like in practice; we didn't find out until quite late that people were actually going to enter onto the register, and then what that would look like was quite unclear, especially for the managers who were trying to support the teams so that the teams could embed the people coming through was challenging. (M_3)

Certain team managers made plans to facilitate accommodation of the new NA role into their system of care delivery. For example, in one mental health ward, Band 6 nurses were encouraged by the team manager to communicate with team members on the NA role and how it should be viewed and used. As the ward manager noted:

> I took a bit of a top-down approach, which was to build up the knowledge base (on the NA role) in the Band 6s. So, this is what this (the NA role) will look like; this is what (NA's) limitations will be; this is what the role will be. We came up with a sort of role model and leadership from the (Band) 6s down on the floor, so that it would eliminate any anxieties around. (M_2)

The NA on this ward confirmed the value of this approach:

> It definitely helped having that, coming from (the ward manager) to all the Band 6s, and then the support from all the Band 6s on every shift that I was on, clearly knowing what I was doing, what I was able to do. (NA_1)

Other teams sought to adopt a similar approach but with their preparation for the new

[8] We did not see this document but it would be very useful to have a copy.

role often hampered by ongoing uncertainty about its nature. As a NA in another team manager noted:

> There was a lot of work by my supervisors and myself in terms of trying to educate as to what the differences would be, but at times I couldn't really answer that question because we didn't know either, because it hadn't been decided. (NA_2)

Indeed, more typically establishing the NA role within the team or unit remained a much more opportunistic, incremental, and largely unplanned process.

For example, the NA in one team noted:

> There was no kind of job description for a nursing associate in the (name of team). They didn't really know what I was going to be used for. (NA_3)

This picture was confirmed by the team manager:

> There wasn't a specific thought process about what the nursing associate role would look like in the (name of team) at the end of the process, which in reflection I think would have been of benefit. (M_2)

In another team the NA was asked 'was it clear what the NA role was going to look like once you became qualified?'

> No, and it still isn't. (NA_3)

This uncertainty was further reflected in the comments from this NA's team manager:

> Maybe because it was the first cohort to go through, so CPFT themselves haven't really got their head round what it means, so there hasn't really been a place for them and I think we're experiencing that; (the NA) is experiencing that: she doesn't know whether she's a nurse or an HCA, and because we have such clear delineation between the two, I guess she falls between two stools really; it's really difficult.(M_2)

Another team manager highlighted the similar treatment of 'student' NAs and student nurses as perhaps obscuring or unhelpfully dissipating the perceived need to prepare for a new and distinctive role:

> The Band 4 (NA) student can do everything that a Band 5 student nurse can

> do; there's no difference there from our perspective, there's absolutely no difference. They can do meds observed, they can be in ward reviews, they can do everything else a Band 5 student would be doing…..So I suppose as a student it was just, 'you're a student, this is how we treat you as a student, as we would any of the other students', and then near the end it, there was a sudden realisation of, 'oh, actually, what's this going to look like in practice', because there was no doubt that (NA's name) was going to be here and be in the role here. (M_4)

Given this uncertainty and lack of clarity, it is perhaps unsurprising that the NAs' scope of practice was developing in an incremental way, tentatively pushing and constantly checking on its boundaries and responsibilities. As a NA noted:

> At first, I think it was 'well, what can they (NAs) do?' 'Well, what am I supposed to do with...?' (NA_1)

As another NA stated:

> The most frequent question I got asked for a long time was, 'can you do that?' (NA_4)

The personal profile of the NAs themselves contributed to how the new role settled down in the teams. It will be recalled that in the main the NAs had been with their teams for some time as support workers, being well known to their colleagues prior to qualifying. This did not always work in the NAs' favour, with co-workers continuing to view and treat them in their previous 'incarnation'. As a NA noted:

> Adjustment has been hard because, quite naturally, they (team colleagues) see the same face, but forget the role's changed. So, for a little while there were times, I was kind of doing HCA stuff, but also doing nursing stuff, and then a bit of both and it was quite blurred as to what my role was, and to an extent it still is. (NA_4)

But at the same time, a level of trust and confidence in the NA as a long-established team member informed the way they were treated on qualifying for the new role:

> She (the NA) was a senior healthcare worker, so she was already involved in discussing care planning and everything with patients and what to do. She's

so well known to us; we know her strengths and weaknesses. (M_3)

(NA's name) is a very knowledgeable person anyway, so I often go to her for advice the same way I would go to a Band 5 or a Band 6, to ask her about things, but I don't know if that's something that she's learned from the associate nursing or that's something she just learned during her time as health care assistant; I'm not clear on that. (M_1)

Moreover, the NA themselves played a proactive part in establishing the scope and boundaries of their role. To team colleagues, they often asserted and advertised their capacity to take on new tasks and responsibilities, but, in addition, were quick to point out where the boundaries of their new role lay. As a NA noted:

People obviously see what I can do and what I'm happy to do, I'm quite blunt in that I will just say, sorry, somebody wants PRN medication[9], I can't do that, thanks very much. (M_4)

As a team manager stated:

There were a few questions about what can't she (the NA) do that a Band 5 can do and what can't she do that a Band 5 can do and a bit of confusion, but (name of NA) has been very proactive in finding that out and then disseminating that knowledge rather than leaving it up to other people to inform us. (M_4)

In another mental health ward, a registered nurse noted initial confusion about the NA role, but the growing confidence of the NA in explaining her scope of practice to colleagues:

There was some confusion about what she could and couldn't do, and she was quite confused at one point as well… It's easier now because (NA's name) has become much more confident in herself, much more able to explain things. She's clear about what she can and can't do. (RN_1)

- **Substantive tasks and responsibilities**

An appreciation of the challenges and uncertainties faced in establishing the NAs'

[9] PRN derives from the Latin: *pro re nata* - 'as needed'. in this context it is unplanned medication as needed or required by a patient at a particular point in time. See below for more detailed discussion of NAs and PRN medication.

scope of practice at CPFT should not detract from the emergence of a NA role with a new and distinctive set of tasks and responsibilities at the Trust. This set of tasks and responsibilities was sensitive to care settings. In the Crisis Home Treatment team, for example, there were slight differences of view about how far the role of the Band 4 STR had changed since the postholder had qualified as an NA. The NA postholder was somewhat sceptical of any significant substantive changes in their role following qualification:

> Even down the line, having been registered for a while now, there's probably little to no difference whatsoever between what I did and what I'm doing now. Actually, there's no difference; I'm practically doing the same job as a nursing associate. (NA_3)

The Crisis Home Treatment was somewhat unusual in having an already existing Band 4 workers moving into a Band 4 NA role. As the team manager noted:

> It's difficult to define within a crisis home treatment team a very clearly different role for a nursing associate compared with an STR worker. These roles work best when there's a very clear idea about what the role is going to look like and how it's going to be different and succinct prior to the person embarking on it, which I think would be something we'd think about doing in future, should we do it again. (M_3)

However, the team manager was still able to cite several specific tasks and responsibilities she felt this NA was now performing and would not have been undertaking as a STR:

- Supporting a registered nurse in establishing and running a new physical and sexual health clinic for clients
- Writing-up patient assessments
- Obtaining medication off the ward out of hours for patients.

Beyond the somewhat atypical context of the Crisis Home Treatment team, there was a more general consensus on a new and distinctive set of tasks and responsibilities being taken on by NAs in the Trust's mental health wards. These were well beyond the remit of the HCA and included:

- Administering most forms of medication[10]: perhaps the most commonly cited new task highlighted by interviewees.
- Acting as the duty nurse on shift: the NA cannot be in charge of a shift but the duty nurse can allocate tasks and responsibilities to team members of a given shift.
- Participating in ward rounds
- Leading on shift handovers
- Acting as an associate, or supporting nurse: so, in the absence of the registered nurse, having a discretion to manage and implement, for example, care planning.
- Providing mentoring and supervisory support to HCAs and student nurses.

In a slightly less precise and formal sense, the NAs were also becoming a more assured and trusted source of advice to registered nurses. As a NA noted:

> I can't give the extra medication that people need, but I could go to a (registered nurse) Band five and say,' I've had a one-to-one with this person, I still think they're quite anxious, they're struggling or ruminating with these thoughts. I've had a look at the PRN medication, I think it's probably a good idea if we suggest them taking this medication'. If I can give a clinical rationale for something to happen, then the nurses will usually just go, 'sure, give me a pen'. (NA_1)

Indeed, a number of interviewees likened the NA status to the registered nurse on preceptorship: working with considerable discretion but with a degree of ongoing supervision and mentorship:

> The way to try and help people to understand the capacity of the nursing associate is to say that you're a nurse, but you're on permanent preceptorship. They are in practice, they're fully registered, they're fully accountable, they're fully responsible, but they've got a mentor and support. So that they can go I've got this situation, what do you think I should do? Or, in this scenario, what

[10] The exceptions being PRN medication and patient group directive medications

would you recommend I do with this? I did this, but is there something else I could do because it wasn't particularly effective? So, it's just somebody to bounce ideas off. (SM_2)

- **Residual Limitations and Uncertainties**

Alongside the sharpening of the NA's scope of practice, there remained ongoing constraints and uncertainties associated with performance of the role at CPFT. Over a year into the first NAs qualifying at the Trust, this continuing lack of certainty about job boundaries was further indicative of a role still finding its place in the systems and procedures of care delivery. In part, these uncertainties were related to the highly regulated nature of care delivery in mental health, underpinned by the Mental Health Act 1983. For example, under the Mental Health Act an NA cannot accept or sign-off papers for detained patients assigned or allocated to their ward. As an NA described the situation:

> So, if a patient's been detained under the Mental Health Act, I can't accept the papers; it has to be a (Band) 5 that accepts the papers to sign. Because obviously all legal documents, they all have to be signed, dated, timed and they've all got timeframes around them, and certain things that have to happen within those time frames for them to remain legal. So that's one of the things they said, is that Band 5s can do the Mental Health Act stuff, but 4s shouldn't. (NA_2)

More generally, the scope for the NA to undertake patient assessments, particularly risk assessments, had been questioned and limited at the Trust. The assessment issue had arisen in relation to two aspects of care in mental healthcare wards, and in both cases prompted the Trust prohibiting NA engagement in the activity. The first aspect of care centred on ***PRN medication***, which, as noted above, is medication as required by the patient to address an unforeseen and immediate need. Clearly the decision to administer such medication requires a clinical assessment of the patient's condition as a basis of providing (or not) the medication. It was a decision the Trust had decided only the registered nurse could make, given this need to assess. But the decision had led to some frustration on the part of NAs:

> I feel that I need to be able to give them a bit more and be able to do their PRN

> medication if they need it, instead of having to then walk back to a Band 5 and say, actually I've spent 20 minutes talking to this lady, but I can't help any further and then having to repeat a conversation that I've had to then get that support for that lady. (NA_1)

The second aspect of care concerned ***Section 17 leave*** (of the Mental Health Act, 1983 as amended by the Mental Health Act, 2007). This is the leave that can be granted to a detained patient to take a short break outside of the ward area (say for a 'cigarette break')[11]. Again, permission for such leave rests on an assessment of the patient's condition, a task again deemed by the Trust to be beyond the remit of the NA. Without delving into the technical detail (the preserve of clinical specialists), as one of NA noted:

> You can only go on Section 17 leave if it's been fully risk assessed by a registered nurse, and we have to follow the instruction of that Section 17 leave that is stipulated by the consultant. (NA_1)

A final, slightly more prosaic uncertainty, connects to the NA's status on in-patient wards during the ***night shift***. Typically, the skill-mix on a night shift comprises two registered members of the nursing workforce, alongside one or sometimes two unregistered workers. As noted, qualified NAs are now counted in the registered numbers at CPFT but this has raised concerns about breaks taken by the registered nurse during that night shift. The NA cannot be in charge of a ward, but during a nurse break would be the only registered member of staff on the shift. At the time of the fieldwork, CPFT had stopped NAs on certain wards from working on the night shift, again much to the frustration of NAs who for various reasons were keen to work it. As a senior manager noted:

> Nursing associates not being allowed to work nights has impacted on some of the nursing associates financially, obviously, but also some of them want to work nights because it fits in with their life. (SM_1)

The introduction of the NA role has broader implications for skills mix at the Trust

[11] Section 17 leave is not an issue on the Trust's female personality disorder ward, where patients are not detained but attending on a voluntary basis.

and these are considered in the next and final findings section.

4.3.3 Co-Workers and Care Outcomes

As a relatively new role, this report has already noted the challenging process of accommodating the NA into existing systems and procedures for care delivery. This process has consequences for how co-workers in the team – HCAs, nurses, other professions - and indeed patients/service users, view and engage with NA postholders. The responses of these stakeholders to the new role will influence how well the role settles down and contributes to care delivery. During the fieldwork we had relatively limited contact with these other stakeholders. However, we did undertake some interviews with HCAs, nurses and ward/team managers, while NAs were asked about their interaction with and treatment by other stakeholders. Certainly, the findings in this section need to be treated with caution but several important themes on co-worker responses to the role did emerge.

The first theme, already briefly touched on, relates to ***skill mix***. It has been noted that, on qualification, NAs were typically counted in the registered numbers, raising issues about the balance and make-up of workforce teams, not solely in terms of registered-unregistered staff ratios on any given shift, but also in relation to the configuration of staff according to pay band and, by implication, seniority.

At the organisational level, the introduction of the NA role at CPFT had encouraged discussion, particularly amongst senior nurse managers, about skill mix. However, with the uneven uptake of the role in different service settings and the limited number of qualified NAs as yet in post, these discussions were ongoing and at an early stage:

> In terms of the change to skill mix, that is very much an ongoing piece of work. Our other Heads of Nursing are keen to get nursing associates in the service, but they're such small numbers at the moment it's not making a big impact on services. District nursing, their hope is to have a nursing associate in every district nursing team, and they're being quite proactive about looking at their skill mix, so converting vacant posts, that kind of thing. Some services are more reluctant, so we're really working with them to try and enable them to understand that it isn't nursing on the cheap. (SM_3)

At the team or ward level, where a qualified NA was in post, these skill mix issues were playing themselves out in more concrete terms. In the Crisis Home Treatment team, there were few if any skill mix consequences: a Band 4 STR worker had simply become a Band 4 NA within the team's staff numbers. Indeed, with a deeper and more extensive training, this newly qualified Crisis Team NA arguably enriched skill mix.

There were more significant skill mix developments in the mental healthcare wards covered in our fieldwork, where former Band 2 and 3 HCAs, previously counted in the unregistered numbers, became NAs and then counted in the registered numbers. Typically, establishment levels on these wards had not been altered as the NAs qualified. This suggested higher staff costs for the team to accommodate a team member now at pay Band 4 rather than at pay Band 2 or 3. This was offset by the fact that the team now had a more qualified and competent member, adding to overall clinical capability and capacity of the team.

Yet, in replacing a Band 5 or 6 nurse on any given shift, the Band 4 NA was in a narrow technical sense diluting the skill mix. The views of participating ward managers differed on how this apparent skill mix change impacted on the dynamics of the team and care delivery. One manager placed particular emphasis on the personal qualities of the NA to question whether skill mix in a looser sense had been diluted:

> It's not diluting skill mix because she (the qualified NA) had a huge amount of skill even before she went onto the nursing associate course, has come back with two years' training, she's working at that higher level, she's able to be a mentor and someone who's in that support role for junior staff coming through. (M_1)

Another ward manager was more inclined to argue that in the final analysis a Band 4 NA was still replacing Band 5 or 6 registered nurses:

> So, the nursing associate is going to be doing the work that that registered nurse you're replacing would have been doing, so you're not adding. (M_3)

A ***second theme*** associated with co-workers and outcomes centred on the breadth

of training received by the NA. A number of interviewees suggested that generic NA workers, trained in different care settings through their placements and with the capacity to provide mental and physical care, had made a distinctive positive contribution to the team and care quality. It is an issue which overlaps with skill mix: while replacing a Band 5 and 6 registered nurse, the Band 4 NA might, nonetheless, be seen as providing a new, more holistic approach to nursing. As a registered nurse noted:

> (NAs name) has actually got more experience than, say, I, in a physical health environment, which is really beneficial, so to have that physical health lead aspect is really important. (RN_1)

This point is more fully outline by a nurse manager, worth quoting at length:

> They (nursing associates) operate in a completely holistic way; they don't separate mental and physical health; they look at a person as a whole being. A mental health setting has got this nursing associate that's gone in and said, what do you mean you don't know how to do blood pressure and pulse, and you can't use a manual blood pressure machine, and so they've gone in and started training the registered nurses who haven't done a manual blood pressure for years because they've been using the automatic electronic one, how to do a manual blood pressure. So that's been really interesting, how they're bringing back skills that the registered nursing staff have lost. And the same works the other way round in the physical health services, so in OPAC (Older People's and Adult Community services), for example, one of the members of staff asked to go on secondment into district nursing after she'd qualified (as an NA) and she brought in all the mental health information and started asking the qualified district nurses how they think that person with that fungating leg ulcer must feel, and would it impact on their mental health.(SM_1)

The ***final theme*** related to co-workers, centres on the degree of ***push back or resistance*** to the NA role from other staff groups within the team. Attention has been drawn to initial uncertainty about the nature of the role amongst team members:

> There was initially a bit of confusion about what does this (the NA role) looks

like, which was actually quite quickly managed, I don't think there's been any push-back. (M_1)

Amongst team managers, a key group essential to sponsoring and supporting the role at workplace, this early confusion was noteworthy. Indeed, a general absence of Band 4, such as assistant practitioner roles within the Trust[12] lent the NA role more novel status than in a Trust with extensive experience of posts at this level:

> Up to now, we've not had Band 4 roles on ward particularly, so that's been quite a difficult thing to adjust to. (M_2)

However, the confusion associated with the NA role had been addressed in various ways including: the regularly convening meeting of managers at Trust level to discuss the role; the production of information sheets; and the Clinical Education Lead for NAs proactively engaging with team mangers to explain the role and explore its value and possible use within their specific care context:

> The managers initially didn't understand the role, and we all listen to the media, it's nursing on the cheap and all that stuff, and how's this role going to fit in with nursing, and I don't have a band four on my payroll, all those... I haven't got a Band four vacancy; a bit of a lack of imagination about how they had control of their own budget. So those things that they raised, we set up the management information days which (the Clinical Education Lead for NAs) now runs; they're really, really well attended. There are also information sheets, factsheets, that kind of stuff, obviously we're available to talk to them at any time, and people phone us quite a lot; (The Clinical Education Lead for NAs) goes out and meets with the managers that are struggling if they don't understand. So, I think the managers are getting there. (SM_2)

In terms of more direct resistance to the NA role within teams, there was little evidence to suggest hostility to the new role. One instance of opposition came from student nurses:

> Our NAs were obviously in placement with the student nurses and we went and did an induction session, we talk to them about the community and all

[12] Acknowledging the presence of some band 4 STP workers in the Trust

> that, and they were so angry about the trainee nursing associates, and they were saying they're taking our jobs, they're... – they used that phrase about nursing on the cheap – they won't be as qualified as we are, when we qualify we'll be telling them what to do. (SM_1)

One NA noted:

> Occasionally you will get a nurse, an agency nurse or a bank nurse come on and say, what is it that you do, or what is the point of your role, and things like that. (NA_1)

But these were isolated examples. As a nurse interviewee noted:

> *Interviewer: As a registered nurse you don't feel that she's encroaching on your...?*
>
> Interviewee: No, not at all. No, not at all. (RN_1)

Indeed, in general the NA role was viewed positively in the Trust:

> Certainly, the feedback that we've had across the board is that people like the role. (SM_1)

This response in part derives from the fact, already noted, that many of the qualified NAs, coming from the team as HCAs, were already well known and trusted by colleagues. There were also signs that the role's registered status gave the NAs greater confidence in dealing with their co-workers:

> Because they're (the NAs) a registered professional, they (the NAs) feel reassured by that and the fact that they've done training that's at a diploma level, so academically they're trained to quite a high level, so they're aware of the underpinning knowledge, so I think that gives a practitioner that has a greater depth of knowledge and understanding than the person they were when they were a health care assistant. (SM_3)

5. Summary and Conclusions

As a first wave pilot site with other Trusts in the Cambridgeshire and Peterborough catchment area, CPFT took on its own cohort of 12 TNAs in late 2016, with 10 qualifying and registering as NAs two years later. These CPFT NAs mainly came

from in-patient mental health wards, although a further six cohorts of TNAs have since been recruited and more broadly distributed across the Trust's diverse care settings. This case study focused on the development and deployment of CPFT's first cohort of qualified NAs, drawing principally on face-to-face interviews with a variety of actors with a stake on the role including the NAs themselves and their co-worker and managers. (The views and experiences of patients and service users will be collected in another part of the evaluation.) The findings were presented in three parts - rationale, process and consequences - with the following key points emerging:

- **Rationale**:
    - CPFT's take-up and deployment of the NA was principally driven by the career opportunity it provided to the Trust's experienced healthcare assistants, often performing in already quite extended roles.
    - Closely related, the NA role was seen by the Trust as an important step on a career development pathway, and a means of the organisation 'growing-its-own' staff, particularly in registered nursing.
    - At the outset the Trust's capacity to take forward the NA agenda with strategic intent was inhibited by the rapid speed with which the first cohort was assembled.
    - A bottom-up approach to generating this first cohort encouraged engagement from teams and TNAs with considerable enthusiasm for and commitment to the programme.
    - It was, however, an approach which led to the programme principally being driven by the career aspirations of particular individuals, rather than the service development and design needs of the Trust and its various services. This was reflected in the narrow concentration of first cohort (T)NAs in mental health wards rather than across the Trust's other services.
- **Process**:
    - For CPFT and other Trusts in the area, the Cambridge and

Peterborough Nursing Associate Partnership, with a reporting line into the local STP, was an important vehicle for taking forward the NA agenda. The development of the Partnership reflected a concern amongst Trusts in the area to ensure the NA role became a system resource. This aim was given by effect by member Trusts sharing job descriptions and uniforms, as well as by Trusts meeting regularly to problem solve, share experience and practice in relation to the new role.

- At the organisational level, CPFT established a new dedicated role to support and manage the NA programme - the Clinical Education Lead for NAs - reporting to the Trust Learning and Development Manager, and NA lead. This was a relatively new role, although the postholder had already established strong links with teams across the Trust to further development of the role.
- The low CPFT attrition rate on the TNA programme, with almost all individuals qualifying, reflected the positive training experience of NA interviewees. With the regulation of the NA role by the NMC ongoing and incomplete at the time of this training, there were uncertainties and disruptions, affecting in particular the curriculum and the NA interface with the HEI. However, NAs viewed the placement experience positively and while at times finding it difficult to untangle their HCA and trainee status, felt they were well support in their base placements.
- Qualified NAs were seen to move into preceptorship, at the time for six, now nine months, allowing them to sign-off competencies and further develop in their new role.
- Those qualified NAs keen to move into registered nurse training could also complete a bridging module, with seven of CPFT NAs taking this step.

- **Consequences:**
    - **For the NAs themselves**, the new role was part a broader career trajectory. Most of the qualified NAs had extensive careers in

various care and non-care related organisations before joining CPFT. However, they also had considerable experience working at the Trust, reflecting the organisation's desire to provide long-established and highly capable HCAs with a career opportunity.

- There was a universal desire amongst NA interviewees to become a registered nurse, perhaps unsurprising given the Trust's keenness to establish such a career pathway. However, some NAs had retained such an aspiration from the outset, while for other individuals it had emerged in a more gradual fashion and as personal confidence built.
- Moreover, progression to registered nursing was by no means unproblematic for these NAs: in one case, it was uncertain whether a Band 5 nurse post would be available; in another the NA was being encouraged by team managers to spend time on the NA role before progressing; while in a final instance, an NA had residual doubts about the prospect of embarking in two further years of intense nurse training off the back of the NA programme.
- **For the delivery of nursing care** at CPFT, the NA role was stimulating a re-distribution of nursing tasks and responsibilities. This was a hesitant and incremental process which reflected considerable uncertainty at team level about the nature of the new role even as the NAs 'hit the ground' after two years training.
- Despite this uncertainty the NA was developing its scope of practice at the Trust. Certainly, this scope was sensitive to care setting: for example, in the Crisis Home Treatment team there was debate on how far the NA, previously on an STR role, had extended their practice post qualification. On the mental health wards, there was a greater consensus that the NA was more involved in the administration of medicines, handovers, care planning, and in managing the ward as the duty nurse.
- At the same time, indicative of residual uncertainty were three outstanding issues being considered at the time of the fieldwork in

terms of whether they fell within the NAs' remit: PRN medication, the granting of section 17 leave, and working on night shifts.

- **For co-workers and indeed patients/service users**, the NA role had implications for skill mix but these implications were nuanced. Counted in the registered numbers, qualified NAs were typically replacing a Band 5 or 6 registered nurse and in this narrow sense were diluting skill mix. Whether care quality was negatively impacted by this change in skill mix is open to greater debate. The qualified NAs were often highly experienced employees who through their NA training were now positioned within the team to deliver a generic, holistic form of nursing care.
- While uncertainties remained about the shape of the role, NAs had not, in general met with significant resistance from co-workers, no doubt helped by the fact that most came from, worked during and returned to their teams once they qualified. They were therefore known and trusted by team members.

Going forward our report raises issues both for CPFT and for future evaluation of the role at the Trust:

- Given the Trust's interest in using the NA role as a career development opportunity, it is perhaps unsurprising that so many of the first wave NAs are seeking to progress into registered nursing. However, this does raise questions about how well the NA role in its own right itself is settling down and becoming established at the Trust.
- We have seen that engagement with and acceptance of the NA role, particularly by work colleagues, has rested in large part of the NAs coming from and being known and trusted by team members. As the Trust seeks to recruit externally to the role this might well generate new challenges in terms of embedding the role and gaining team buy-in.
- Views on the NA role from one stakeholder group have been conspicuous by their absence and that is patients and other services users. We hope to return

to the Trust at a later date to pick up on this perspective.

- The skill mix implications of developing the NA role were still working their way through the Trust. As the role rolls-out across a broader range of service areas, it will be of interest to explore how it impacts on skill mix with implications for staff cost and care quality.
- Indeed, our focus on the first wave of NAs mainly concentrated in mental health wards, leaves open whether and how the NA role has been taken-up in other Trust care settings.
- Perhaps most obviously the Covid-19 crisis raises questions about the development of the NA role: whether the crisis is impacting the scope of NA practice, the way it is being used and managed. We hope to address this context in future fieldwork.

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