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NHS Trust Survey 2020 on the Nursing Associate Role: Emerging Findings

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1. Introduction

Commencing in Spring 2019, the evaluation of the Nursing Associate (NA) role by the NIHR Policy Research Unit in Health and Social Care Workforce (HSCWRU), King's College London, has to date completed and reported on: a series of expert interviews and two NHS Trust case studies. It also administered a survey to Trusts over a year ago in 2019 and, given the continued roll-out of the NA role in changing and challenging times, it was deemed timely to conduct a repeat survey at the end of 2020. This repeat survey was undertaken independently from but in partnership with Health Education England (HEE), which provided support in developing the questionnaire and in distributing it to potential respondents across NHS England.

The 2020 survey reported here was administered in the context of unprecedent pressures faced by the NHS, and a reminder email to potential respondents planned for early 2021 was cancelled to avoid any undue distraction from care delivery. Despite these challenges, we received responses from a third of Trusts in NHS England and, given the remarkably difficult circumstances, we are most grateful to those senior managers and other staff able to respond[1].

After setting out details of the survey methodology and sample, this report presents the initial findings from the survey in three main parts:

- Employment and Deployment
- Management
- Organisational Approaches.

In the main, the report presents descriptive frequencies and analysis. The size of the sample did not lend itself to more sophisticated analysis, although at a couple of points in the report we present a cross tabulation of variables.[2] Throughout the survey respondents were given opportunities to provide free text comments, with an open-ended question at the conclusion of the survey asking respondents to provide their views on any issue covered in the questionnaire. Indeed 29 respondents, close to half, chose to submit comments. At various points in the report these free text comments are drawn on to elaborate the survey data.

2. Methodology and Sample

The Nursing Associate (NA) is a new registered role in health and social care, positioned at Agenda for Change Pay Band 4 between the unregistered Healthcare Support Worker (HCSW) and the Registered Nurse (RN) in the NHS, and requiring the completion of a two-year Level 5 qualification (now an apprenticeship). The first two Trainee Nursing Associate (TNA) cohorts, comprising respectively a thousand individuals, commenced their training in early 2017. These cohorts were followed by a cohort of 5,000 TNAs in early 2018 and another cohort of 7,500 in 2019, with plans for a further cohort of 5,000 launched in early 2020. With many of the 2017 and 2018 TNAs having now completed their training programme, there are around 3,000 registered NAs in post.

In autumn 2019, we carried out our first NHS Trust survey on the role. At the time, the Unit's main focus was NHS Trusts employing ***qualified*** NAs, so those starting training in 2017-18. This initial survey elicited close to 50 Trust responses, principally from Directors of Nursing. As the (T)NA

[1] A draft of this report was sent for comment to a member of the Unit's Patient and Public Involvement and Engagement Advisory Group. We are also most grateful for the valuable comments she provided.
[2] Clearly cross tabulation is a relatively basic form of statistical analysis, unable to control for the range of factors affecting patterns under discussion. However, in the report such analysis is included to encourage discussion of the possible relationship between variables and point the way to future research.

programme continued to unfold in new and challenging circumstances, we felt it timely to repeat the survey in late 2020, broadening the focus to capture developments related to NAs ***and*** TNAs. The interest in a repeat survey was further prompted by HEE, keen as part of its planning processes to ascertain Trusts' intentions on the take-up of NA and TNA posts.

The 2020 survey was conducted online, with two links to the questionnaire. The first link, in the form of a personal invitation to participate in the survey, was sent to the Directors of Nursing and Human Resources in all Trusts in NHS England. This constituted a sample of 469 individuals (the Directors Sample). The focus on Directors of Nursing and Human Resources replicated the approach taken in the 2019 survey, although our mailing list for the 2020 survey was more precisely targeted at the relevant postholders[3]. As a means of accessing a wider range of health and social care providers, a second 'open' questionnaire link was posted by HEE through its communication networks and publicised through Twitter. Both survey links became live at the beginning of December 2020, with a single reminder being sent to the Directors Sample on 15th December 2020.

In total, 86 individual responses were received through to the two survey links:

- 77 via the survey to Directors
- 9 via the open survey promoted by HEE.

Clearly, the open link was unable to generate a significant number of responses from the broader community of health and social care providers and this report focuses on responses from Trusts in NHS England, drawn overwhelmingly from the Directors Sample. Taking account of multiple responses[4], we received responses from a total of ***67 Trusts***. With a base figure of 208[5] Trusts this represents a survey coverage of around a third (32.2%), which is the average response rate from organisations to a survey of this type (Baruch and Holtom, 2008)[6].

The profile of Trusts responding was broadly representative in terms of region and type. As Table 1 below indicates, Trusts from London were slightly over-represented in the survey - 19.4% of Trusts in the survey came from London, with only 16.8% of all Trusts in NHS England coming from this region. It can be seen that Trusts in the East of England were also marginally over-represented, while those from the North West and the Midlands were slightly under-represented. In terms of Trust type, Table 2 below indicates that Acute Trusts were somewhat under-represented in our sample: 37% of all Trusts in NHS England are Acute (non-specialist), in our sample only 28.4%. By the same token, Combined Acute and Community Trusts were a little over-represented in our sample. Nonetheless, in general, the distribution of Trusts by region and type in our sample was not significantly out of line with the distribution of Trusts in NHS England and our sample is broadly representative in these terms.

[3] For the 2019 survey, we relied on a third party organisation to provide us with a mailing list of Trust Nurse and Human Resource Directors. As a consequence, we had little control over the accuracy and precision of this list.

[4] There were multiple responses from 4 Trusts and in these instances the most authoritative respondent (typically the senior nurse managers) was included in the survey, while replies to open questions were also considered from the excluded sets.

[5] HEE provided us with a figure of 218 including Ambulance Trusts. With no responses received from Ambulance Trusts, we agreed with HEE to exclude such Trusts from our base figure to come up with 208.

[6] Baruch Y, Holtom BC. (2008) Survey response rate levels and trends in organizational research. *Human Relations*, 61(8):1139-1160. doi: 10.1177/0018726708094863

Table 1: Sample by Region		
Region	**NHS England % (n=)**	**Respondents % (n=)**
London	16.8 (35)	19.4 (13)
South East	13.5 (28)	11.9 (8)
South West	9.6 (20)	10.5 (7)
Midlands	19.2 (40)	16.4 (11)
East of England	10.6 (21)	13.4 (9)
North East & Yorkshire	14.9 (31)	14.9 (10)
North West	16.4 (33)	13.4 (9)
	100 (208)	**100 (67)**

Table 2: Sample by Trust Type		
Trust Type	**NHS England % (n=)**	**Respondents % (n=)**
Acute Trusts	37.0 (77)	28.4 (19)
Combined Acute and Community Trusts	23.6 (49)	29.9 (20)
Community Trusts	6.7 (14)	7.5 (5)
Acute Specialist Trusts	7.2 (15)	6.0 (4)
Mental Health (MH) / Learning Disability (LD) Trusts	9.6 (20)	11.9 (8)
Combined MH / LD and Community Trust	15.4 (32)	16.4 (11)
Combined Acute, Community, MH / LD and Ambulance Trust	0.4 (1)	0 (0)
	100 (208)	**100 (67)**

There was also a spread of respondent Trusts by operating budget and nursing workforce size, although, as yet, we have not calculated whether our sample was representative of the NHS in England in these terms.

It can be seen from Table 3 below that just over a third of our sample (37.8%), had an operating budget of below £300 million and around a quarter above £600 million (27%). Around a half of our sample (47.4%) had a Registered Nurse workforce of between 1,000-2000 and just under three quarters a Healthcare Support Worker workforce below 1,000 (73.7%)[7].

Table 3: Sample by Budget and Workforce	
Operating Budget (n= 37)	**% (n=)**
Under £300 ml	37.8 (14)
£301-600 ml	35.1(13)
Over £600 ml	27.0(10)
Registered Nurse Workforce (n=57)	
Under 1000	24.6 (14)
1000-2000	47.4 (27)
Over 2000	28.0 (16)
Healthcare Support Worker Workforce (n=55)	
Under 1000	72.7 (40)
1000-2000	21.8 (12)
Over 2000	5.4 (3)

[7] Responses were difficult to analyse as not every respondent indicated if numbers were provided as headcount or as Whole Time Equivalent. We have decided to provide bands and to give the range.

As with our 2019 survey, we were much more likely to receive responses from Directors of Nursing, than Directors of Human Resources. As Table 4 below indicates, around a third of responses were received from the former (35.8%) and only nine percent from the latter. This no doubt reflects where accountability for and information about Trust NA programmes rest, but it is still noteworthy that over a third of the responses came from non-nursing Education Leads (35.8%), many of whom will sit within a Human Resource (HR) Directorate.

Table 4: Respondents' Trusts only by Job Role % (n=67)	
Chief Nurse/Director of Nursing	35.8 (24)
HR/People Director	9.0 (6)
Nurse Education Leads	19.4 (13)
Other Education/Development Leads	35.8 (24)

3. Employment and Deployment

3.1 Scale

In general, the survey indicates that most Trusts are employing NAs and TNAs, deploying them in modest but growing numbers, in a wide range of clinical areas, albeit with a degree of concentration in general medical and surgical wards.

More specifically, as Table 5 below indicates, well over three-quarters of Trusts (79.1%) are employing both TNAs and NAs, suggesting that Trusts joining the NA programme in 2017-18 (with now qualified NAs) have continued to employ TNAs in subsequent years. In our sample, there were only two Trusts still not taking-up the role at all.

A single Trust clearly tried the NA role and then decided not to continue by recruiting TNAs. A small but noteworthy proportion of Trusts (16.4%) is employing only TNAs, evidently only joining the programme in more recent years (post 2018 waves). As one respondent noted:

> 'We are only completing our first cohort of TNAs so it is still learning for the organisation' [27-69827093]

Table 5: Does your organisation currently employ trainee nursing associates (TNAs) and/or nursing associates (NAs)?	
	% (n=67)
Both TNAs and NAs	79.1 (53)
NAs only	1.5 (1)
TNAs only	16.4 (11)
Neither	3.0 (2)

Table 6 below suggests that the number of NAs in any given Trust remains quite modest: around half (44.4%) employ 10 or fewer NAs and close to three quarters (72.2%) 20 or fewer. This is not particularly surprising: with only some 3,000 registered NAs at present, this would work out at an average of only 14 NAs per Trust. More noteworthy perhaps, the survey suggests that Trusts are establishing a significant pipeline of NAs in taking on TNAs at scale. Table 6 indicates that over a third of the Trusts have employed more than 30 TNAs. Striking are six Trusts currently employing more than 60 TNAs. Whether the significant scale of TNA employment reflects an intention to build up the NA workforce and or to use the NA qualification as a stepping-stone into pre-registration nurse training remains an open question, to which we will return (see Section 4).

Table 6: If yes, approximately how many NAs/TNAs are employed in your organisation?		
	NAs % (n=54)	**TNAs % (n=64)**
1-10	44.4 (24)	17.1 (11)
11-20	27.8 (15)	31.2 (20)
21-30	20.1 (11)	15.6 (10)
31-40	2.0 (1)	7.8 (5)
41-50	0	9.3 (6)
51-60	0	7.8 (5)
More than 60	2.0 (1)	9.3 (6)
Don't know	4.0 (2)	1.5 (1)

Exploring in greater detail the size of the TNA workforce, Table 7 below suggests that the larger the Trust's operating budget the greater the scale of TNA employment. Thus 12 of the 14 Trusts with an operating budget of between £100k and £300k employed under 30 TNAs, while four of the five Trusts employing more than 60 TNAs had operating budgets of over £600k. This is an unsurprising finding with operating budget a likely proxy for the size of the Trusts in terms of service provided and overall workforce.

Table 7: Number of TNAs by Budget				
Budget	**Number of TNAs**			
	1-30	**31-60**	**More than 60**	
£100-300K	12	1	1	14
£301-600K	7	5	0	12
Over £600K	3	3	4	10
No. of Trusts	22	9	5	36

Table 8 below presents the pattern of TNA employment by region. The pattern is fairly similar across the regions, with a few noteworthy differences: for example, in the South West, almost all Trusts are employing under 30 TNAs, while the North West and North East have two Trusts with over 60 TNAs. Any differences between regions may well reflect variation in the distribution of Trusts by size and type across these areas.

Table 8: Number of TNAs by Region				
Region of England	**Number of TNAs**			
	1-30	**31-60**	**More than 60**	**No. of Trusts**
East of England	4	4	0	8
London	8	3	1	12
Midlands	8	2	1	11
North East	4	3	2	9
North West	6	1	2	9
South East	5	2	1	8
South West	6	1	0	7
No. of Trusts	41	16	7	64

3.2 Distribution

3.2.1 By Trust Type

The question of (T)NA distribution both between Trust types and within Trusts remains of interest to our evaluation, providing an insight into how the role is being rolled-out and whether take-up and use are sensitive to different organisational and clinical contexts. Table 9 below sets out the ***TNA*** numbers by Trust type, revealing the following patterns:

- ***Acute Trusts*** are likely to employ relatively large numbers of TNAs: over half of Acute Trusts (10 of the 19, or 52.7%) employ over 40 TNAs, while only 3 employ between 1 and 20 TNAs.
- ***Combined Acute and Community Trusts*** have a bipolar distribution of TNAs: 8 of these Trusts, a significant proportion (44%), employ only between 1-20 TNAs, but a noteworthy number (4) also employ over 60 TNAs.
- The relatively small numbers of TNAs employed in ***Community Trusts*** is perhaps unexpected. Certainly a survey respondent noted:

  > 'It is easier to introduce the role into the community nursing teams, more challenging in the inpatient units due to safer staffing templates and confidence in the role as new' [27-68963007].

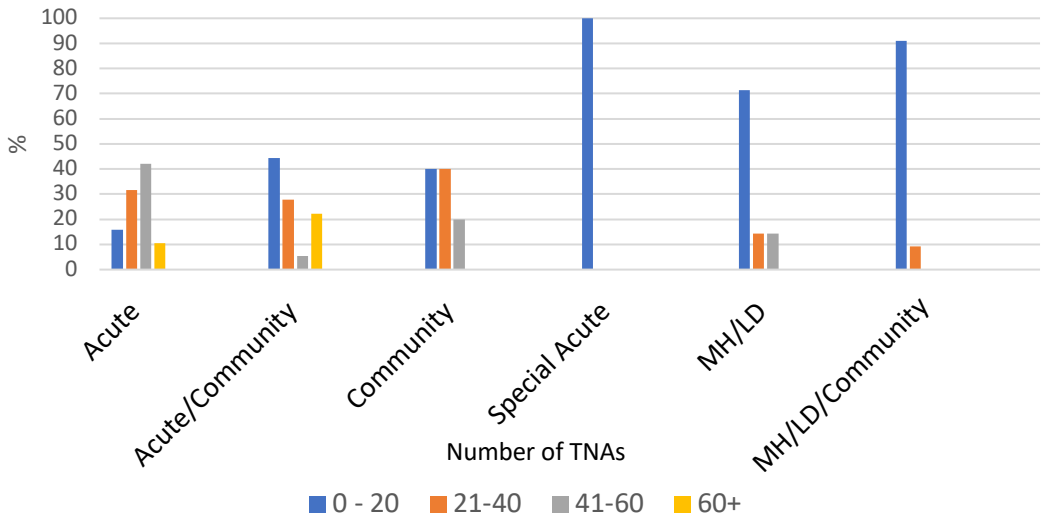
  However, community nursing teams are only one part of a Community Trust workforce, and the survey reveals that 4 out of the 5 Community Trusts employed 40 or fewer TNAs. At the same time, the number of such Trusts in our sample was quite small, suggesting some caution in interpreting these findings.
- ***Combined Mental Health (MH) and Learning Disability (LD)Trusts and Combined Mental Health (MH), Learning Disability (LD)and Community Trusts*** employ smaller TNA numbers: as can be seen from Table 9, 15 of these 18 Trusts employed only 1 to 20 TNAs.

These different patterns of TNAs employed by Trust type come through even more sharply in Figure 1. This presents the same Table 9 data in a visually more striking way.

Table 9: Number of TNAs by Trust Type

	Number of TNAs % (n= 63)				
	1-20	**21-40**	**41-60**	**60+**	**Total**
Acute	15.8 (3)	31.6 (6)	42.1 (8)	10.6 (2)	100.0 (19)
Acute/Community	44.4 (8)	27.8 (5)	5.5 (1)	22.2 (4)	100.0 (18)
Community	40.0 (2)	40.0 (2)	20.0 (1)		100.0 (5)
Special Acute	100.0 (3)				100.0 (3)
MH/LD	71.4 (5)	14.2 (1)	14.2 (1)		100.0 (7)
MH/LD/Community	90.9 (10)	9.1 (1)			100.0 (11)

Figure 1: Numbers of of TNAs by Trust Type (%)



3.2.2 By Clinical Area

Table 10 below indicates that NAs are distributed across a variety of clinical areas but in a slightly uneven way. Confirming the pattern highlighted in our first Trust survey, the NA is most likely to be found in medical, surgical and care of older people wards. Around a half of the Trusts noted deployment of NAs in these clinical areas. However, a noteworthy proportion, around a quarter to a third, also signalled NA presence in other areas: Outpatients (32.2%), Community Nursing Teams (39.0%) and Accident and Emergency (28%). Of course, this pattern of deployment in large part reflects the distribution of Trust types both generally and in our sample.

Indeed, while further analysis reveals that on average Trusts have NAs in four clinical areas, there is clearly some variation in how broadly the role is being implemented by Trusts. Around a half of Trusts (45.8%) have the role in one to three clinical areas and over a third in three to seven areas (35.6%). It is striking that close to one in five (18.6%) had the role in seven to nine areas.

Table 10: If you are currently employing nursing associates: in which clinical areas/departments/health settings are they working? (As many as appropriate ticked)	
Clinical Area	**% (n=59)**
Medical Ward	55.9 (33)
Surgical Ward	49.1 (29)
Care of Older People (In-patient Ward)	59.3 (35)
Children's Wards	27.1 (16)
Outpatients	32.2 (19)
Community Nursing Team	39.0 (23)
Community Mental Health team	20.3 (12)
Theatres	15.2 (9)
Accident and Emergency	28.8 (17)
Intensive Care	5.1 (3)
Maternity	5.1 (3)
Mental Health Care (In-patient Ward)	25.4 (15)
Inpatient Learning Disability	6.8 (4)
Community Learning Disability Team	5.1 (3)
Dementia Team	11.9 (7)
Renal	11.9 (7)
Oncology Ward	16.9 (10)
Other(s): Ambulatory Care Community Children's Services (eg CCN) School nursing Research Clinical Trials - Drug Development Unit Community in-patients Dermatology Physical health team Infection control team Community bed-based rehabilitation	13.5 (8)

3.3 Nursing Associates and Associate Practitioners

Our study continues to show an interest in the interface between the NA and the Assistant Practitioner (AP) role. The AP is a much longer standing healthcare role than the NA, introduced in early 2000, also as a senior support worker positioned at Pay Band 4. However, in contrast to the NA it functions as an unregistered role. The AP role can and has been used to support a range of healthcare professions but given our interest in the interface between APs and NAs, our survey specifically asked our respondents to report on the number of APs 'working the field of nursing'. The survey suggests that the AP role continues to be quite widely used by Trusts, although with some variation in organisational take-up. As Table 11 below indicates, around a quarter of surveyed Trusts employ five or fewer APs but over a third (34.3%%) more than 20.

There is further scope to explore whether and how the presence of nursing APs impacts the take-up and use of NAs. From our previous interview and case study work[8] different scenarios present themselves: on the one hand Trusts which have already built-up their senior nursing support workforce through the AP role are sometimes less inclined to engage with the NA role; on the other hand, Trusts familiar with and experienced in introducing and using the AP in nursing are better prepared and able to 'run with' the new NA role at scale and pace.

Table 11: Approximately how many Assistant Practitioners working in the field of nursing does your organisation employ?	
Number of APs	**% (n=67)**
None	7.5 (5)
1-5	16.4 (11)
6-10	16.4 (11)
11-15	10.5 (7)
16-20	7.6 (5)
More than 20	34.3 (23)
Don't know	6.0 (4)
No reply	1.5 (1)

Cross tabulating Trusts by the number of APs and TNAs they employ, the latter scenario appears to have greater support than the former. Table 12 below suggests that those Trusts taking on TNAs at scale, also employ significant numbers of APs. Thus, the five Trusts employing 60 or more TNAs, also have more than 20 APs. Indeed, of the ten Trusts employing 41-60 TNAs, six employ more than 20 APs. At the other end of the scale, those Trusts taking on relatively few TNAs do not appear to have a strikingly high number of APs, which might explain this tardiness: of the 29 Trusts employing 1-20 TNAs only seven (a quarter) have more than 20 APs and close to half (44.8%) employ only 1-10 APs.

Table 12: Number of TNAs by Number of APs				
	Number of TNAs			
Number of APs	**1-20**	**21-40**	**41-60**	**60+**
None	10.3 (3)	0	20.0 (2)	0
1-10	44.8(13)	33.3(5)	20.0(2)	0
11-20	20.7(6)	26.7 (4)	0	20.0 (1)
20+	24.1 (7)	40.0 (6)	60.0(6)	80.0(4)
	100.0 (n=29)	***100.0 (n=15)***	***100.0(n=10)***	***100.0 (5)***

[8] Evaluating the Introduction of the Nursing Associate Role: The Livewell Southwest Case Study - Research Portal, King's College, London (kcl.ac.uk)
Evaluating the Introduction of the Nursing Associate Role: The Cambridgeshire and Peterborough NHS Foundation Trust Case Study - Research Portal, King's College, London (kcl.ac.uk)
Introducing the Nursing Associate role: early findings - Research Portal, King's College, London (kcl.ac.uk)

4. Management

Our interest in the management of NAs, in part, centred on the availability and nature of preceptorship programmes. However, given data from our first survey suggesting the importance attached by Trusts to the NA role being a pipeline into pre-registered nurse training, we also asked a series of questions on the regulation of career progression in these terms: whether NAs were required to spend a minimum period of time in the NA role before progressing; whether Trusts had a nurse degree apprenticeship; and more substantively what proportion of NA were moving straight on to nurse training.

4.1 Preceptorship

It can be seen, in Table 13 below, that preceptorship programmes for NAs are almost ubiquitous, perhaps unsurprising given that the Nursing and Midwifery Council 'strongly recommends' them for NA (and nurse) registrants.[9] Over three quarters of Trusts (77.6%) already had one in place, although it is noteworthy that a fifth of Trusts (19.4%) were still planning to introduce one.[10] In general, these programmes last for a year - the case in close to two thirds of Trusts - with a noteworthy minority - over a quarter - lasting six months (Table 14 below).

Table 13: Do you have a preceptorship programme for your nursing associates?	
	% (n=67)
Yes	77.6(52)
No but planning to introduce	19.4 (13)
No and not planning to introduce	1.5 (1)
No reply	1.5 (1)

Table 14: If yes, please state how long the preceptorship lasts?	
	% (n=52)
6 months	28.8 (15)
1 year	61.5 (32)
18 months	1.9 (1)
Other	7.7 (4)

4.2 Pre-Registration Nurse Training

Clearly, NA opportunities to progress in career terms into pre-registration nurse training are enhanced by the availability of a readily accessible nurse degree apprenticeship offered by their employer Trust. There has been considerable debate about the (financial) viability of nurse degree apprenticeships, reflected in the slow take-up of them by Trusts[11]. Our survey suggests that just over half (55.2%) offer such an apprenticeship (Table 15 below). Most of the remainder, over a third of Trusts (34.3%), are planning to introduce it.

[9] Principles of preceptorship - The Nursing and Midwifery Council (nmc.org.uk)

[10] This likely cover Trusts still in the process of training NAs and yet to have qualified individuals in post as yet (see Table 5 above).

[11] Nursing degree apprenticeships: in poor health? - Education Committee - House of Commons (parliament.uk)

Table 15: Does your organisation offer the registered nurse degree apprenticeship?	
	% (n=67)
Yes	55.2 (37)
No but planning to	34.3 (23)
No and not planning to	10.5 (7)

More striking is the marked variation in the regulation of NA progression into nurse training introduced by Trusts. In only around a quarter of Trusts (27.8%) are NAs able to move straight into the nurse degree apprenticeship on qualifying as an NA (Table 16 below). Most commonly, in close to 40 percent of Trusts (39.7%), NAs can progress only after completing their preceptorship, and indeed almost a third of Trusts (29.3%) require a further period within the NA role after completing the preceptorship, before allowing progression. Our previous research suggests various possible reasons for Trusts seeking to manage NA career progression: allowing newly qualified NAs to settle into their new role and consolidate their skills; seeking some organisational return on the organisational investment made in NA training; attempting to build a meaningful NA component of the workforce; and lacking the workplace capacity to support NAs moving onto the apprenticeship. As one of the survey respondents noted:

> 'Many NA candidate[s] see the role as a stepping stone to degree apprenticeship so they are not staying in the role long enough for the workforce to see the value of the role/ understand the role. As we only have small number of NAs, many managers don't know what [the] NA role is therefore the full potential of the role is not always explored and embraced resulting in the NA sometimes feeling under-used and under-valued' [27-69205122].

Table 16: On qualifying does your organisation require NAs to spend a minimum period of time in the NA role before moving onto to Registered Degree Nursing Apprenticeship?	
	% (n=58)
No, they can move straight onto the Registered Degree Nursing Apprenticeship	27.6 (16)
Yes: after completing the preceptorship	39.7 (23)
Yes: after completing the preceptorship and spending a minimum time in the NA role	29.3 (17)
Yes: after spending a minimum time in the NA role (but we don't offer a preceptorship programme)	3.4 (2)

A more tangible sense of NA progression onto the nurse degree apprenticeship is provided by the survey question on the proportion of qualified NAs that have already moved into nurse training. In one of our responding Trusts all of the qualified NAs were now undertaking nurse training. Clearly this was an outlier case, with over half (53.3%) of the Trusts running a nurse degree apprenticeship noting that none of their NAs had moved on to the nurse degree programme. This is no doubt partly explained by the need for many NAs to complete their, typically, a year-long preceptorship (see above). Indeed, while one in four Trusts had seen a quarter of the NAs progress in nurse training (26.7%), in only one in five (20.0%) had a half or more qualified NAs moved on in this way.

5. Organisational Approaches

5.1 Plans

Our survey found that the overwhelming majority of Trusts (82.2%) were keen and planned to continue rolling-out the NA role in their organisations (see Table 17 below). Indeed, our early discussion (page 5) suggests that in some Trusts, this roll-out is at significant scale with a number employing large TNA cohorts. Just seven Trusts plan only to maintain their current NA establishment level, by simply replacing NAs who leave, while only one Trust indicated an intention to reduce NA numbers.

Table 17: What plans does your organisation have for increasing, maintaining or reducing the NA workforce?	
	% (n=67)
Plan to increase the current NA establishment level	82.1 (55)
Plan to maintain the current NA establishment level (i.e. where NA posts are vacated, they will be filled again)	10.5 (7)
Plan to reduce the current NA establishment level (i.e. where NA posts are vacated, they will not be replaced)	1.4 (1)
Don't know	4.5 (3)
No reply	1.5 (1)

These plans to continue rolling-out the role reflect the positive free text comments on NAs provided by several survey respondents:

- 'Excellent role, very positive in respect of integration into the team. Can see the value of the role in the wider health and social care settings' [27-68771525]
- 'Really valuable addition to our nursing workforce and has been welcomed across the organisation' [27-69703124]
- 'Fantastic role which has been embraced across our system' [27-69490926]
- 'Fully supportive' [27-68710721]
- 'Really keen to promote the role' [27-69628041]
- 'It's a great role' [27-69014210]
- 'The NA role is part of our 5-year workforce plan. The role is to be embedded on a sustainable basis'. [27-69769530]
- 'Committed to a rolling programme for the next 4 years to train and recruit more NA's.' [27-69459077].

5.2 Influences

With a continuing Trust interest in and commitment to the NA role, the survey provided information on the range of factors driving this process. Confirming findings from the first survey, Trust engagement with the NA role was driven by a range of factors. Table 18 below indicates that Trusts attached a degree of importance to a variety of factors. However, there was a difference of emphasis or priority given to these factors, reflected in the proportion of Trusts attaching 'considerable importance' to an influence and in the mean scores for the respective factors.

Table 18: How important are the following factors in influencing the introduction of the NA role in your organisation? The NA role is helping to... (n=67)								
	Considerable importance	**Some importance**	**Little importance**	**No importance**	**Don't know**	**No reply**	**Mean* (Rank importance)**	**SD (n=63) ***
...establish a pipeline for growing our own registered nurses	49 73.1%	14 20.9%	1 1.5%	1 1.5%	0	2 3.0%	3.71 (3)	.580
...keep healthcare support workers (HCSWs) by providing a new career opportunity	54 80.6%	12 17.9%	0	1 1.5%	0	0	3.78 (1)	.522
...develop a new NA role of value in its own right	53 79.1%	9 13.4%	4 6.0%	1 1.5%	0	0	3.70 (4)	.663
...improve care quality	58 86.6%	4 6.0%	2 3.0%	1 1.5%	1 1.5%	1 1.5%	3.76 (2)	.734
...re-design services	32 47.8%	28 41.8%	4 6.0%	1 1.5%	1 1.5%	1 1.5%	3.33 (7)	.803
...cope with Covid-19 pressure	13 19.4%	25 37.3%	16 23.9%	11 16.4%	1 1.5%	1 1.5%	2.57 (9)	1.027
...recover services	14 20.9%	21 31.3%	19 28.4%	8 11.9%	3 4.5%	2 3.0%	2.51 (10)	1.105
...reduce staff costs	6 9.0%	24 35.8%	21 31.3%	12 17.9%	2 3.0%	2 3.0%	2.29 (11)	.991
...recalibrate skills mix	23 34.3%	35 52.2%	4 6.0%	3 4.5%	1 1.5%	1 1.5%	3.13 (8)	.852
...widen participation	48 71.6%	15 22.4%	1 1.5%	1 1.5%	2 3.0%	0	3.56 (5)	.876

*Calculated on n=63 replies (list exclusion)
(Considerable importance =5; … No importance =1; Don't know =0)

While broadly framed, interest in 'improving care quality' was viewed of 'considerable importance' by almost all Trusts (86.6%). More tangibly, three factors emerged as being particularly influential:

- The first was the ***capacity of the NA role to provide new career opportunities for existing HCSWs***: in terms of mean score (3.78) this was the highest ranked factor and viewed as being of 'considerable importance' by over 80% of Trusts. As a couple of survey respondents highlighted:
    - 'There is lots of interest from HCSW in the role to develop their careers' [27-69169661]
    - 'The TNA programme provides a great opportunity to widen access to registered nursing and support growth and development for HCSW level staff' [27-69578621].

  Another survey respondent echoed these sentiments at a greater length:

    - 'The NA apprentice model and previously the AP programme has enabled staff who were "stuck" in a particular role but wished to develop and learn and do more the opportunity to grow both academically and professionally. It has opened new horizons enhanced their confidence both personally academically in their developmental opportunities. This was not as accessible before unless the individual left to attend university full time which was not always an option for some who need to gradually build their confidence in their abilities. Also for some it was not an option for financial reasons as they would have needed to leave their role and self fund. This model grows our own staff and recruit new staff with a career /developmental pathway and contributes to recruitment and retention of staff within the system' [36-674227-68834623].

A further respondent outlined the positive personal and organisational outcomes derived from HCSWs training for the NA role:

- 'I've personally witnessed current HCSW's train to become a NA and have seen first-hand these members of staff become extremely confident and competent practitioners. I have seen the HCSW - NA candidates change not only developing skills and knowledge but they have embraced this role within practice, demonstrating professional behaviours as they have developed. This in turn has most definitely enhanced patient care' [27-69160666].

- The second influential factor was the ***use of the NA role to help develop a pipeline for 'grow-your-own' nurses***. This factor received the third highest mean score, and was viewed by close to three-quarters of Trusts (73.1%) as being of 'considerable importance'.

- The third was ***developing the NA role in its own right***, receiving the fourth highest mean score and seen as of 'considerable importance' by over three-quarters of Trusts (79.1%). As one respondent noted:

  - 'We really value the Nursing Associate role within its own right' [27-69455529].

  Echoed by another stressing:

  - 'Fully advocate the role' [27-69333328].

Factors associated with labour costs and workforce organisation were given less weight by respondents. Nonetheless most Trusts (86.5%) attached 'considerable importance' or 'some importance' to the NA role as underpinning a recalibration of skill mix, while close to half (44.8%) attached a degree of importance to the role as helping control staff costs. Similarly, it is striking that well over half of Trusts (57.7%) felt that the NA role had 'considerable importance' or 'some importance' in helping to cope with Covid-19 pressures, suggesting the value of exploring in more detail how the role has been used during the pandemic.

Few respondents took the opportunity (in an open question) to list any further influences on the take-up of the NA role, although a couple of other reasons were presented:

- 'To support the management of increasing complexity of patients in the community' [27-68963007]
- 'To help with long term vacancies' [27-69173218].

This latter influence is particularly worth noting. In our earlier work, Trusts have mentioned the use of NAs to address high local vacancy levels amongst nurses. Given deep seated local difficulties recruiting registered nurses, some Trusts have seen the NA not as a nurse substitute but simply as a practical means of filling a post which would not otherwise be filled or would be filled by an agency worker. Reflecting the view that the NA role is sometimes seen by the Trust in default terms as a means of dealing with local recruitment difficulties, a survey respondent noted:

> 'We have minimal RN /HCA (Healthcare Assistant) vacancies and a positive recruitment pipeline so have not needed to introduce NAs' [27-69010626].

5.3 Challenges

Given the overwhelming proportion of Trusts intending to continue employing NAs, the challenges to the introduction of the role should not be overstated. Nonetheless, our survey suggests that some challenges remain. From Table 19 below it is clear that the stand-out challenge is the lack of system support. With the highest mean score (3.31), just over half of Trusts (50.7%) attached 'considerable

importance' to this challenge. There is scope to debate precisely what kind of system support is lacking. However, in prompting respondents with a reference to financial support, especially in training NAs, this is likely to be the central cause of concern. This is reflected in some of the free text comments provided by survey respondents:

- 'Financial aspect is the main issue when trying to introduce this role' [27-69006209]
- 'One NA costs more than one HCA so introduction will reduce WTEs' [27-69010626]
- 'Support for TNAs is reliant on financial support from HEE' [27-69173218]
- 'Financial implications and impact of top up degree for NAs/APs is extremely challenging' [27-68712899]
- 'Not yet secured funding for the RN Degree Apprenticeship, however the Trust has supported 2 NA's to undertake the degree by providing 50% funding' [27-69787353].

Table 19: How important are the following as ongoing challenges to the introduction of the NA role in your organisation?

n=67	Considerable importance	Some importance	Little importance	No importance	Don't know	No reply	Mean * (ranking)	SD *
Difficult to find suitable TNA recruits	12 17.9%	24 35.8%	20 29.9%	9 13.4%	0	2 3.0%	2.60 (3)	.949
Lack of system support (e.g. financial support)	34 50.7%	21 31.3%	8 11.9%	3 4.5%	0	1 1.5%	3.31 (1)	.865
Lack of organisational capacity to support the role (e.g.to mentor/supervise)	13 19.4%	32 47.8%	10 14.9%	10 14.9%	0	2 3.0%	2.74 (2)	.957
Role being resisted by team members	3 4.5%	26 38.8%	26 38.8%	10 14.9%	0	2 3.0%	2.34 (6)	.796
Ongoing limits on what NAs can do	5 7.5%	33 49.3%	20 29.9%	7 10.4%	0	2 3.0%	2.55 (4)	.791
Role not fitting into team service routines	6 9.0%	26 38.8%	23 34.3%	10 14.9%	0	2 3.0%	2.43 (5)	.865

*Calculated on n=65 replies (list exclusion)
(Considerable importance =5; … No importance =1; Don't know =0)

The weight attached by Trusts to the other challenges listed is not great, although they do attribute a degree of importance to them all:

- With second highest mean score (3.0), one in five Trusts (19.45%) attached 'considerable importance' to the ***lack of organisational capacity*** to support the role', with a further half viewing this challenge as being of 'some importance'. Several survey respondents elaborated on this challenge:
    - 'There is increased pressure on placements due to an increase in student nurse and AHP numbers' [27-69173218]
    - 'Need for 'protected time for learning' [27-68909545]
    - 'Managers' only happy to support 1-2 TNAs at a time to ensure service delivery continues' [27-68731196].

  Various of these financial and broader organisational capacity challenges are covered in the comments of a survey respondent worth quoting at length:

  > 'From a manager's perspective, the new NMC model of Trainee Nurse Associates apprenticeship does not fit the conventional apprenticeship model. i.e the employer does not get any benefit of [from] putting their employee on an apprenticeship programme. The new TNA programme requires the apprentice to be away from

their clinical area most of the week (placement, study days, supernumerary time). The service doesn't get any funding to backfill the absence to cover their workload. For services struggling with staffing and budgeting issues this offers no incentive to support an apprentice for 3 years with no guarantee they will stay in the service when they qualify' [27-69205122].

- Over half of Trusts attached 'considerable importance' or 'some importance' to difficulties in ***finding suitable TNAs to recruit***. This may well reflect the reduced pool of internal candidates for the role as ongoing waves of trainees are recruited. We did not ask respondents whether their Trusts were recruiting externally to the role, but one respondent noted:

    - 'We are scoping and intend to offer direct entry routes with internship type placements to get applicants ready' [27-69014210].

  The difficulties in finding suitable recruits may also be linked to the ongoing challenge of ensuring that TNA applicants have the necessary functional skills:

    - 'Lots of interest but most candidates need to complete Functional Skills for eligibility and this is difficult from an organizational and time point of view' [27-68731196]
    - 'Functional skills is a barrier for existing staff and new recruits. We offer this via local colleges, but the current remote learning is not as effective' [27-69500362].

- Our earlier research has suggested that the NA role was taking a little while to settle down and find a place within established care systems and procedures. This was reflected in ongoing challenges highlighted in the survey as the role continues to seek a place within the team and to calibrate its scope of practice. Well over half of Trusts attached 'considerable importance' or 'some' importance to '***the ongoing limits on what NAs can do'***. Close to half of respondents (47.8%) attached 'considerable importance' or 'some importance' to the role not as yet fitting into routines. Indeed, there is even a residual low level of resistance by team members to the role, with 43.3% of respondents attaching 'considerable importance' or 'some importance' to this challenge.

  These challenges are reflected in various comments from survey respondents:

    - 'The role is still relatively new' [27-69169661, echoed by another respondent]
    - 'There is a cultural aspect re. being seen as 'dumbing down' the RN role rather than upskilling the HCSW role' [27-69006209]
    - 'Understanding and "buy-in" from the workforce has been difficult initially, but as the pilot cohort have completed, managers are keen to support SNAs (Student Nursing Associates) where safe staffing allows' [27-68731196]
    - 'There is a need to help staff understand the contribution the RNA role can make - this may be better understood and accepted as the number of RNA's increases' [27-69578621]
    - 'Some concern that the TNA programme is not sufficient to prepare TNA's to administer medicines without significant risk of error/adverse patient outcomes' [27-69578621].[12]

[12] Although this would suggest that the Trust itself needs to be proactive in providing the necessary training and protocols to allow the NA to administer medications (steps many other Trusts have taken)

6. Summary and Conclusions

In unprecedently difficult times we are grateful to senior nurse, human resources managers and other staff in helping us achieve a representative survey sample covering a third of Trusts in NHS England and to shed light on the ongoing introduction of the Nursing Associate role. The findings from the survey indicate that:

- Trusts are employing NAs often in small numbers but with signs of increasing scale, not least reflected in the substantial size of TNA cohorts.

- NAs are most likely to be found in general medical and surgical wards, but also in a wide range of other, often more specialist, clinical areas.

- Many Trusts continue to employ APs, suggesting the NA is often complementary rather than alternative to this role.

- Most Trusts now have preceptorship programmes for NAs in place or are planning to introduce one, typically lasting one year and in some cases six months.

- Many Trusts require NAs to at least complete this preceptorship before moving onto the pre-registration nurse training, with the majority of Trusts offering a nurse degree apprenticeship for those willing and able to take this step.

- The overwhelming majority of Trusts plan to continue recruiting to the NA role.

- This future commitment to the role is driven by three main goals: providing HCSWs with meaningful career opportunities; generating a pipeline of registered nurses; and developing an NA role of value in its own right.

- Given this ongoing commitment to the NA role, the challenges to its introduction should not be overstated. However, many Trusts view ongoing system, particularly financial, support as implicitly required, and attached some importance to addressing the challenge of ensuring the role finds its scope of practice and place within care teams and routines.

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