The development of the nursing associate role: the postholder perspective

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<th>Abbreviation</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ARRS</td>
<td>Additional Roles Reimbursement Scheme</td>
</tr>
<tr>
<td>CSW</td>
<td>Clinical Support Worker</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled Drugs</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>DN</td>
<td>District Nurse</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>HCA</td>
<td>Healthcare Assistant</td>
</tr>
<tr>
<td>HEE</td>
<td>Health Education England</td>
</tr>
<tr>
<td>HEI</td>
<td>Higher Education Institution</td>
</tr>
<tr>
<td>HSW</td>
<td>Healthcare Support Worker</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MSW</td>
<td>Maternity Support Worker</td>
</tr>
<tr>
<td>N</td>
<td>Number</td>
</tr>
<tr>
<td>NA</td>
<td>Nursing Associate</td>
</tr>
<tr>
<td>NG</td>
<td>Nasogastric</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Directive</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Health Nurse</td>
</tr>
<tr>
<td>RNA</td>
<td>Registered Nurse Apprenticeship</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SNA</td>
<td>Student Nursing Associate</td>
</tr>
<tr>
<td>TNA</td>
<td>Trainee Nursing Associate</td>
</tr>
<tr>
<td>T/NA</td>
<td>Trainee Nursing Associate and Nursing Associate</td>
</tr>
</tbody>
</table>
1. Introduction

The Nursing Associate (NA) is a registered role at National Health Service (NHS) Pay Band 4², typically positioned between the care assistant and the registered nurse. It is a relatively new role, adopted by health and social care employers since 2017 when the first 2,000 Trainee Nursing Associates (TNA) were taken on, completing their Level 5 qualification two years later. TNA cohorts have been recruited by employers in each of the subsequent years. At the time of writing (Autumn, 2021), there are around 4,000 registered NAs in post and 6,000 TNAs in training³.

Over the last couple of years researchers from the NHIR Policy Research Unit in Health and Social Care Workforce have been evaluating the NA role, concentrating on its use, management, and impact. Two surveys of Nurse Directors in NHS Trusts (2019 and 2020) have been completed, along with two NHS Trust case studies. Two sets of interviews with expert policy makers and practitioners in health and social care have also been undertaken. The first in mid-2019 with around 40 participants, was designed to explore the policy context for the development of the role, and the second, covering most of the same interviewees, in late 2020 and early 2021, sought to examine how the NA role was settling down, particularly in the context of the COVID-19 pandemic (henceforth Covid)⁴. Largely missing from the evaluation to date, however, have been the voices of the TNAs and NAs themselves.

We have made efforts to pick-up these voices at various points in our evaluation. For example, during our case study work, we interviewed those training for and performing the NA role. Beyond our evaluation, other researchers have surveyed T/NAs. As part of their study on the training received by the 2017 cohorts, Traverse, an independent research-based consultancy, conducted three surveys of TNAs (July, 2017 Numbers (N) =1030; February, 2018 N=797; and April, 2018 N = 650). These surveys generated demographic background data on the early cohorts but focused exclusively on the learning and teaching experiences of TNAs, with no follow-up surveys of qualified NAs. A more recent survey undertaken by King et al (2021)⁵ covered a small number of qualified NAs (N=21) along with a slightly larger group of TNAs (N=43), but with a specific focus on how postholder training and work experience had been impacted by Covid. This paper reports on the findings from a survey of over 500 TNAs and NAs, conducted in Summer, 2021. This total sample comprised around 200 qualified NAs, making it the largest dedicated survey of this group of employees to date, and over 300 TNAs. The report examines the views of both groups, not only in the context of Covid, but as more generally they relate to work and employment experiences.

There continues to be much debate on the nature and consequences of the NA role, which in the absence of strong evidence has often been impressionistic, anecdotal and in some instances speculative⁶. Drawing on a large sample of T/NAs, the reported survey provides a firmer empirical foundation for informed discussion on who T/NAs are, what they do, how they experience employment or training, and how they view their working lives.

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² The NHS pay bands covered in the report relate to the pay and grading structure set out in the Agenda for Change agreement covering the NHS in England. The social care sector is not covered by this agreement.
³ Estimate provided in interview with HEE.
⁴ The findings from the research work to date are published in various reports; all freely available on the Unit website: www.kcl.ac.uk/research/nursing-associates
⁶ See, for example, NHS trusts hiring non-nurses for nursing roles, union warns | Nursing | The Guardian
After briefly outlining our survey approach and the nature of the sample, the report is divided into the following parts:

- Personal backgrounds.
- Patterns of employment.
- The training experience.
- The work experience.
- Futures\(^7\).

\(^7\) The views of patients, service users and carers are missing at this stage. We hope to hear from them about the NA innovation when it is deemed appropriate to undertake research with individuals in person.
2. Research Approach

2.1 Method

Our survey of T/NAs was conducted online between 2nd June until 17th July 2021. Over a couple of years into our NA evaluation project, the timing of the survey was influenced by two main factors. First before surveying postholders, we needed an initial understanding of the context for and nature of the new NA role. The earlier expert interviews and especially our case studies established a sensitivity to the nuances of the role, and its associated use, development, and training, which could then be used to develop a meaningful and precise survey questionnaire. Following our expert interviews and case studies, a pilot online questionnaire was drafted in April 2021 and administered to the 60 or so TNAs and NAs at a Trust in the south-west of England. With responses from around a third of these employees, we were able to make important modifications to the draft survey. These modifications mainly centred on the questions dealing with training, where our pilot Trust’s approach to TNA placements encouraged us to introduce a sharper distinction between training models (see section 5.1 below for a full discussion of these models.) The revised survey was then sent out to a selection of experts, who at this stage felt the questionnaire was ‘fit for purpose’.

The second factor influencing the timing of our survey was the more prosaic challenge of accessing T/NAs, to administer the questionnaire. With a focus on the first two waves of TNAs covering a limited range of locality-based partnerships, Traverse was able to contact its survey respondents mainly through the email contacts held by the respective higher educational institute (HEI) delivering the training programmes. King et al’s (2021) survey also relied on HEI contact details to access T/NAs although the geographical spread of these HEIs and the T/NAs in their study remains a little unclear. In contrast to these approaches, we sought to develop more direct access to T/NAs through their employer, and particularly through these organisations’ senior nurse manager. In each of our NHS Trust Nurse Director surveys we asked whether the respondent was prepared to circulate our survey link to their T/NAs, with 68 agreeing to do so. This ensured the distribution of the survey to many T/NAs within the same Trust, along with a cover note from a senior manager lending legitimacy to the survey and encouraging a response. There were drawbacks to our approach: relying on access to Trust employees we were unable to reach trainee self-funders; our approach did not reach T/NAs in social care; and, of course, with not all Trust Nurse Directors responding to our surveys, those kindly agreeing to pass-on the survey link could only reach a sub-set of the total T/NA population. We attempted to address some of these shortcomings by contacting NA leads in our completed and planned case study Trusts to pass on the link to their T/NAs and by using the social media platform Twitter to publicise the survey and its online link, with tags such as @WeNursingAssocs, #NursingAssociate, #Wenursingassociates, #RegisteredNursingAssociate, #Naambassadors, #NA, and #TNA.

2.2 Survey Design

Accessing the survey through a shared online link, NAs and TNAs were asked the same questions on their organisational affiliation and then, having identified themselves as either NAs or TNAs, were directed to two separate sets of questions. For both groups, there were common banks of questions on aspects of job satisfaction, career intentions, and background characteristics e.g., age, ethnicity, etc.

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8 Ethical approval for our T/NA survey work was secured from King’s College London on 13th March 2020, reference number: MRA-20/21-22549.

9 As well as the two completed case studies, we had planned to undertake case work at three further Trusts employing T/NAs at scale. Covid prevented this case study work but we had already built-up strong contacts with senior nurse managers at these Trusts, willing to pass the survey link to their T/NAs.
and domestic circumstances, allowing some comparative analysis. However, given obvious variation in the nature of the roles, other questions were tailored to pick up different aspects of the employment and work experience. Thus, for NAs a core bank of questions focused on scope of practice: how often on any given shift they performed a range of specified tasks. For TNAs interest naturally concentrated on aspects of training, with questions posed on the nature of training arrangements and the barriers they faced. Covid represented a cross cutting theme raised in similar questions to both NA and TNAs on whether and how the pandemic had impacted their role.

At the end of each survey section respondents were given an opportunity to provide comments, and the very final survey question asked for any additional comments on the issues covered in the questionnaire or on any other matter related to their employment experience as NAs or TNAs. Many participants expressed their views in these open sections, adding a richness to the findings. The free text comments provided at the end of each survey section are drawn upon in the main body of the report to illustrate and elaborate on the findings. The high volume and quality of the comments received within the survey’s final catch-all call for comments encouraged a more detailed analysis, the findings of which are presented in an annex. Where comments are included in the report a code number of the respondent is used, safeguarding anonymity.

2.3 Sample

A total of 516 survey responses was received, broken down as follows:

- There were 201 Qualified Nursing Associates\(^{10}\) and 315 Trainee Nursing Associates. (Unless otherwise stated, these are the base numbers used for the analysis in the report.) With around 4,000 NAs and 6,000 in post, this represents around 5% of the totals. However, as noted, not all T/NAs were approached, and in the absence of the numbers of T/NAs from the Trusts covered by the survey, we are unable to precisely calculate an overall organisational response rate.

- The respondent NAs and TNAs were employed by 73 and by 90\(^{12}\) different employers respectively. These employers were largely NHS Trusts (see below in section 3), so T/NAs from around a quarter to a third of Trusts were covered by the survey. The number of responses from any given Trust ranged from 1 to 18 in the case of NAs and from 1 and 21 for TNAs.

- Figure 1 below presents the regional distribution of our T/NA respondents from NHS Trusts (n=455\(^{12}\)) set aside the regional distribution of the total population of T\(\backslash\)NAs in NHS Trusts (n=7329)\(^{13}\). The Figure indicates a reasonable spread of respondents from across the seven regions of the NHS. However, there is clearly some unevenness in response by region, with some regional biases. The pattern of survey responses from the East of England, the Midlands, the North-East/Yorkshire and the South-East, mirrors the distribution in T/NAs across Trusts in those regions. For example, the 21.1% of T/NAs in our sample coming from Midlands Trusts

\(^{10}\) According to the survey, all but 8 of whom had registered with NMC, with the remaining respondents intending to do so in the near future.

\(^{11}\) This number of employers is clearly higher than the 68 directly sent the survey link but reflects T/NAs from additional employers accrued through other contacts and social media.

\(^{12}\) We had 470 responses from T/NAs in the NHS, but 15 did not provide information allowing us to classify their region.

\(^{13}\) NHS Digital provides a breakdown of the number T/NAs employed in each NHS Trust. We have coded these Trusts by region to come up with our NHS regional distribution of T/NAs. The NHS Digital total 7,300 figure of T/NA falls a little short of the our more generally HEE reported number of 10,000 qualified NA and TNAs in training. The discrepancy might be accounted for by the fact that the NHS Digital figures do not include the 2021 wave of TNAs. Their figures are also reported as Full Time Equivalents rather than as ‘Headcount’.
compares to a figure 22.3% of T/NAs in total coming from Trusts in this region. However, it is equally apparent that T/NAs from London and the North-West were underrepresented in our survey, while those from the South-West were overrepresented.

Figure 1: Survey Response by Region (%) *

*7329 T/NAs in NHS Trusts and 470 T/NAs in the survey

- In terms of employer type, the overwhelming majority of TNA and NA survey respondents (around 90%) were employed by NHS Trusts. Only a small concentration was drawn from other organisational forms: independent social enterprises or community interest companies (20 respondents), or primary care employers (6 respondents). We received only two responses from the social care sector. As implied earlier, in large part this pattern of responses derives from the approach to the distribution of the survey, but it also reflects the fact that NHS Trusts are still the main employer of T/NAs.

Table 1 below indicates that amongst NHS employers, our T/NAs respondents were drawn from across different types of Trust. Around 40% of both TNA and NA respondents worked in an acute Trust but sizable proportions, respectively a quarter of NA respondents and a third of TNA respondents, came from combined community and acute Trusts.

Table 1: Distribution of Respondents by Type of NHS Employer

<table>
<thead>
<tr>
<th>Employer Type</th>
<th>NA (%)</th>
<th>TNA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust (incl. specialist acute)</td>
<td>40.7*</td>
<td>45.5*</td>
</tr>
<tr>
<td>Other Single Type Trust (Community; Mental Health)</td>
<td>9.2</td>
<td>11.9</td>
</tr>
<tr>
<td>Combined Community and Acute Trust</td>
<td>26.1</td>
<td>30.8</td>
</tr>
<tr>
<td>Other Combined Trust (e.g. Mental Health/Learning Disability (MH/LD) and Community Trust)</td>
<td>23.9</td>
<td>11.8</td>
</tr>
</tbody>
</table>

*NHS Employer Trusts only (i.e. excluding other types of employer)
Finally, as Table 2 below indicates, the survey generated responses from each of the T/NA cohorts since the first in 2017. Well over half (57.2%) of our NA respondents had begun their training in 2018, and therefore had been in the qualified role for about a year. But over a fifth (21.4%) were in the 2017 TNA cohorts and had therefore been in the qualified NA role for over two years. Close to half of the TNA respondents (47.3%) started their training in 2020, so were currently halfway through their programme. The relatively small proportion of 2021 starters (19.7%) no doubt reflects some of the challenges presented by Covid in recruiting to the most recent programmes.

Table 2: Distribution of Respondents by Year NA Training Started (%)

<table>
<thead>
<tr>
<th></th>
<th>NAs (N=201)</th>
<th></th>
<th></th>
<th>TNAs (N=315)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>21.4</td>
<td></td>
<td>2019</td>
<td>32.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2018</td>
<td>57.2</td>
<td></td>
<td>2020</td>
<td>47.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2019</td>
<td>20.4</td>
<td></td>
<td>2021</td>
<td>19.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>1.0</td>
<td></td>
<td>Other</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

In summary, our survey is the largest covering qualified NAs, as well as the most extensive in including post-2017 cohorts of TNAs. Substantively, the survey is also the most broadly based, not only examining T/NA views on training and the impact of Covid on their role, as touched on by previous studies, but venturing further to explore the work and employment experiences of these employees. While there is some geographical unevenness in the pattern of responses, views from T/NAs across the seven NHS regions were received. The overwhelming majority of the survey respondents are employed in NHS Trusts, mainly a consequence of our approach to disseminating the survey link. However, at this stage of the role’s development, NHS Trusts are by far the largest employer of T/NAs. We turn now to the survey findings, structured by the themes set out in the Introduction, and commencing with a consideration of T/NA backgrounds.
3. Backgrounds

3.1 Personal Characteristics

The backgrounds of T/NAs were explored in two ways. First, we considered the personal characteristics of our T/NA sample according to sex, age, disability, ethnicity, and domestic responsibilities (young children at home and status as the sole/main earner). These demographic data need to be treated with some caution. Most obviously they allow for an assessment of the survey sample, often with a view to examining whether it is representative of the group being studied. In the absence of aggregate data on the demographic details on T/NAs, this was difficult in our study, and opens the possibility that there was some covert bias in the pattern of our responses: for example, it may well be that younger T/NAs were better able than older ones to access and respond to an online survey. Indeed, the possibility of such bias suggests the need for care in comparing the demographics of our T/NA sample to those in the wider NHS workforce, although such comparisons may provide general benchmarking on the nature of the T/NA workforce. The personal background data also have analytical value, allowing for a comparison of NA and TNA demographic profiles, and for the possibility that experience of and engagement with the roles are affected by such characteristics.

Table 3 below sets out the sample demographics, highlighting the following points:

- Broadly, the demographics of our TNA and NA samples are similar.
- Unsurprisingly, reflecting the gendered nature of the nursing profession, TNAs and NAs are overwhelmingly women.
- Notwithstanding similar demographic profiles there is a slight but noteworthy difference in the age profile of the TNAs and NAs. Almost half of the NAs (47.8%) compared to just over 40% of TNAs were over 35 years old. This suggests perhaps that experienced HCAs were drawn into the early waves of NA training, with Trusts more recently engaging younger, less experienced entrants to the role.
- A small but noteworthy proportion of both our TNA and NAs, one in ten, has a disability. This is markedly higher than in the NHS workforce overall where 5.2% have stated a disability, although a quarter of employees in the NHS data declined to state whether they had a disability (almost all our respondents gave details of their disability status.)
- While most of our NAs and TNAs are ‘White British’, one in ten has a black or minority ethnic background. In benchmark terms, this is close to the ‘headline figure’ of the NHS workforce in general. However, figures on ethnic background across the NHS workforce vary markedly by occupation and grade: for example, around a quarter of pay band 5 workers, a stratum of the workforce including many internationally qualified nurses, have a minority ethnic background, much higher than our T/NA figure.
- A significant proportion of our NAs and TNAs, close to half, have responsibility for children, and between a quarter to third of our total T/NA sample workers remain the sole or main household earner. The high level of domestic responsibility amongst many in our sample

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14 We do did not include other caring responsibilities, for example looking after elderly parents, but these might also impact work-life balance

15 A look at the diversity of our workforce - NHS Digital

16 A look at the diversity of our workforce - NHS Digital
points to the challenges faced, especially by TNAs, as they train for the role, a point returned to below (see Section 5 and annex with free text comments).

Table 3: T/NA Demographics (%)

<table>
<thead>
<tr>
<th></th>
<th>NA (N=201)</th>
<th>TNA (N=315)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>91.5</td>
<td>91.4</td>
</tr>
<tr>
<td>Male</td>
<td>8.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Missing</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>13.4</td>
<td>19.7</td>
</tr>
<tr>
<td>26-35</td>
<td>38.8</td>
<td>37.1</td>
</tr>
<tr>
<td>36-45</td>
<td>23.9</td>
<td>25.7</td>
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<tr>
<td>46-55</td>
<td>21.9</td>
<td>15.2</td>
</tr>
<tr>
<td>56-65</td>
<td>2.0</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Disability:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11.9</td>
<td>10.5</td>
</tr>
<tr>
<td>No</td>
<td>87.1</td>
<td>87.6</td>
</tr>
<tr>
<td>Prefer not to say</td>
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<td>1.0</td>
</tr>
<tr>
<td>Missing</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Children aged 0 to 17 living at home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>40.8</td>
<td>45.1</td>
</tr>
<tr>
<td>No</td>
<td>57.2</td>
<td>52.4</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Missing</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Sole or main income earner in household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>34.8</td>
<td>27.6</td>
</tr>
<tr>
<td>No</td>
<td>61.7</td>
<td>68.6</td>
</tr>
<tr>
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<td>3.0</td>
<td>3.5</td>
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<td>Missing</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Ethnic groups</strong></td>
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<td></td>
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<tr>
<td>White British</td>
<td>84.6</td>
<td>79.4</td>
</tr>
<tr>
<td>White - Any other</td>
<td>2.0</td>
<td>5.7</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>4.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Multiple ethnic group</td>
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<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>2.0</td>
<td>2.2</td>
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<tr>
<td>Missing</td>
<td>1.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

17 NHS workforce - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)
3.2  Previous Employment

As well as personal characteristics, the survey also explored T/NA backgrounds by examining their previous employment experiences. Both TNAs and NAs were asked where they had worked before starting their TNA training and directed to tick as many sectors as appropriate. These data help establish the career routes of individuals into the T/NA role, and more generally provide insight into the nature of the labour market for care support workers.

Figure 2 below presents the findings, with the following points emerging:

- The patterns of previous TNA and NA employment are similar, although TNAs appear to have a slightly broader range of employment experience in different sectors, than NAs.18

- On average both NAs and TNAs have worked in a couple of sectors before becoming T/NAs. For many this will include working in healthcare with their current employers as an HCA (see below). However, this still means that on average respondents would have worked in at least one non-healthcare sector before joining the NHS.

- The common sectors of prior employment were healthcare and social care. Although more TNAs (43.5%) had previously worked in social care, over a third of NAs respondents (34.8%) had also worked in this sector, suggesting a career pathway between these two care domains. This is an unsurprising finding given that many Trusts will include ‘previous experience of care work’ as a requirement in their Person Specification for recruitment to their healthcare support roles.

- As striking is the fact that many of our T/NA respondents, over a third, had previously worked in retail, and around quarter in leisure and hospitality, indicative of these as sectors with which Trusts compete for employees.

- Other sectors, especially utilities, finance and manufacturing, are less likely to provide a point of departure for individuals moving to health and social care support roles, with much lower proportions of our respondents previously being employed in them.

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18 ‘Other’ areas of employment to figure prominently were the armed forces, the prison service and self-employment. But the diverse and unusual range of backgrounds is worth noting: for example, one TNA had been a ‘Dancer/Aerialist performer in Circus’. 
In summary, our T/NA sample is unsurprisingly heavily gendered, reflects the ethnicity of the NHS workforce in general, and with a somewhat higher proportion declaring a disability. A significant number of T/NAs have domestic responsibilities. TNA and NA demographic profiles are similar, but with NAs slightly older than TNAs. Many of the T/NAs have an extended work history, with experience of employment in health and social care and to a lesser extent in retail and leisure/hospitality.
4. Patterns of Employment

This section focuses on patterns of employment amongst T/NAs within their current employing organisations and, in so doing, reveals a little more about internal career progression, as well as how Trusts are deploying the role within and across different clinical care settings.

4.1 Progression into TNA role

The patterns of employment were considered in various ways. First, we explored where the T/NA was employed just before starting their NA training, revealing not only whether the individual had come from outside their current healthcare employer, but also whether they had been working in the same or a different ward/team prior to their move into T/NA training. Our previous, mainly qualitative, research suggested that the typical pathway for a T/NA was from being a healthcare assistant (HCA) in a team, to moving with the support and sometimes encouragement of their line manager, into NA training within the same team. The survey provided partial confirmation of this sequencing. As indicated by Table 4 below, most of our TNA (80.9%) and NA (87.6%) respondents had been employed in their current organisation before their NA training. Asked their job title prior to NA training, the overwhelming majority referred to ‘healthcare assistant’, ‘support worker’, ‘nursing auxiliary’ or ‘assistant’, with around a half being paid at pay band 2 and around 40% at pay band 3\(^1\). Just over half of T/NAs (50.3/53.0%) had previously been employed in the same ward/team. However, significant proportions of respondents, over a third of NAs (37.3%) and over a quarter of TNAs (27.9%), had moved onto NA training from different ward/teams. (In other words, the ward/team they worked in as a TNA was different to the one worked in previously as an HCA or other role.) It is also noteworthy that while most of our respondents had worked with their current employer before becoming TNAs, a somewhat higher proportion of TNAs (17.6%) than NAs (11.9%) had come from outside of their current employers, perhaps early signs of the internal pipeline to the NA role ‘drying-up’. The Table 4 data are re-presented in Figure 3 below to give a clearer sense of the different pipelines into the TNA role.

<table>
<thead>
<tr>
<th>Job Immediately Prior to Starting NA Training (%)</th>
<th>NA</th>
<th>TNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was working in the same organisation (e.g. my current NHS Trust) and in the same ward/team</td>
<td>50.3</td>
<td>53.0</td>
</tr>
<tr>
<td>I was working in the same organisation (e.g. my current NHS Trust) but in a different ward/team</td>
<td>37.3</td>
<td>27.9</td>
</tr>
<tr>
<td>I was working in another organisation in paid employment (e.g. in another Trust or in another type of organisation altogether)</td>
<td>11.9</td>
<td>17.6</td>
</tr>
<tr>
<td>I was not in paid employment</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Other (please state)</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

\(^{1}\) There was a spattering of respondents previously in other job roles - technicians, assistant practitioners, ward clerk, phlebotomist - even in some cases at band 4
Figure 3: Movement into TNA Role

<table>
<thead>
<tr>
<th>NA Respondents</th>
<th>TNA Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Ward/Team</td>
<td></td>
</tr>
<tr>
<td>Different Ward/Team</td>
<td>37.3%</td>
</tr>
<tr>
<td>Outside Trust</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

4.2 Distribution by Clinical Setting

Second, we examined patterns of employment by mapping the distribution of T/NAs by clinical setting. Figure 4 below confirms the picture presented in our two earlier Nurse Director surveys, highlighting a concentration of NAs and TNAs in general medical and surgical wards. At the same time, it is striking that just around two thirds of NAs and just under half of TNAs are to be found in other clinical settings. There are noteworthy proportions of both TNAs and NAs in district nursing teams and care of elderly wards, and in the case of NAs in mental health in-patient wards. Our T/NA respondents can also be found in A&E, ICU and Rehabilitation Units albeit in smaller numbers. The distribution profiles of TNAs and NAs are similar, but with some significant differences. For example, NAs (34.3%) were less likely than TNAs (44.8%) to be found in general medical and surgical wards - perhaps suggesting the role is gaining increasing traction in such wards - although a markedly higher proportion of NAs than TNAs were to be found in mental health wards\(^\text{20}\). There do also seem to be a few clinical settings stubbornly resistant to the NA role, for example outpatients and theatres, suggesting teams and areas where the role might not be suited.

\(^{20}\) Clearly caution is needed in interpreting these findings with the lesson to be drawn depending on whether respondents came from the same or different Trusts.
In summary, the survey confirmed the main pathway into the T/NA role as being through the individuals’ current team or ward. However, movement from another ward/team was also quite common, and a not insignificant, possibly increasing, minority had come from outside the current employer. The distribution of TNAs and NAs by clinical setting was similar, in both cases with a continued concentration in general medical and surgical wards. However, T/NAs are now to be found in a wide range of clinical settings, suggesting the value of the role in a variety of care contexts.
5. The Training Experience

With the views of now qualified NAs on their training largely picked-up by the Traverse study, our survey concentrated on the training experience of current TNAs. These experiences might well be different from earlier TNA cohorts. Current TNAs are trained on programmes approved by Nursing and Midwifery Council (NMC), whereas early TNA cohorts were involved in programmes quality assured by Health Education England (HEE)\textsuperscript{21}. Indeed most, if not all, current TNAs have had a distinctive training experience, most obviously facing the unique challenges of Covid. In this section we draw exclusively on the views of our TNA survey respondents, exploring in turn:

- Training models
- Training challenges
- The impact of Covid on training

5.1 Training models

TNA training comprises three main elements: a college component where the TNA engages in formal ‘classroom’ and assignment centred activities, whether on a given day of the week or for a more concentrated block of time; an anchored workplace learning experience in a particular team or ward, designed to acquire and sign-off on relevant competencies; and a series of shorter learning placements away from the anchor workplace in different care settings. In relation to these latter two elements, our previous and preparatory work revealed two main TNA models: one, sometimes referred to as the ‘hub and spoke’, founded on a single base placement from which the TNA periodically completes various time-limited placements in different care settings; the other, without a single base placement, but resting on a small number of rotations, complemented by an ongoing series of placements in other care settings. The base placement model was revealed by the survey as by far the most common, currently being experienced by around 90\% of our TNA respondents. There was, however, some variation in the design of this model, reflected in differences in the number and length of placements away from the base. For close to 40\% of the TNAs there were four placements (excluding the base placement), a similar proportion of TNAs accessing between six and eight placements. The length of these placements varied both between and within Trusts, but on average lasted just over four weeks.

The capacity and opportunity for TNAs to learn and acquire the necessary competencies are heavily dependent on their status in the team. Where the TNA is supernumerary, they are not included in the staff numbers, with scope to use the shift to develop their competencies and learn. Overlapping with, but often an alternative to supernumerary status (and a way of saving backfill costs), protected learning time is a defined period of working time blocked off for the TNA to devote solely to workplace learning and study even where they are routinely included in the staff numbers. For the TNAs on the base placement model, Table 5 below indicates that while away from their base placement the overwhelming majority (86.4\%) had supernumerary status. Back at their base placement a not insignificant minority, close to a quarter (22.6\%), were also supernumerary but more typically (60.9\%) they had only protected learning time.

\textsuperscript{21} The NA training model has been through various iterations over recent years, in large part reflecting the process of aligning training with the development of the NMC registration in infrastructure. From November 2017 and prior to the development of the NMC NA Standards of Proficiency, there was an NA apprenticeship largely quality assured by HEE. In April 2019 a new NA apprenticeship aligned with the NMC Standards was introduced and the former apprenticeship withdrawn.
Table 5: Status while Training amongst those on Base Placement Model (%)

<table>
<thead>
<tr>
<th>Status</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supernumerary on placements outside of base placement</td>
<td>86.4</td>
<td>12.2</td>
</tr>
<tr>
<td>Protected learning time on placement outside base placement</td>
<td>74.6</td>
<td>22.6</td>
</tr>
<tr>
<td>Supernumerary on base placement</td>
<td>22.6</td>
<td>74.9</td>
</tr>
<tr>
<td>Protected learning on base placement</td>
<td>60.9</td>
<td>36.9</td>
</tr>
</tbody>
</table>

These supernumerary and protected learning time arrangements prompted considerable comment from our TNA respondents, over 50 choosing to provide a remark. In a few cases, the TNA usefully indicated the amount of time allocated to protected learning, most commonly a single shift a week (7.5 hours). Elsewhere the approach to protected learning time was more flexible and informal, sensitive to workplace pressures:

- With regards to protected learning time in my base placement, I don’t get set times allocated to be able to undertake protected learning time; it usually has to happen when I can get it in. [79569277]
- Protected learning time within my base placement is something which I have to be extremely flexible with and realistically often consists of researching things I have seen in my own time. [79329301]

The perceived disparity in treatment between TNAs and student nurses on training was raised by a couple of different respondents as a concern:

- On placement TNAs always seen as less important than nursing students and therefore never prioritised. Been used as a spare pair of hands many times. [79625561]
- Feel it would be more beneficial to be supernumerary at all times when on base wards as on times as TNAs we get forgotten about and student nurses are always put first before us as we get told you’re counted in the healthcare numbers. [79261390]
- As a TNA, all time should be protected learning and supernumerary time just like the student nurses as we are being expected to carry out the same role as a RGN. [79350001]

Indeed, the call for TNAs to be granted supernumerary status on the base placement to enhance learning opportunities was echoed:

- I feel we should be supernumerary when working in our base placement. Being counted in the numbers restricts us to gaining crucial learning opportunities. [79394412]

However, most comments on training centred on the more insidious erosion of TNA learning time. In part this was linked to the inclusion of TNAs in staff numbers as an HCA at the base placement, for example:

- Not always getting protected learning time in host placement as we are counted in numbers for staffing for support worker roles. [79353935]
- It is hard to get the learning you require for the role because you are counted in the HCA numbers for the ward, so the learning opportunities are not always there. [79603533]
Being counted as part of the staff sometimes make it hard to learn. You are expected to do the healthcare assistant job as well as learn from the nurse which is practically impossible. [79604825]

It can be difficult to have protected learning time at your work base due to being in the numbers it leaves the ward short of staff and has been extremely difficult to obtain them learning hours without impacting on the team and the patients. [79256202]

Having protected learning time is vital but you can end up being used (as) an HCA on busy shifts and your learning is compromised [79787998]

As noteworthy was an undermining of learning time at both base and non-base placements that derived from workplace pressures, in some cases linked to Covid challenges, but also to longer standing staff shortages:

Working outside on placement even though I should be supernumerary I’m not and not used in that capacity. I am used as an extra pair of hands and work as an HCA. [79217384]

Due to short staffing protected learning time is very limited as the ward simply use us as healthcares. [79231976]

Due to low staffing any extra study time has not been possible. [79312300]

I am supposed to have protected learning time but haven’t had as much as I should due to staff shortages. [79338554]

Due to staffing issues within my base placement, there is hardly any time for supernumerary and protected learning time. Therefore, always put into a clinical support worker role. This is going to have a massive effect once I am qualified as I haven’t had much opportunity to manage 12 patients and to manage my time effectively. [79350001]

When we are short staffed, I will always be used as an auxiliary nurse so protected learning and Supernumerary time can be something I do not always get. [79387776]

When I was on placement, they still had me as a HCA. So, every time I went to work I was counted in the numbers and I have to explain that I am on placement they would take me off the board but then it would make them short of staff. So eventually I would end up doing HCA to help out. Protected learning some of the nurses would help. But would have to keep asking. In my base ward it is the same. [80089793]

5.2 Training Challenges

The range and nature of the problems faced by TNAs during their training were explored in a more structured and systematic way in a bank of questions asking how much importance they attached to various specified challenges (a five-point scale ranging from ‘considerable importance’ to ‘no importance). Table 6 below suggests that for most TNAs training is an intense and perhaps difficult process. Over half of TNAs regarded all the challenges as being of ‘considerable importance’. Indeed, with the inclusion of respondents attaching ‘some importance’ to the challenge, none of the listed challenges is viewed by more than one in ten of TNAs as being of ‘little’ or no ‘importance’. At the same time, there are some differences of emphasis given by TNAs to these challenges. The greatest weight is placed on challenges related to formal college-related learning. Almost all TNAs (86.0%) attach considerable importance to the challenge of completing academic assignments, while a similar
proportion (83.2%) view finding time to study a challenge. As hinted at in the last sub-section, there are also challenges associated with workplace learning: three-quarters of TNAs attached considerable importance to the challenge of finding learning opportunities in base (78.1%) and non-base placements (72.1%) (the latter especially significant and surprising given that, as noted, most TNAs will be supernumerary away from their base). In relative terms, less concerning is the challenge of switching between trainee and non-trainee status and maintaining contact with their college supervisor.

Table 6: Importance of Training Challenges (%)

<table>
<thead>
<tr>
<th>Challenge</th>
<th>No importance</th>
<th>Little importance</th>
<th>Some importance</th>
<th>Considerable importance</th>
<th>Don’t know</th>
<th>Blank / no reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic responsibilities alongside the programme</td>
<td>2.5</td>
<td>7.0</td>
<td>27.0</td>
<td>60.3</td>
<td>1.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Finding time to study</td>
<td>1.3</td>
<td>3.5</td>
<td>10.5</td>
<td>83.2</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Completing academic assignments</td>
<td>1.3</td>
<td>1.9</td>
<td>9.5</td>
<td>86.0</td>
<td>1.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Learning online</td>
<td>2.9</td>
<td>5.1</td>
<td>21.6</td>
<td>67.3</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Switching between trainee and non-trainee status</td>
<td>5.7</td>
<td>7.0</td>
<td>26.0</td>
<td>50.2</td>
<td>10.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Finding learning opportunities in base placement</td>
<td>1.0</td>
<td>3.8</td>
<td>14.6</td>
<td>78.1</td>
<td>1.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Finding learning opportunities in non-base placements</td>
<td>1.9</td>
<td>5.1</td>
<td>17.1</td>
<td>72.1</td>
<td>2.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Maintaining contact with college tutor</td>
<td>3.8</td>
<td>11.8</td>
<td>25.7</td>
<td>55.6</td>
<td>2.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Getting competencies signed off</td>
<td>1.8</td>
<td>5.1</td>
<td>8.9</td>
<td>81.9</td>
<td>2.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Maintaining contact with base placement mentor</td>
<td>3.2</td>
<td>7.3</td>
<td>18.7</td>
<td>66.0</td>
<td>4.4</td>
<td>0.3</td>
</tr>
</tbody>
</table>

These findings are confirmed in Table 7 below, where TNAs were requested to list their ‘top three’ challenges. Most cited in the top three, by around half the TNA respondents, were challenges associated with finding study time and with completing college assignments. However, the challenge of dealing with domestic responsibilities alongside programme requirements also emerges as a pressing issue, listed in the top three by close to 40% of respondents.

Table 7: Top Three Training Challenges (%)

Finding the time to study 52.7
Completing college/academic assignments 47.6
Managing domestic responsibilities alongside the programme 39.7
Finding learning opportunities in base/rotation work area 34.6
Learning/teaching online 28.9
Getting competencies signed off 27.6
Maintaining regular contact with base placement mentor 18.7
Switching between trainee and non-trainee status 18.1
Finding learning opportunities in placements 13.0
Maintaining regular contact with college tutor 9.8
5.3 The Impact of Covid on Training

The survey suggests that current TNAs have been on the frontline of care delivery during the pandemic, with consequences for their training. As Table 8 below indicates, close to three-quarters of the TNA respondents (72.7%) were working in an area directly dealing with patients affected by the pandemic. Over two-thirds of these TNAs note that their training was consequently disrupted, for close to a third (31.1%) significantly so. There was not a great deal of redeployment amongst our TNAs in the context of Covid, although a not insignificant proportion, a fifth (21.9%), did move clinical areas during the pandemic. Again, around two-thirds of those redeployed felt their training was disrupted consequently, a third (30.4%) significantly so:

I have been redeployed twice, second time to a vaccination pod to set 1st centres in (area name), done all the training relevant to immunise, still not allowed to immunise patients. [79403337]

Table 8: Impact of Covid on Training
Worked on a Covid-19 specific ward/area at any time during the pandemic (n=315)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>229</td>
<td>72.7</td>
</tr>
<tr>
<td>No</td>
<td>85</td>
<td>27.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

If yes, disrupted your nursing associate training
N=229

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, significantly</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>Yes, but not significantly</td>
<td>36.7</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>31.9</td>
<td></td>
</tr>
</tbody>
</table>

Redeployed due to the Covid-19 pandemic at any time?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69</td>
<td>21.9</td>
</tr>
<tr>
<td>No</td>
<td>246</td>
<td>78.1</td>
</tr>
</tbody>
</table>

If yes, disrupted your nursing associate training?
N=69

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, significantly</td>
<td>30.4</td>
<td></td>
</tr>
<tr>
<td>Yes, but not significantly</td>
<td>37.7</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>31.9</td>
<td></td>
</tr>
</tbody>
</table>

Of the 300 TNA respondents, around 40 submitted comments on this Covid-related part of the survey, providing insight into the disruptive impact of the pandemic on their training. These comments suggest that Covid had a direct effect on the design and delivery of TNA training, while also prompting more general organisational change such as service re-calibration and the re-purposing of clinical settings, with downstream consequences for their training arrangements. These consequences included:

- **Placement restrictions/delays:**

  The pandemic meant we could not be deployed into placements so had to stay at our bases and seek new learning experiences to meet learning objectives [79217384]
I was unable to go on my placement due to Covid and I had to have an alternative, then I got Covid myself and missed 2 weeks of my placement [79787998]

- **Suspended programmes (with some instances of a misalignment between Trust and College suspension):**

  My trust suspended our apprenticeship in March 2020 for 6 or 7 weeks so worked as a HCA [79227343]

  Our trust paused our course for 3 months; but the university didn’t. Therefore, when we could start again, we had 3 months of work to catch up on, on top of working full time and doing the current work [79231976]

- **Workplace pressures weakening occupational boundaries:**

  I was on placement on a Covid ward for 18 weeks. I was expected to cover for nurses on several occasions due to lack of staff and expected to do this with no support. Following the NMC code I refused as this would put myself and the patients in a serious and dangerous situation. [79237552]

- **Reduced capacity to assess, supervise and mentor:**

  I started during the pandemic. It has reduced staff availability for learning when they are redeployed. This has meant more reluctance to supervise and assess. [79243672]

  Placement on a ward during Covid - mentor was asked to work on another ward and no other member of staff was allocated as my mentor meaning that I was counted in the numbers as a HCA and very little skills were learnt as a result of this! [79685701]

  During Covid, there was less support. My ward also went through a lot of changes - from being colorectal surgical ward, we became endocrine, diabetes, then Covid, then medical ward and never really got back to being 100% colorectal. It did broaden my overall knowledge but at the same time impacted the surgical elements of my training. [80172632]

- **Erosion of supernumerary status:**

  When working on my placements I have struggled to get supernumerary time or shadowing time with the qualified nurses. I have been left to ‘chip in’ due to short staffing and utilised as a healthcare assistant. All skills are of great importance but it is not what I should be focusing on learning. [79464283]

- **Diminished workplace interest in TNA role following service re-configuration:**

  My acute respiratory ward was converted into a high dependency ward. While work was being carried out, I was redeployed to another unit who were very uninterested in my role. Then my course was paused. Overall, my course has been significantly disrupted. [80041624]

- **Difficulties with online teaching:**

  Covid-19 stopped my course for 4 months, which delayed our finish date and ability to be qualified sooner. Covid-19 meant that I have not returned to face-to-face university lectures (except 4x Simulation sessions) since June 2020. Online teaching is unsuitable for a course like this and is very challenging. [80062380]
• **Work intensification reducing scope to develop skills:**

Due to Covid, the course was disrupted. Then the redeployed staff returned to their areas and the wards remain heavy due to Long Covid ITU patients being stepped down to the wards, these patients needs are greater with no extra staff makes keeping my TNA skills up difficult as safety must be maintained. [80393905]

This period was too busy to learn. We need to work and use our responsibilities to help as much as possible. [79354880]

• **Concentration on Covid care limiting the range of skills acquired:**

Patient exposure has been limited due to a decrease of patients during Covid, so clinical skills were hard to come by. [80042805]

The latter two sets of comments on the impact of Covid on skill development do need to be placed in context. Rather than constraining such development, more generally and despite the organisational disruption to training, the broader survey findings suggest that the pandemic may well have served to extend and perhaps accelerate the acquisition of capabilities of TNAs. As Table 9 below indicates, over 40% of NA respondents felt the tasks and responsibilities performed had broadened to a great or some extent, reflected in follow-up comments:

I work in Paediatrics and found during Covid I started taking care of adults. There was not enough staff so did not go on my placement however the placement was on an adult ward so the fact that I started caring for ventilated adults was a positive and extremely hard, invaluable time and training. [79276876]

I was redeployed to ED and worked alongside the emergency nurse practitioners and learnt so much and improved my skills considerably. [79287581]

Due to working on a surgical ward made up of single side rooms, we were used as the Covid ward when it became very busy for the isolation rooms, and because surgery was kept minimal. We had lots of staff off sick, or shielding, and I was always used as a HCA. But learnt so much about respiratory nursing! [79363256]

I had to transfer from surgical to medical ward so helped me with medication. [79387776]

**Table 9: Change in TNA range of tasks and responsibilities performed since start of Covid (%)**

<table>
<thead>
<tr>
<th>Change in Tasks and Responsibilities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broadened to a great extent</td>
<td>8.3</td>
</tr>
<tr>
<td>Broadened to some extent</td>
<td>33.3</td>
</tr>
<tr>
<td>Remained the same</td>
<td>41.0</td>
</tr>
<tr>
<td>Narrowed to some extent</td>
<td>12.4</td>
</tr>
<tr>
<td>Narrowed to a considerable extent</td>
<td>4.1</td>
</tr>
<tr>
<td>Missing</td>
<td>1.0</td>
</tr>
</tbody>
</table>

In summary, TNA training is most typically organised around a base placement, or ‘hub and spoke’, model. In the main, this provides TNAs with supernumerary status in placements away from their base and allows them protected learning time whilst back at their base. Notwithstanding these arrangements, the range and intensity of the challenges faced by TNAs in their training are highlighted by the survey. These have been exacerbated by Covid. TNAs have been at the forefront in dealing with the pandemic, disrupting their supernumerary status, and learning time as well as their opportunities to study and the capacity of others to support them. However, the survey also suggests that the workplace pressures faced under Covid have served to broaden and deepened their skill development.
6. The Work Experience

The survey examined the work experience of NAs and TNAs in two main ways: first, by focusing on specific tasks and responsibilities being performed by or developed within the respective roles; and second through a more general assessment of postholders’ views on their working lives, including in the case of NAs, the consequences of Covid. Each dimension is considered in turn.

6.1 Tasks and Responsibilities

6.1.1 Understanding

One of the main aims of the survey was to develop a firmer evidence base on the substantive nature of the NA role. In regulatory terms the NA role is framed by broadly drawn and generic NMC Standards of Proficiency, which provide considerable scope for healthcare and social care employers to develop T/NA competencies to reflect care setting and perceived contribution to care delivery. It is an arrangement which implies the role may well assume different forms across and within different parts of the health and social care systems. However, our previous fieldwork suggests the emergence of the role’s scope of practice, both in terms of tasks performed and how it is perceived by colleagues, is an incremental process. As a new role, the NA was only gradually finding a place in established care delivery routines and becoming understood and appreciated by colleagues.

The survey findings confirmed this picture, suggesting the NAs’ scope of practice is still very much a ‘work-in-progress’. Thus, it is noteworthy from Table 10 below that well under one in ten of T/NAs felt their colleagues fully understood their role, and significant majorities, over two-third of TNAs (69.8%) and half of NAs (53.7%), felt their colleagues understood their role only partly or not at all.

Table 10: work colleagues understanding the nature and purpose of the nursing associate role

<table>
<thead>
<tr>
<th></th>
<th>TNA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully understand it</td>
<td>7.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Largely understand it</td>
<td>21.9</td>
<td>36.2</td>
</tr>
<tr>
<td>Partly understand it</td>
<td>53.3</td>
<td>40.8</td>
</tr>
<tr>
<td>Don’t understand it at all</td>
<td>16.5</td>
<td>12.9</td>
</tr>
<tr>
<td>Missing</td>
<td>0.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

This uncertainty about the role was reflected in various T/NA comments:

- My employer does not have a job description for nursing associates as they are still figuring out the role and if we should be allowed to do medication [79201308]
  
- I still come across some colleagues who don’t know what our job entails, and what we can and can’t do. [79223224]

- Despite avid knowledge of role by the Practice and Development Lead some colleagues are unable to understand the gap bridged by NA’s and are reluctant to engage with the new role and this has been challenging. [79244318]

- I feel my role is extremely new within my service and they don’t know how best to utilise my skills and knowledge. [79345763]

- This Trust is currently looking at our roles and responsibilities as they don’t really know what they are. [79367409]

- I feel that most managers do not know what is allowed within my job role. [79819108]
There’s still a big lack of understanding on wards. The support workers think we are support workers and the qualified think we are qualified. I am often expected to carry out the work of both roles within my shift which I feel is unfair. [80124582]

Where we stand with our role has been quite confusing, on what we can and can't do. [80164441]

Due to the lack of understanding of the role, it can be hard for nurse associates and other staff members to know what this role is. Other trusts are also giving out different responsibilities that others are not, a more concrete set path would be beneficial to all, across the country. [80196978]

There is still minimal understanding of the role. I often find members of my team (qualified and unqualified) querying my role. [79366587]

What we are and not allowed to do is a very grey area as it is down to local trust policies and lack of understanding of the role. [79387776]

Indeed, this uncertainty about the nature of the role encouraged various of our respondents to call for more information about and planning around it:

This role has been rushed through without much thought or clarification about where it fits. There is so much uncertainty and it becomes frustrating to constantly have to explain ourselves. [79365461]

The TNA role has not been explained to staff within the hospital I work at, nobody understands my role. [79224159]

I am the first within my team to complete the course. There have been no decisions as to what my role will look like when I qualify. [79253924]

Education sessions for managers/colleagues would be very useful for the NA role so they understand I am not a HCA or Nurse. [79354801]

6.1.2 Contours of the role

In exploring the contours of the NA role, we focused on a list of around a dozen tasks. Clearly this was not an exhaustive list, and to be meaningful to T/NAs in various care setting, it was framed in generic terms. Some of the tasks we selected were at the likely limits of the role’s scope of practice, hence the inclusion of administering intravenous (IV) drugs and making a first home visit (the latter relevant in community care settings), so testing the boundaries of the role.

Asking T/NAs whether they had or were likely to be trained to perform the listed tasks, the survey provided a picture of the kind of NA role emerging, and a clue to how the TNAs felt it would develop. Table 11 below is colour coded to reflect the proportion already trained in the task. There were red tasks - taking observations and bloods and carrying out an ECG - where a significant proportion of TNAs, two third or more, had already been trained. Given the extended nature of HCA roles in many Trusts, this training was likely in many instances to have been completed pre-TNA programme22. A set of blue tasks, where around half of the TNAs had already been trained, interestingly included the

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22 Whether our respondents picked on some of the nuances of these tasks is perhaps debatable. For example, we asked about observation within the first hour of admission - respondent may have simply interpreted this as observation at any time.
administration of oral, intramuscular and subcutaneous drugs. The orange tasks, where only between a third and quarter have been already trained, includes catheterisation and cannulation, although there is a strong feeling that they are still likely to be trained to perform these tasks. The administration of IV drugs stands out as the one task where very few TNAs have already been trained, with close to 40% of TNAs suggesting that they will not be trained to perform this task.

Table 11: TNA Views on Likelihood of being Trained to Perform Task (%)

<table>
<thead>
<tr>
<th>Task</th>
<th>Already trained to perform</th>
<th>Likely to be trained</th>
<th>Unlikely to be trained</th>
<th>Unsure whether I will be trained</th>
<th>I will not be trained for this task</th>
<th>Blank/no reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer intravenous drugs</td>
<td>3.8</td>
<td>18.7</td>
<td>20.0</td>
<td>15.6</td>
<td>39.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Administer oral drugs</td>
<td>58.7</td>
<td>39.1</td>
<td>1.6</td>
<td>0.3</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>Male catheterisation</td>
<td>21.9</td>
<td>42.5</td>
<td>13.7</td>
<td>12.1</td>
<td>9.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Administer intramuscular drugs</td>
<td>44.4</td>
<td>43.8</td>
<td>3.5</td>
<td>6.0</td>
<td>2.2</td>
<td>0</td>
</tr>
<tr>
<td>Administer subcutaneous drugs</td>
<td>55.2</td>
<td>37.1</td>
<td>1.6</td>
<td>3.8</td>
<td>1.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Take a blood sample from a patient/care user</td>
<td>68.9</td>
<td>27.9</td>
<td>0.3</td>
<td>2.2</td>
<td>0.6</td>
<td>0</td>
</tr>
<tr>
<td>Female catheterisation</td>
<td>29.8</td>
<td>48.3</td>
<td>8.3</td>
<td>7.3</td>
<td>5.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Complex wound care</td>
<td>46.7</td>
<td>40.0</td>
<td>6.0</td>
<td>5.7</td>
<td>1.6</td>
<td>0</td>
</tr>
<tr>
<td>Carry out an ECG</td>
<td>72.7</td>
<td>21.3</td>
<td>2.5</td>
<td>2.2</td>
<td>1.3</td>
<td>0</td>
</tr>
<tr>
<td>Cannulate</td>
<td>36.2</td>
<td>39.7</td>
<td>7.9</td>
<td>7.9</td>
<td>6.4</td>
<td>1.9</td>
</tr>
<tr>
<td>Revise care plan</td>
<td>53.0</td>
<td>35.4</td>
<td>5.4</td>
<td>3.5</td>
<td>2.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Take observations in the first hour after patient admission</td>
<td>90.2</td>
<td>7.30</td>
<td>1.5</td>
<td>1.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Take observations after rapid tranquilization</td>
<td>29.8</td>
<td>28.3</td>
<td>13.3</td>
<td>21.8</td>
<td>6.7</td>
<td>0.6</td>
</tr>
<tr>
<td>First visit to a patient’s home</td>
<td>13.3</td>
<td>23.2</td>
<td>19.1</td>
<td>20.6</td>
<td>22.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Administer controlled drugs under supervision</td>
<td>21.0</td>
<td>44.1</td>
<td>8.6</td>
<td>9.8</td>
<td>16.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Support patient’s family / relevant others after unwelcome news</td>
<td>48.3</td>
<td>45.4</td>
<td>1.8</td>
<td>3.8</td>
<td>1.3</td>
<td>0</td>
</tr>
</tbody>
</table>

The frequency with which tasks are performed on any given shift by NAs provides a sharper picture of substantive form assumed by the NA role. NAs were asked to comment on a broader range of tasks than TNAs, with the inclusion of a couple of more routine tasks - washing patients and making beds - with a view to establishing whether NAs retained or discarded these tasks as they moved into a more senior nursing support or bridging role. NAs signalled on a four-point scale how likely they were to perform the given task on a shift (from ‘very likely’ to ‘never’) with the option to note that the task was not applicable in their clinical area (in other words, given the care setting, not performed).

Table 12 below provides the frequency scores (%) for each task with, in the final column, the mean score for each. The colour coding loosely categorises the proportion of respondents who indicated
they were ‘very likely’ to perform the task. This colour coded material is drawn out in Figure 5 below to indicate which tasks are ‘very likely’ to be performed by the NA. The means scores have also been pulled out and presented in Figure 6, to highlight the relative likelihood a task will be performed.

<table>
<thead>
<tr>
<th>Table 12: Likelihood of NAs Performing Tasks on Shift (%)</th>
<th>Very likely</th>
<th>Quite likely</th>
<th>Not likely at all</th>
<th>Never</th>
<th>Not applicable</th>
<th>Missing</th>
<th>Mean*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer intravenous drugs</td>
<td>4.0</td>
<td>1.0</td>
<td>8.0</td>
<td>61.7</td>
<td>24.9</td>
<td>0.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Administer oral drugs</td>
<td>70.2</td>
<td>11.0</td>
<td>5.5</td>
<td>6.0</td>
<td>7.0</td>
<td>0.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Carry out male catheterisation</td>
<td>20.9</td>
<td>18.9</td>
<td>16.4</td>
<td>21.9</td>
<td>20.9</td>
<td>1.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Administer intramuscular drugs</td>
<td>34.3</td>
<td>27.4</td>
<td>21.4</td>
<td>12.4</td>
<td>4.0</td>
<td>0.5</td>
<td>2.9</td>
</tr>
<tr>
<td>Administer subcutaneous drugs</td>
<td>53.7</td>
<td>22.4</td>
<td>11.9</td>
<td>6.0</td>
<td>5.5</td>
<td>0.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Carry out female catheterisation</td>
<td>25.4</td>
<td>21.9</td>
<td>12.9</td>
<td>18.9</td>
<td>19.4</td>
<td>1.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Take a blood sample from a patient/care user</td>
<td>63.7</td>
<td>17.9</td>
<td>6.0</td>
<td>7.0</td>
<td>5.0</td>
<td>0.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Carry out complex wound care</td>
<td>42.8</td>
<td>23.9</td>
<td>17.4</td>
<td>7.0</td>
<td>8.5</td>
<td>0.5</td>
<td>3.1</td>
</tr>
<tr>
<td>Carry out an ECG</td>
<td>60.7</td>
<td>17.9</td>
<td>10.0</td>
<td>4.5</td>
<td>6.0</td>
<td>1.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Cannulate</td>
<td>33.8</td>
<td>10.5</td>
<td>12.4</td>
<td>20.4</td>
<td>20.9</td>
<td>2.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Update or revise a care plan</td>
<td>62.7</td>
<td>18.9</td>
<td>8.0</td>
<td>6.5</td>
<td>3.0</td>
<td>1.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Take observations in the first hour after patient admission</td>
<td>75.6</td>
<td>6.5</td>
<td>1.0</td>
<td>3.5</td>
<td>11.9</td>
<td>1.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Administer controlled drugs under supervision</td>
<td>40.3</td>
<td>10.0</td>
<td>8.5</td>
<td>25.9</td>
<td>14.9</td>
<td>0.5</td>
<td>2.9</td>
</tr>
<tr>
<td>Wash a patient</td>
<td>60.2</td>
<td>8.5</td>
<td>11.9</td>
<td>6.0</td>
<td>12.4</td>
<td>1.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Make a patient’s bed</td>
<td>65.7</td>
<td>6.5</td>
<td>6.5</td>
<td>6.5</td>
<td>13.9</td>
<td>1.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Undertake a first visit to a patient’s home</td>
<td>13.4</td>
<td>5.0</td>
<td>10.0</td>
<td>27.9</td>
<td>43.3</td>
<td>0.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Support a patient’s family / relevant others after unwelcome news and life-changing diagnoses</td>
<td>49.8</td>
<td>26.9</td>
<td>8.0</td>
<td>7.0</td>
<td>7.5</td>
<td>1.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

*Means calculated from columns 1-4 (‘very likely’ to ‘never’)
Figure 5: Very likely to carry out task on shift

Figure 6: Mean Score on Likelihood of Tasks Performed
The main points to emerge from Table 12 and Figures 5 and 6 on the frequency with which tasks are performed, and from the free text comments received in this section of the survey, are as follows:

- There are important differences in the likelihood with which different tasks are performed by NAs: few NAs are ‘very likely’ to administer IV drugs, but most are ‘very likely’ to take observations. As one NA noted, these differences in the range of tasks undertaken might even arise within the same Trust:

  Not all Nursing Associates across the board have the same level of responsibility, even across individual directorates. Some do more than others. [79202300]

- This variation in the scope of NA practice may reflect an unevenness in the propensity of Registered Nurses and ward managers to delegate to NAs:

  My current manager does not allow the trained nursing associate in our department to undertake all the duties she is trained to do. [757679]

- There are technical clinical tasks which NAs remain unlikely to perform, the implication being they continue as the preserve of the Registered Nurse (or other healthcare professionals). This is most obviously the case with the administration of IV drugs with only 4% of NAs ‘very likely’ to perform it, further reflected in it being the task receiving the lowest mean score (1.3).

- At the same time NA involvement in the administration of other medications is quite extensive although varying by type of drug: for example, while involvement in the administration of intermuscular drugs is modest (mean score 2.9), administration of subcutaneous drugs is more likely (mean score 3.3). Indeed, the administration of oral drugs is ‘very likely’ to be undertaken on a shift by three quarters of NAs (70.2%) and with one of the highest mean scores (3.6).

- In many Trusts this (non-IV) drug administration is likely to differentiate the NA from the HCA. Indeed, drug administration might be labelled as a ‘bridging task’, sitting between the HCA and the RN: very unlikely to be performed by an HCA, but formerly undertaken mainly by a Registered Nurse. Other tasks can be similarly viewed in these ‘bridging’ terms: for instance, dealing with complex wounds and revising care plans, respectively undertaken by almost a half (42.8%) and two thirds (62.7%) of our NAs.

- It is also noteworthy that NAs do not appear to be divesting themselves of the more routine care tasks: over three quarters of NA are very likely to take observations; two thirds make a bed; and over 60% wash a patient. In short, whilst taking on ‘bridging tasks’ likely to go beyond the remit of HCAs, NAs are continuing to perform more direct, bedside care tasks.

Of course, the capacity of NAs to perform these bridging tasks - dealing with complex wounds, administering drugs and maintaining care plans - crucially depends on NAs being counted in the registered rather than the unregistered staff numbers on any given shift. In earlier fieldwork we found instances of qualified NAs continuing to be included in the unregistered numbers and therefore drawn into playing a mainstream HCA rather than their qualified NA role. The survey suggested this is not a common practice (see Table 13 below): over 60% of respondents noted that as NAs they were always included in the registered numbers. However, a residual group of around a quarter of our NA respondents are still included with some regularity in the unregistered numbers, with implications for the role they play on the shift.
As various NAs noted:

My skills and knowledge gained being a NA are not being utilised. [79201863]

Due to the ambiguity of my role, I feel I'm either expected to either do more than I'm qualified for or treated as an HCA. [79863608]

The hardest balance is going between roles and never knowing what I am going to be expected to do (either trained or non-trained) each shift. [80190649]

6.2 Working Lives

6.2.1 Job Satisfaction

In exploring the working lives of the T/NAs in a broader sense, the survey used a bank of items from an established job satisfaction scale. Indeed, several of the items are routinely used in the NHS Staff Survey, allowing us to benchmark our results. Table 14 below provides comparative levels of satisfaction between TNAs and NAs (on a five-point scale running from very dissatisfied (1) to very satisfied (5)) with the mean score for each item. The Table also provides in parenthesis the results from the NHS Staff Survey 2019 (since this is pre-Covid and therefore might represent a more 'business as usual' time) where our items align.

<table>
<thead>
<tr>
<th>Table 13: NAs Counted in Un/Registered Numbers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always in registered numbers</td>
</tr>
<tr>
<td>Most shifts the registered numbers</td>
</tr>
<tr>
<td>Rough balance between in registered and unregistered numbers</td>
</tr>
<tr>
<td>Most shifts in unregistered numbers</td>
</tr>
<tr>
<td>Always in unregistered numbers</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>

Table 14: Satisfaction with aspects of work and employment (%)

<table>
<thead>
<tr>
<th></th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
<th>Mean score (n=315)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNA</td>
<td>6.7 (4)*</td>
<td>2.0</td>
<td>9.2 (8)</td>
<td>5.0</td>
<td>11.8 (16)</td>
<td>13.9</td>
</tr>
<tr>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TNA</td>
<td>2.0</td>
<td>2.5</td>
<td>5.0</td>
<td>3.0</td>
<td>18.1 (13)</td>
<td>9.5</td>
</tr>
<tr>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The support from immediate manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The support from work colleagues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount of responsibility given</td>
<td>3.2</td>
<td>2.0</td>
<td>13.0</td>
<td>13.4</td>
<td>21.0</td>
<td>19.9</td>
</tr>
<tr>
<td>The opportunities to use (T) NA skills</td>
<td>5.4</td>
<td>5.0</td>
<td>13.0</td>
<td>10.0</td>
<td>22.9 (17)</td>
<td>10.5</td>
</tr>
<tr>
<td>The extent organisation values my work</td>
<td>8.6</td>
<td>7.5</td>
<td>12.7</td>
<td>13.4</td>
<td>24.8 (29)</td>
<td>22.9</td>
</tr>
<tr>
<td>Level of pay</td>
<td>17.8</td>
<td>21.4</td>
<td>29.2 (24)</td>
<td>34.3</td>
<td>26.0 (26)</td>
<td>25.4</td>
</tr>
<tr>
<td>The support developing my skills</td>
<td>6.4</td>
<td>7.0</td>
<td>11.1</td>
<td>11.4</td>
<td>23.8</td>
<td>20.4</td>
</tr>
<tr>
<td>The quality of care I can give to service users</td>
<td>1.6</td>
<td>3.5</td>
<td>4.1 (5)</td>
<td>5.0</td>
<td>9.8 (10)</td>
<td>7.5</td>
</tr>
</tbody>
</table>

*( ) = 2019 NHS Staff Survey
In general, both TNA and NAs are satisfied with the different listed aspects of their work. However, the pressures and uncertainties of being a trainee rather than a qualified NA might be depressing TNA levels of satisfaction. Thus, the mean satisfaction scores of TNAs are slightly but consistently lower than those of NAs (except for pay). For both groups, satisfaction levels are especially high in relation to support from the line manager and work colleagues, both items received the joint highest means scores, 4.1 for NA and 3.9 for TNAs. However, as one NA noted, the value attached to the role by immediate colleagues does not always extend to the wider Trust workforce:

My immediate ward value my work immensely and advocate for my role however the wider Trust neither understand or care to learn about my role [79395960]

The satisfaction levels associated with the responsibilities given to T/NAs and the opportunities to use their skills are also noteworthy, not least given uncertainties about the nature of the role, reported above. This is not to detract from the occasional concern voiced in free text comments:

I feel my team have a lack of knowledge with regard to my nursing associate degree and they err on the side of caution when giving me tasks to complete. [79345763]

I don’t feel that as NA’s we are fully trusted by the Trust unless and until it suits them. [79819108]

The one item with a low satisfaction score is pay, with around a half of the TNAs (47.0%) and NAs (55.7%) either very dissatisfied or dissatisfied and respective means scores of 2.7 and 2.523. This dissatisfaction is reflected in follow-up comments:

I basically do the job of the DN (District Nurse) but get paid less. [79219081]

Level of pay is poor for the responsibilities we have. Due to the poor level of enhancements on a Sunday or Bank Holiday if you are working with HCA’s/ cleaners / catering staff that are top Band 2 you can be the lowest paid member of staff on the ward. [79227798]

In the area I work in there are only minor differences between the role of a Nursing Associate and Registered Nurse. Depending on the skill mix 50% of the time I get allocated the 'heavy' team with sicker patients over the Registered Nurses. There have been many shifts where I should be the 4th qualified member on but I am the 3rd and it remains that way for the full shift. I feel for the quantity of work and pressure I experience I am underpaid and that I am given significant amounts of responsibilities. [79314580]

I feel the pay gap between NA and RN in my area of work is not fair as we do the same job exactly and do not get the same pay. We are trusted with airways on our own and get to recover children. [79367520]

The cost of living has become more expensive however my pay is not matching or reflecting these rises and I struggle each month even though I am in full time employment. [79276876]

Table 14 above suggests that the T/NA job satisfaction scores are broadly in line with those from the NHS Staff Survey 2019, although it is worth noting that T/NAs are less inclined than the overall NHS workforce to be very satisfied or satisfied with: support from work colleagues; the opportunity to use their skill; and their pay. For example, while well over a third of the NHS workforce (38%) is

23 It is not unusual in an employee survey for the satisfaction level with pay to be relatively low.
very/satisfied with its pay, this is the case for barely a quarter of TNAs (26.7%) and a under a fifth (18.9%) of NAs.

6.2.2 NAs and Covid

Having looked at the impact of Covid on TNA training, the survey also examined the impact of Covid on the working lives of NAs. As with TNAs, the pandemic was revealed as having workplace consequences for NAs. Table 15 below indicates that just over 60% of NAs worked in a Covid specific area, a smaller proportion than TNAs (72.2%), although NAs (28.8%) were slightly more likely to be redeployed than TNAs (21.9%). Our survey was a blunt instrument for examining the fuller impact of the pandemic on the quality of the NAs’ working lives, but the free text comments provide a more textured impression of the disruption and pressures faced:

I trained on the Covid ward in my Trust, and I didn’t have a good experience. The stress has been horrendous, there were no staff and I feel I lacked any training at this time but due to demands of the ward and level of patients there was nothing to be done about this. [79390522]

I was on the end-of-life Covid ward for 6 weeks before being redeploy again to a health care of the elderly ward. The wards were very different to the one I was training with but help me gain more knowledge around different conditions. [79400102]

Nurses under a lot of pressure so asked to take on more responsibility. [79573849]

More 1 to 1 nursing with acutely ill patients. [80125016]

I have been moved to ICU. Theatre recovery and now moving to another new area to admissions. This has been extremely difficult as a newly qualified. [80130367]

Despite the work pressures conveyed by these comments, it is also clear that as with the TNAs, the NAs were driven by the situation to pick up new skills and extend their responsibilities. This is reflected in Table 15 below indicating that just over 40% of NAs broadened their skills to a great or some extent in the context of Covid.

Table 15: Impact of Covid on NAs* (%)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked in a Covid-19 specific ward/area</td>
<td>60.7 (72.7)</td>
<td>38.1 (27.0)</td>
</tr>
<tr>
<td>during the pandemic</td>
<td>28.8 (21.9)</td>
<td>70.7 (78.1)</td>
</tr>
<tr>
<td>Redeployed during Covid</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Range of tasks and responsibilities you perform as a nursing associate changed since Covid...

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Broadened to a great extent</td>
<td>4.4 (8.3)</td>
<td></td>
</tr>
<tr>
<td>Broadened to some extent</td>
<td>36.8 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Remained the same</td>
<td>43.2 (41.0)</td>
<td></td>
</tr>
<tr>
<td>Narrowed to some extent</td>
<td>3.5 (12.4)</td>
<td></td>
</tr>
<tr>
<td>Narrowed to a considerable extent</td>
<td>2.0 (4.1)</td>
<td></td>
</tr>
</tbody>
</table>

*( ) TNA figure

In summary, T/NAs suggest an ongoing lack of understanding amongst work colleagues and line managers about their role, with implications for how the role is viewed and used. Despite or perhaps because of this lack of understanding the NAs’ scope of practice remains broad, extending from the
regular performance of direct and routine care tasks such as making beds and washing patients, to complex clinical tasks such as the administration of (non-IV) drugs. The performance of more complex clinical tasks is especially striking. There are tasks which largely remain beyond the NAs’ scope of practice: the most obvious being the administration of IV drugs. However other such tasks - complex wound care, the maintenance of care plans and the administration of non-IV drugs - are regularly performed on shift by NAs. We have labelled such tasks ‘bridging tasks’ in that they remain beyond the HCAs’ remit and might previously have been performed by Registered Nurses. Their performance by NAs adds weight to the distinctive contribution the role might make to care delivery, freeing up RNs to deal with more complex patient needs. However, the capacity of NAs to contribute in this way depends on them being included in the registered staff numbers, with a residual minority of NAs indicating that they are still occasionally counted in the unregistered numbers.

With the exception of pay, and despite being in the frontline in dealing with Covid, T/NA levels of job satisfaction remain relatively high. TNA satisfaction is slightly lower than NA satisfaction perhaps reflecting the particular pressures faced in training for the role in exceptionally difficult times.
7. Futures

The development of the NA role rests on various assumptions held by policymakers. The first centres on the ability and willingness of employees, especially HCAs, to move into the NA role and in some cases progress their careers further by moving into RN training. The second, perhaps more ‘heroic’ assumption suggests a degree of balance in employee aspirations, between those willing to stay as an NA, ensuring the new role becomes established, and those keen to transition from the NA to the RN role, so creating a new pipeline to help address nurse shortages. Are these assumptions well founded? Certainly, previous research suggests that HCAs are highly aspirational, keen to seize development opportunities, but equally that they are uncertain about their capacity to fulfil their ambitions and face personal, material, and systemic challenges in seeking to do so. In this final section, we explore survey findings on the career ambitions of TNAs and NAs with a view to assessing whether these policy assumptions are well grounded. The section is divided into two parts: the first examines the nature of T/NA aspirations and the second their behavioural intentions.

7.1 Aspirations

The survey explored T/NAs career aspirations by asking a broadly drawn question on where T/NAs saw themselves in the future: in the NA role, as an RN, in a different health/care profession or in a different sector altogether. In the case of the qualified NAs, we were able to ask how they viewed their futures in these terms, both before they started their TNA training and after they had completed it and been in the NA role for some time. There are possible reasons why NAs’ ambitions might have changed over this period: understandable uncertainty about the nature of the role at the outset of training may well have dissipated, sharpening intentions to stay or leave it; the experience of intensive NA training along with an exposure to the full role and its responsibility might have increased confidence and encouraged a continuation onto RN training; alternatively the pressures of NA training might have prompted a short or even an indefinite pause on further career progression.

Clearly, it was difficult for NA respondents to express retrospective views on their career intentions, with the past often being seen through the lens of the present. However, we separated these questions in the survey, and as Table 16 below indicates there were some noteworthy differences in NA aspirations before and after qualifying. Both before and after their training our NA respondents come across as confident about the future: under 10% suggested uncertainty about their future before and after their NA training. As striking is the proportion keen to move onto RN training, with a marked increase in those keen to take this route after completing their NA training. Over two thirds (67.7%) of NAs wanted to be an RN when they commenced their training, but the figure increased to three-quarters (72.3%) after training. Those keen to stay in the NA role had reduced from one in ten before training, to one in 20 after. As one respondent noted:

Ultimately the NA role will only be successful if it is treated as a role in which you can grow and develop. If not, it will only be a stepping-stone to band 5. Which would be a shame as it provides value to patient care and safety. [79390660]

This is not to detract from the uncertainties about career progression emerging in some of the free text comments. There were suggestions, for example, that moves into RN training might be undermined by a lack of Trust support:

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I would like to become a registered nurse however due to lack of support from my Trust and the bad experience I am no longer sure. [79201308]

I would have liked to either study further to become an RN and to be supported by the Trust to do so. Or to continue studying by bolting on to the Nurse apprentice scheme, this wasn’t offered by our Trust too. [79863608]

I’m waiting for my Trust to let me top up and if I don’t hear something soon I will be self funding. [80164441]

Indeed, various respondents highlighted the financial challenges of moving on to nurse training, while also noting the apprenticeship route as a means of addressing them:

My main goal is to become a registered nurse however self-funding back at university was not an option for me, therefore the apprenticeship and still having a salary would be the best process to gradually becoming a registered nurse. [79667916]

I would top up if I was paid a band 3+ to top up, I will not top up for £4.13 (per hour) on an apprenticeship wage with the skills I have gained. [79770131]

Table 16: Most like to do in the future (%)

<table>
<thead>
<tr>
<th>NA</th>
<th>Start</th>
<th>Now</th>
<th>+/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay working as a nursing associate</td>
<td>21.9</td>
<td>10.7</td>
<td>-11.2</td>
</tr>
<tr>
<td>Become a Registered Nurse</td>
<td>67.7</td>
<td>72.3</td>
<td>+4.6</td>
</tr>
<tr>
<td>Become another registered healthcare professional</td>
<td>0.5</td>
<td>1.9</td>
<td>+1.4</td>
</tr>
<tr>
<td>Take-up a non-care job role outside of healthcare</td>
<td>0.0</td>
<td>1.0</td>
<td>+1.0</td>
</tr>
<tr>
<td>Unsure what to do in the future</td>
<td>8.5</td>
<td>9.6</td>
<td>+1.1</td>
</tr>
<tr>
<td>Other</td>
<td>1.5</td>
<td>1.9</td>
<td>+0.4</td>
</tr>
</tbody>
</table>

In seeking to examine the substance behind this broadly framed career aim to become an RN, NAs were asked a follow-up question about whether they had taken steps to realise it. Table 17 below indicates that almost a quarter of NAs had already applied and been taken onto a RN training programme, with over a third noting they would apply within the next two years. Only 14.9% of NAs had no intention of applying for nurse training. It is also worth noting that of those expressing an ‘Other’ view, most were also taking forward their nurse aspiration, either having already applied and just waiting for a response or close to completing their nurse training from their current role as NAs.

Table 17: Steps to Nurse Training

<table>
<thead>
<tr>
<th>NA (n=200)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied for RN training and been accepted</td>
<td>23.4</td>
</tr>
<tr>
<td>Applied for RN but not accepted for the programme</td>
<td>5.0</td>
</tr>
<tr>
<td>Not yet applied for RN training but will in next two years</td>
<td>36.3</td>
</tr>
<tr>
<td>Not yet applied for RN training &amp; currently no intention to do so</td>
<td>14.9</td>
</tr>
<tr>
<td>Other (please state)</td>
<td>8.9</td>
</tr>
<tr>
<td>Missing</td>
<td>1.0</td>
</tr>
</tbody>
</table>

We asked TNAs the same question about where they saw their future as they embarked upon their training. As the NA role has begun to settle down, with perhaps greater certainty about its shape and nature, one might have expected a higher proportion of TNAs to express an intention to remain in the
NA role. Figure 7 below comparing TNA and NA responses to their futures indicates that this was not the case: again, the absence of TNA uncertainty about their future is striking, along with the fact that same proportion, almost three quarters (73.0%), expressed a wish to become an RN and only one in ten (10.7%) to remain in the NA role. Once more there were TNA comments highlighting the challenges of moving straight into nurse training:

I have struggles with managing home life, children, working and assignments along with home schooling so far. My intention was always to work for a while as NA then top up however currently unsure if I could manage another 18 months of academic learning, placements and assignments and the idea of a dissertation sets me in a panic. [79391561]

7.2 Behavioural Intentions

The second means used to explore T/NA futures was a focus on potential behaviours: intentions to leave or stay. In the case of the T/NA these intentions have different dimensions. As noted throughout this report one such dimension focuses on intention to stay in the NA role or leave to become an RN. Another is the extent to which T/NA are keen to stay with their current employing organisation or move to another. In a national, occupationally regulated service there has always been scope for RNs to move between health and social care employers. As a newly registered profession, the same is the case for NAs, and as the role becomes more widely known and valued, a national or regional labour market for the role might well develop where employers ‘buy-in’ as well as ‘grow-their-own’ NAs. At the same time with so many NAs drawn from existing HCAs who are generally deeply rooted in their local community, and with NA programmes having a strong Widening Participation element designed to attract and retain these HCAs, the likelihood of movement to other employers beyond the locality might be expected to be modest (especially as status, terms and conditions of employment within social care often do not rival those of the NHS).

TNAs and NAs were asked a similar set of questions on intention to stay or leave their current employer and the role, with just slight modifications to reflect the fact that the former had yet to qualify. Table 17 below set out the findings, with the TNA results presented in parenthesis.
The following points emerge:

- Unsurprisingly given the ambition to become RNs highlighted earlier, over two thirds of NAs (67.2%) agree or strongly agree that they are keen to become an RN ‘in this organisation’ as soon as possible. The emphasis here is on the desire to become a nurse with their current employer rather than elsewhere, and the high proportion wishing to stay as nurses suggest some success in Trusts ‘growing-their-own’. Even with nurse ambitions, NAs still seem anchored to their Trust although a noteworthy residual minority, just under a third (30.3%) strongly/agreeing to seeing themselves as ‘an RN in another organisation some time in the future’. In part this finding may well relate to some of the financial challenges highlighted above, with a lack of financial support from their current employer leading them to move to another to find it. As noted by NA respondents:
  
  I may leave my trust if nursing training becomes available somewhere else. [79254896]
  
  I would like to become an RGN but there are no opportunities with my employer. [79478293]

- TNAs appear similarly connected to their current employers, although understandably less certain at this stage of their development whether they might work as RNs: well over half (55.2%) agree/strongly agree that they are keen to be nurses in ‘this organisation’.

- The findings on whether NA respondents are likely to remain as an NA in their current organisation over the next 12 months are less easy to interpret. Under a half (49.3%) agree/strongly agree that they will be NAs this organisation in 12 months, However, this is likely explained by the fact that many are keen to move into RN training or even RN roles over this period.

- A higher proportion of TNAs, close to two-thirds (61.3%), agree/strongly agree to wanting to become NAs in their current organisation when they qualify. Again, this is not too surprising: our previous survey of Trusts’ practice revealed that many Trusts require qualified NA to complete a preceptorship of between 6-12 months before moving onto nurse training. But there were also some signs that continuation as an NA was contingent on how the Trust chose to utilise the role. As one TNA noted:
  
  I would like to see how the qualified NAs are deployed in my Trust before deciding if I will remain as one or try to top up straight away. If the role appears to have progression / development in its own right I would happily remain a NA. If that is not the case, I will look to top up asap. [79390660]

- With few TNAs or NAs seeing themselves as working in another organisation as an NA the strong connection between respondent and their current employer is confirmed.

- Despite this strong connection, striking is the significant minority, over a quarter (29.2%), who agree/strongly agree that they ‘often think about leaving the TNA programme’. This is a finding which chimes with the challenges faced in TNA training and perhaps the disruption

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25 We picked up such concerns in some of our last series of expert interviews.
caused by Covid to their development raised earlier in this report:

Sometimes I do question why I started the training, this I feel is due to the amount of academic work that we have to do in our own time, I didn't understand the amount of independent study it involved. [79263790]

I think about leaving (the TNA programme) when I have a day where I cannot find someone to do my IVs, CDs etc. The pumps are ringing, the patients are in pain and it is my responsibility but I am not allowed to perform the task at this stage in my career. This makes for a long and difficult two years. [79533047]

Due to the pandemic my home life conflicted a lot with the (TNA) course and my studying, which is why there were many times I felt like leaving the course. [79704549]

- Despite the challenges of Covid, T/NA commitment to working in health and social care remains firm: over two-thirds of TNA and NA disagree/strongly disagree that they ‘often think about leaving employment in the sector:

  I will always work within healthcare as my passion is driven by caring for others. [79237552]

However, it is worth noting that a not insignificant proportion of NAs, one in five, (20.9%), agree/strongly agree that they did think about leaving the sector:

  The lack of support and supervision in this role has made me completely reconsider ever working for care again. [79231976]

Occasionally I feel I would benefit in working in non-health sector for more money and less pressure. [79613534]

<table>
<thead>
<tr>
<th>Table 17: (T)NA Intentions (%)</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keen to become Registered Nurse in this organisation as soon as possible</td>
<td>8.0 (5.4)</td>
<td>9.5 (12.4)</td>
<td>13.9 (26.7)</td>
<td>20.9 (25.4)</td>
<td>46.3 (29.8)</td>
<td>3.9 (3.6)</td>
</tr>
<tr>
<td>See myself as Registered Nurse in another organisation sometime in the future</td>
<td>15.9 (15.9)</td>
<td>17.9 (23.5)</td>
<td>33.3 (34.0)</td>
<td>14.4 (16.6)</td>
<td>15.9 (9.8)</td>
<td>3.0 (2.8)</td>
</tr>
</tbody>
</table>

26 A comment from a TNA on their current experiences is worth quoting at length and in full as indicative of some the pressures faced by programme participants:

Currently struggling with mental health, having started training in October. Moving wards and the role transition has been a significant factor, as well as the pandemic. I feel unfit to practice as registered band 4 with associated professional responsibility. I find shifts on my home ward exhausting and need my days-off for down-time and recovery at the moment. The stress of coursework and deadlines is too much for me. I enjoy working as a HCA but it is challenging enough on my frequently short-staffed ward. Attempting to train in that environment has been a nightmare. I really enjoy the academic side of the course, but don't have the time or energy to fully engage at the moment, so have asked to take a break in learning. I intend to have another go in 6-12 months. However, after 3 years and 8 months in care of the elderly, I am often considering going to work for Royal Mail or something else entirely. [79788691]
See myself staying as nursing associate in this organisation in the next 12 months or so*

(When I qualify) Probably look to become a nursing associate at new organisation in the next 12 months or so*

Often think about leaving the nursing associate role altogether (the trainee nursing associate programme)

Often think about leaving employment in the health and social care sector

*‘in the next 12 months’ not included in TNA survey

In summary, the policy assumptions about the career intentions of T/NA find partial confirmation in the survey. T/NAs are aspirational while also being firmly anchored to their current employer and keen to remain with it whether as a qualified NA or RN. However, the ambition to become an RN rather than stay in the NA role is strong amongst both TNA and NAs, possibly raising challenges for employers in establishing the new role. Our earlier fieldwork suggests employers are seeking to address this challenge by requiring qualified NAs to stay in the role for a given period, at least the length of the NA preceptorship. More generally, T/NA ambitions to progress into RN training are not necessarily reciprocated by a willingness on the part of the employer to support this progression, which might, in time, frustrate the T/NA and encourage movement to an employer willing to do so.
8. Summary and Conclusions

With the direct voice of the T/NA largely missing from debate on the Nursing Associate role, this report has presented findings from a survey of over 500 individuals training for and performing the job, drawn from close to a hundred Trusts and care organisations in all seven regions of NHS England. Listening to this voice is crucial to policy developments in several important respects. First, in previous reports we have drawn attention to the various policy goals underpinning the introduction of the NA role: to provide a new career opportunity for existing support workers; to establish a new bridging role between the HCA and the RN; and to provide a stepping-stone into pre-registration nurse training, and in so doing create a new pipeline of ‘grow-your-own’ registered nurses. These goals have been predicated on quite a nuanced set of assumptions about the attitudes and behaviours of those individuals taking-up the NA role, not least in relation to their career aspirations and their capacity to fulfil them. Whether these assumptions are well grounded has, however, remained an open question. In examining the working lives of T/NAs and asking them about their career intentions, the survey findings provide a means of addressing this question, with implications for the likely achievement of the diverse policy goals.

Second, there has been a marked paucity of evidence on the nature and consequences of the NA role. While there has been discussion about the role, on how it is being used and with what impact on various outcomes, this has largely been based on impressions, limited examples and even speculation. In asking T/NAs about their in-role development and experience, the survey results provide a much firmer empirical foundation for debate on who NAs are, what they do, and how they are used and viewed by their work colleagues.

Third, as waves of TNAs have been recruited, trained and qualified, questions have arisen about the demographics and orientations of these rolling NA cohorts: whether the role has been attracting individuals with different personal backgrounds and contrasting life histories, and with distinctive interests and ambitions going forward. In capturing the personal characteristics and experiences of T/NAs from across these successive waves, the survey has been able to compare cohorts in these terms. Finally, the T/NA work experience has inevitably been affected by Covid, with the timing of our survey able to track the pandemic’s impact on the working lives of this growing group of workers.

The survey has shed light on these different policy issues, by focusing on key themes and, in turn, generating the following key findings:

- **Background**
  - The demographic profile of TNAs and NAs is very similar. In general, T/NAs are older workers, often reflecting considerable prior work experience as HCAs. TNAs are, however, slightly younger than NAs, suggesting perhaps that this internal recruitment of long-established HCAs to the role is beginning to weaken.
  - Both TNAs and NAs have significant domestic responsibilities - typically with children at home and often the sole or main householder earner. These are seen later in the survey as contributing the pressures TNAs, in particular, face in training for the role.
  - In terms of other background characteristics, for example, ethnicity and disability, the T/NA workforce aligns quite closely with the broader make-up of the NHS workforce.
  - Many T/NAs have extended work histories, typically being employed in a couple of jobs before taking up their current role. They are most likely to have been employed in health and social care, but with a significant proportion previously working in retail and hospitality, pointing to these as sectors competing with the NHS for the same source of labour.
**Patterns of Employment**

- Most T/NAs have progressed to the role from an HCA post with their current employer. Indeed, they are still usually embedded in their previous ward or unit team, although a noteworthy stream of T/NAs has moved from another part of the organisation into the new role.
- The proportion of T/NAs drawn from outside the organisation remains small, although higher for TNAs, again suggesting that the internal employee flow into role may be beginning to reduce.
- T/NAs are to be found in a wide range of clinical settings. The biggest concentrations of respondents were in general medical and surgical wards. However, T/NAs are dispersed, albeit in small numbers, in a wide range of other clinical settings. Indeed, there were signs of the NA role extending to a broader range of such settings with a higher proportion of TNAs than of NAs in mental health wards, district nursing teams, children’s wards and, to a lesser extent, emergency departments and ICUs.
- At the same time, there are clinical settings stubbornly resistant to the NA role, for example, outpatients’ departments and operating theatres.

**Training**

- Drawing on the sub sample of TNA survey responses, the most common training model was one founded on hub and spoke arrangements - a core base placement supplemented by several placements in other clinical settings over the two-year training period.
- On placements away from the base team or unit, TNAs were usually supernumerary while in their base placement they were more likely to have protected learning time.
- Training was challenging for TNAs. Respondents attached importance to a wide range of challenges, although particular emphasis was placed on the difficulties presented by the College element of the programme, for example completing formal assignments, and on the pressures faced in seeking to deal with competing demands of work, home and college. The significance of these challenges is highlighted later in the survey with over one in four TNAs noting that they ‘often think about leaving the training programme.’
- The Covid pandemic had deepened these challenges. Training had been disrupted by, for example, the shift to online teaching, the deferment of placements and most strikingly the erosion opportunities for workplace learning and supervision.

**Work experience**

- Understanding of the new role amongst the T/NAs work colleagues remained limited, suggesting the need for greater information on and more preparation for the role amongst team members. NAs indicated a higher level of understanding of their role among their colleagues than TNA, suggesting an appreciation of the role develops only as the worker qualifies and begins to fully enact the role.
- As originally intended by policy makers, the substantive contours of the role suggested the NA was developing as a bridging post between the HCA and the RN. Thus, NAs were undertaking tasks, such as dealing with complex wound care and administering a range of medicines, labelled in our report as ‘bridging tasks’. These tasks were certainly outside the scope of the HCAs’ practice. They would more typically be performed by RNs, who now appeared to have greater confidence in delegating them to a registered NA colleague, in the process freeing themselves up to deal with the complex cases.
At the same time the NAs’ scope of practice remained broad. In taking on these ‘bridging task’ NAs had not divested themselves of activities related to the fundamentals of care, such as washing a patient and making beds. At the NA-RN interface certain boundaries remained, with more complex clinical tasks unlikely to be performed by the NA. For example, IV drugs were rarely administered by NAs, although with a small number doing so, even this residual boundary displayed a degree of porosity.

The capacity of NAs to work to their full scope of practice was dependent on them being included in the registered numbers on any given shift, and in the main this was the case. However, a small residual group of NAs noted some unevenness in whether they were counted in the registered or unregistered numbers, prompting, in turn, concerns amongst them as to whether their skills as NAs were being fully utilised.

While expressing some dissatisfaction with pay, TNAs and NAs were generally satisfied with other aspects of their job, for example support from colleagues and line managers, and the scope to develop their skills. There were small but consistently lower levels of satisfaction amongst TNAs, perhaps reflecting the specific training related pressures they faced.

NAs had certainly been on the frontline in dealing with Covid, most working in clinical areas dealing with the pandemic and a noteworthy minority being redeployed to cope with it. The free text comments clearly articulated the workplace pressures faced during this period, although the survey suggested NA skills were often broadened and deepened because of the experience.

**The Future**

T/NAs displayed considerable certainty about their futures and emerged from the survey as highly aspirational. A significant majority of both TNAs and NAs were keen to move on to become Registered Nurses. Indeed, amongst NAs this desire had deepened following completion of their NA training. With NAs principally using the post as a stepping-stone, important organisational questions are raised about the capacity of the new role to embed itself. Healthcare employers sometimes limit funding to support immediate NA moves into Registered Nurse training. However, as highlighted in the free text survey comments, this could prompt NAs to move to an employer willing to provide such funding, or even to become self-funders.

More generally T/NAs are committed to their current organisation, keen to remain whether as an NA or RN. It is, however, noteworthy that around one in five T/NAs ‘often think about leaving employment in the health and social care sector altogether’ perhaps indicative of the recent workplace pressures faced and an apparent tightening of the labour market.
Annex: Free Text Comments

The final item in the questionnaire gave T/NAs an opportunity to provide free text comments on any issue covered by the survey or more generally on their role and work and employment experience. 144 chose to comment, around a quarter of the respondents. The comments need to be treated with some caution. Those T/NAs offering comments remain a minority, with those feeling especially strongly on an issue most likely to express a view. Such comments do not necessarily reflect the overall pattern of responses. Partly related, those with negative views are perhaps more likely to comment than those with positive ones. Certainly, positive views were expressed about the T/NA role and experience, and indeed it was not uncommon for the comment to balance a positive and negative point. There were, however, more negative comments and again it is important that they do not distort the general picture presented by the overall survey findings.

The need for caution should not detract from the value of processing and presenting the free text comments, which lies in the following:

- **Emphasis:** while some of the comments echo points made elsewhere in the report, the reiteration of a comment by a T/NA at the end of the survey suggests that it is strongly felt.
- **Nuance:** for various reasons surveys are a blunt means of gathering data, unable to pick on the nuance of situations and perspective: free text comments provide more refined insights into some of the issues covered by the questionnaire.
- **Complementarity:** partly related, surveys direct respondents to a specific set of issue: free text comments allow new issues to be raised, of importance to the T/NAs but not covered by the questionnaire.

Almost all the 144 comments provided useful substantive detail: just four raised very general points, being removed for the analysis. The comments were coded to highlight the following general themes, with a various more refined sub-themes then developed:

- Training
- A career
- Valuing and supporting
- Understanding the role
- Scope of Practice
- Progression into Registered Nurse training
- Reward/Recognition

In some instances, comments link key themes, for example the NAs’ scope of practice was sometimes related to the value placed upon the role. In classifying such comments for coding purposes, a judgement has been made on where the main emphasis in the remark lies. There were also comments which raised various separate points. In these cases, the remark has been unpacked and its various elements allocated to the appropriate code.

The comments are ordered and presented according to the main coded themes and their sub-themes, using indicative quotes rather than the full range of comments submitted. The Annex concludes with a brief discussion of the themes and comments.
1. Training

- Earning and learning

This course has been hard at times but worth it and it has been a great way to get into nursing for people who still need a full-time salary. [80135993]

Overall, the role is incredibly valuable, as it makes nursing accessible and enables people to progress in their career, whilst getting paid and contributing to work on their ward. It is a great way to learn, as it is constantly on the job and I have gained so much experience. Thank you for this opportunity! [79363256]

Having this course as an apprentice route has allowed me to better myself and if this was not available, I would not have been able to gain these qualifications as university was not an option for me as a full-time wage was required. [80164441]

- Intrinsic enjoyment

I am enjoying learning and having more responsibility. [79914493]

Still feel privileged to have done it. Highly recommend it. [79243492]

I was glad I undertook the training and proud to be part of the pilot group. [80200126]

- Workplace learning

It’s the best way to learn. On the job and one day a week at university to learn the underpinning theory.... The Nursing Associate programme is more work based which is a much better way of teaching Nursing, as a practical and hands on subject. The Nursing Associate Team at ( ) University are brilliant and really care, as a result I had a really positive experience with them. [79202300]

I was really lucky to be able to obtain my Nursing Associate role via the apprenticeship route and believe you learn better this. [79211012]

The role is thoroughly rewarding but does have its challenges throughout, including both university work and ward work. It is a great way to get hands on experience and see different aspects of the nursing/NA roles and responsibilities. [80574159]

- Assignments

I struggle with assignments although I know the field. I wish TNA Course was more workplace orientated and assessed. [80291438]

The time frame in which you are given your assignments to adds so much unnecessary stress, considering we have to work 30 hours as well, also Uni(versity) are not very supportive and the lesson via teams lack the ability to draw you in. [79234008]

- Work and Domestic Responsibilities

Sometimes the role is overwhelming, particularly for older people with home responsibilities as you have home life to manage, then assignments and university, then pebble-pad/placement documentation and then full-time employment as well. This is something that needs to be
considered and looked in to. You want to do good assignments/pay full attention in class and do well at work but it's hard to excel in any when you're juggling so much at once. [80173752]

It's been a difficult year and I don't think course leaders appreciate that we have worked full time through a pandemic; and had to study from home with family present etc. [79580091]

Whilst the NA role is a great way to build on good HCA skills and experience and working toward become a registered nurse, it is hard work doing both a full-time job and put in the necessary hours for the academia. [79532100]

Although enjoying the course I feel there is an awful amount of course work to be completed alongside working and personal life commitments. This is meant to be a course to do alongside these but it's proving impossible! [79394412]

It’s been a challenge juggling home and study but I have absolutely loved it all and learnt so much. [79289322]

- **Protected learning**

  I appreciate its hard with apprenticeship rules but we need some protected learning time when on our base where we are not supernumerary. [80156884]

  As an SNA (student NA), it is difficult to have protected learning time on our ward as we are always counted in the numbers. [80064878]

  More consideration needs to be given to allowing trainees set protected learning on their base ward. Even if it was just one shift a week. It’s impossible to learn when you are needed as a support worker every shift. [79405861]

- **Supervision and support**

  Given the current state of the NHS it can be difficult to get enough supervision - I have struggled to meet with my practice assessor because the ward is so busy. The RNs are so busy, it is a struggle to find time for learning whilst providing adequate care for unwell and often very confused patients. This is obviously exacerbated by chronic short-staffing and, in my case, antiquated facilities. I have also been significantly affected by Covid. [79788691]

  I’m loving the course; I wish it wasn’t online as much and also I feel the support from managers above my manager (Band 7) could be a lot more supportive and helpful. I’ve been waiting for over 6 months for study support and equipment. [79360150]

  I enjoy the job practically but have really struggled academically and I don’t think there is enough support to help with that side. Also having to work through a pandemic and contending with other health issues I don’t feel the job role helps. [79346665]

  My main concern is that nursing students are allocated a supervisor every day and apprentice nursing associates are not, so I am often working unsupervised. [79338554]

  Not enough guidance from NMC. No support from my manager. Poor teaching since Covid has forced it online. Over half my cohort have left or been kicked off. I am struggling with assignments despite having completed 3 a levels 5 years ago. Very disappointed with the course and not very
positive about it the future. Hopefully I can move to another Trust and maybe do a top up soon as I don’t want to wait too long. [79403085]

It has been tough training in a Trust with very little support and through a pandemic, not getting supernumerary /protected learning time and working in high stress/acuity and very busy areas. Keeping going on the course has drawn every ounce of strength and aim once qualified to get a RNA (Registered Nurse Apprenticeship) position at a different Trust. [79388391]

- **Placements**

  Need more time for external placement to challenge different skills. [79789140]

  Placement areas should be aware of TNA responsibilities before they start a placement. There should be an element of choice when being moved to a new clinical area for the apprenticeship - disparity in cohort of those who have remained in their original place of work. [79367828]

  I’ve been super supported by my organisation to complete my training it’s a shame I can’t say the same for placement areas. [79217384]

- **Supernumerary status**

  It would be helpful to be supernumerary on my base area, as I am when on placement. Although I have been forced to learn more when assigned patients the team work aspect can be difficult. With 6 months left my manager has promised to try and fix this for me. Interestingly other wards in the same hospital do have supernumerary TNAs for the duration of their study. I know this as we are in the same class. Standardisation across Trusts, organisations would be helpful. [79533047]

  As a Trainee Nursing Associate you don’t always get the sheltered time with nurses on your ward and are often used as HCA. [79244002]

- **Online learning**

  It has been hard to academically learn online due to the Covid 19 pandemic. I started the course right at the beginning and it has impacted my learning ability and performance. [79424124]

- **Covid**

  Placements was stop for pandemic, trainings face to face cancelled, short staff, working more as auxiliary nurse on that time, not much practical tasks. [79277486]

- **Understanding the TNA role**

  The role is not understood properly or set out in a way that enable TNA appropriate learning time. [79350001]

  As a TNA there seems to be poor communication of what we are permitted to do and not do during training and even when qualified with varying/conflicting information given to us from our Trust and university. [79387326]
• **Unevenness**

There are disparities in the Nursing Associates role and training in different Trusts; some students are supernumerary throughout whereas others have difficulties to get their 20% off the job and learn on the job. Salary difference where some Trusts keep students on same pay and others to take reduction as low as £10,000 a year to do top up apprenticeship degree. [79218372]

• **Intensity**

Please can the TNA programme be less of a whirlwind. I find it difficult to concentrate when two years’ worth of work is thrown at us before everyone is on the same page. Also, I’m finding difficult to not have things prioritised and ordered correctly so before we’ve completed one task, we’ve been asked to do four more and by that time the first task has been forgotten about and then it’s due in by the time it’s been spoken about it next. [79245095]

2. **A Career**

• **Personal Development**

Just before I took on the role of TNA and qualifying as a NA, I had only basic knowledge in healthcare delivery. I am so delighted I took on the studies as the role has given me the opportunity to gain more in-depth in regards to social, mental and medical health. I have acquired the knowledge of questioning reasons for every task embarked on to justify such task. This role has made me realise the importance of the MDT, and effectiveness of teamwork and its efficiencies. The role has boosted my confidence in time management, multitasking and increased my critical thinking with every task I carry out day to day. I will implore all Trusts to invest in more TNA’s and NA’s and fund their paths to being a registered nurse. [80144706]

I am really enjoying the training; I am new to academic writing and referencing but have really enjoyed the challenge of this. My confidence has grown since I started and I look forward to my second year. [80049808]

• **Widening Participation**

This role and way of developing professionally within the Trust is incredibly valuable to older students with family/financial commitments. It’s given me so much growth as a person. I feel privileged to of been able to be part of it. [79543552]

• **Career Development**

It’s an opportunity for health care workers to expand their knowledge base and for career development. Be determined to stick to it once you start without giving up. It will be worth it in the end. [79475763]

The Nursing Associate role provided me the experience, knowledge and academic requirements to secure my place at university for Midwifery training, as well as be able to supplement my income with a better wage. It has put me in a very good position in my first year of training, as I have extensive knowledge of the NMC code, person centre care and professionalism, as well as be able to juggle home life, work life and studying. Had I not had the opportunity to become an NA, I may not be where I am now. [79407999]
Undertaking the Nursing Associate foundation degree has opened up a whole new career path for me. [79205372]

It is an amazing opportunity to get into nursing. It is a challenging learning curve that requires a lot of support to make it. [79243672]

I would not have been able to qualify if it wasn't for the NA apprenticeship route. I am providing a vast amount of care to patients that I would not have been able to without this. Very thankful. I have been accepted as a new role into my team, and look forward to graduating soon. [79349928]

- **In role development**

  I would like opportunities to extend skills beyond current role with specialised competencies. [80054125]

  As with any other NMC registrant, I am constantly learning and upgrading my skills, my hope is that as there is no cap on the NA role, that we will see Band 5 and even Band 6 NA's in the future. [79665374]

3. **Valuing and Supporting**

- **General Support**

  Becoming a Trainee Nursing Associate has provided me with a great opportunity to develop in my career. Support is always available if I need it. [79893699]

  I feel undervalued and a lack of support from managers really effects development. [79287581]

  I went into this degree with so much hope for the NA role. Through lack of support and respect, also seeing how qualified NAs are treated I am not sure the NA role is being used for the correct purposes. It is not being fully used by certain wards and this is so sad to see. I have given my all in this degree and will complete. I am scared and so unsure of what will happen in September when I graduate. [79237552]

  I feel NA's are undervalued and are not utilised well enough. [79400128]

- **Using the Role**

  Since completing my training my skills have been wasted as I am employed in community mental health and unable to use many of the skills. Hoped I would go onto top up training sooner but over a year now and having to apply to Open University which has an extremely long and onerous application process for prior learning as [University name] did not run the mental health top due to lack of numbers so very disjointed. Wish I had left earlier and just done the top up for post grads but could not afford to train that way. [79439280]

  (Trust name) does not support there nursing associates in their role treating the NA role same as a HCSW role. [79201308]

  Following my qualification, my previous Trust treated me like an advanced HCA but would not support my development. They moved me to a completely different area against my wishes and
then wanted me to do admin type work (such as write rotas) so I made the decision to leave for another local Trust. I have had lots of support here and we've recently been able to express an interest in topping up. [79224057]

There needs to be more support on the wards throughout the training and after. Still being used as an HCA to do 1:1 or cohorting. [79231752]

Not in the RN numbers only the HCA numbers share a bay with a RN still feel like a HCA [79392866]

It is currently under debate in my Trust as to whether we get a band 4 NA post when we qualify however this was promised to us when we started the programme. This is not fair. [80119902]

As a trainee nursing associate, you don’t always get the sheltered time with nurses on your ward and are often used as HCA. [79244002]

4. Understanding the role

- Colleagues

More awareness and education are required to inform colleagues of my role and responsibilities. [79356425]

Please could you promote this role within current RN/RMN training, the students I meet know nothing about us. [79959422]

There is lack of understanding with our role and some staff are weary of delegation to us. [80101398]

This role is in its infancy and needs promoting, other health care professionals still lack understanding in the role, on occasions amongst the TNA’s and NA’s themselves. There is still bad press and comments coming forth within professional articles and magazines. This needs time, money and effort to succeed and not become another innovation that does not succeed. I feel the title does not help either, I feel registered assistant nurse would have been better and largely more acceptable to Band 5 RN's. [79944939]

Nursing staff need more education on the role in some areas. [79569277]

Both the TNA and RNA positions need the workplace to have more education around the role. [79367409]

No one knows what to do with this role. [79201788]

The role is not understood by nurses and other staff, is not celebrated in its own right, and the training course is poorly thought out. [79229603]

- Management

I would not do it again. Management do not understand the role and take advantage of the band 3 pay and expect us to perform as a band 5. [80275327]
• **Organisational**

There is no clear job role as an NA the Trust has no guidelines yet as to what we can do. [79389629]

There is not enough understanding of the job role. [79393673]

The role is interpreted very differently not only country wide but also within the same Trust. I believe the NMC should intervene and determine exactly what the role consists of. [79395065]

Most organisations need more education about the role and its responsibilities. [79397942]

As a Nursing Associate, we are finding that our role is becoming clouded with more nursing responsibilities; the job role is not very clear to employers. [79407075]

• **Public/Patients**

The Nursing Associate role should be publicised more in the media. As the general public always ask what my role is, also due to our responsibilities. There should be a reconsidered regard to our pay, as there is a fine line between us and a registered nurse, just a little more recognition. [79223224]

Lots of grey areas / not enough people know of our role. Expected to drop role / pick up role at drop of a hat to suite wards needs. Totally understandable but also can be very mentally tiring going between roles. [80190649]

• **General Information on the role**

There is not enough knowledge out there regarding the Nursing Associate role. People often wonder what the job is about, as unsure of what we can and can’t do in the role. [79209427]

There needs to be a clearly defined list of what an NA can and can’t do across several sectors to give guidance to organisations to help NAs. [79217384]

5. **Scope of Practice**

• **Limits**

I don’t feel the NA role is fully supporting RN’s as cannot practise NG or IV administration. This would really help my ward as it is a neurological rehab medical ward, so we have many patients on NG’s and IV’s. I feel like I’m only supporting a small amount, when I could really take the pressure off of them if I were able to do these tasks. Also, there is some inconsistency as HCA’s on our neonate wards can insert an NG, but TNA’s under supervision cannot. [79900597]

I am really disappointed with the level of responsibility I am given now qualified as my manager won’t allow me to be accountable and often says why would I get you to do it when I have 7 nurses, therefore being deskillled and working as a better paid HCA. [79420736]

I have heard of another Trust that has just stopped their RNA’s giving medications altogether, due to a lack of pharmacology knowledge, essentially talking to the staff they are now back in HCA numbers and being used as such as they are no longer able to take their own patients- things like
this make me fearful for the future of my role; could my trust just train me up for everything and
then pull the rug out from under me sending me back where I started? [79256354]

I believe that other job specific tasks should be available to all nurse associates as well such as
bloods, cannulas, ECG, IV fluids and second checker for CD (controlled drugs) and IV meds. as part
of the training is to know how these medications are given. [80164441]

- **Uncertainty**

Unsure of role regarding medications, checking blood products, being a second checker.
[79450761]

There is such a big grey area around the role, its scope of practice and responsibilities and the
restrictions around shift availability and enhanced pay conditions at my current Trust that I am
somewhat deterred from registering with the NMC (if indeed I qualify). [79258124]

- **Unevenness by Trust and care setting**

Some RNAs are performing duties and skills that my Trust does not allow. A universal skill set
across all Trusts would be more appropriate. [79442909]

I would like to say that not all the learning is for nursing and residential home I find it hard to try
and see how we fit in to the course and understand what our roles are. [80361589]

I feel the role in the community is a non-starter. My ledger is now no different than as an HCA.
We will not be given any extra responsibilities. The RN role is threatened by us due to a lack of
understanding. I have struggled to find learning opportunities in my base placements and I am
used to take visits. I am rushed and feel pressured. I feel I have wasted 2 years at university.
[79675578]

There are very limited roles for us in ( ). I am looking for a job but may need to go back to be an
HCA until I can get a place to top up. These places are few and far between. All in all I would not
recommend this course. [79217461]

There should more support given to those who wish to progress onto RMN’s because little
emphasis is placed on this area of nursing, which leaves a lot of students from Mental Health
backgrounds, feeling disadvantaged. [79366587]

- **Nurse comparison**

I am grateful that this programme was developed and also as an apprenticeship; I would not have
been able to progress otherwise. However, I am concerned that the only difference between
myself and an RN is IV administration meaning that I will be doing almost as much as an RN for a
lesser wage. I am thankful that I’m my Trust and on my ward I will not be looked at as a fully
trained person however I feel that this may not be the case for everyone and some are still being
used as HCA on their base wards. [79391561]

The role was massively mis-sold and little information was around when I first applied for the
role. We were told we would be adult nursing, we do all 4 fields. We were told we would be band
3, I am band 2, yet two thirds of the staff on my Uni cohort are band 3. We were told it would be
a 12 month top up to nursing and we could start as soon as we completed this course and that it
would be funded - none of this is true. My Trust has said IV’s and CD’s are now mandatory once
we qualify, essentially meaning I am doing the same job as a band 5 in my Trust for band 4 salary other than a few minor things that don’t apply to the area I work. I hear the term cheap nurses on a regular basis, it used to annoy me - now I can’t even argue with it anymore with all the additional tasks added to the role. [79675578]

Within clinical practice it often feels there are little differences between an NA and an RN, this leads to some frustration. [80278131]

6. Progression in Registered Nurse Training

- Enthusiasm and Reasons for progression

I do not feel that there is much difference between what we are expected to and a registered nurse and I would like to top up as soon as possible. [80135556]

I wish to continue and progress with my training and become a registered nurse. [79807758]

I would like to thank you for the opportunity I have been given. I work in a wonderful team. However, I would like to be given more responsibility hence why I am progressing further. I do feel the N/A role needs to be more recognised and in due course I hope it is for fellow N/As. [79675578]

I would have liked to go straight into my top up to band 5 when I completed my foundation degree. However, I am extremely grateful for the opportunity. [79526150]

- Stepping-stone

This is a great role as a stepping-stone to becoming an RN. The NA’s who don’t want to become an RN will become disheartened if they stay in the role long term. I welcome all the extra competencies and feel it’s a great way to learn and develop but these extra competencies should have some credit to reducing the time it takes to top up. 2 years is a very long time considering I have more skills already than a lot of the newly qualified nurses on the wards. [80124582]

- Organisational support for progression

I attended ( ) University to complete my training, their support and education was outstanding. They were disappointed I had not been offered a place to continue my studies. I was 100% committed with 100% attendance and loved the academic study. [79981872]

I would like to top up my qualification to become a band 5 RN but the Trust I work for want to drop us to a band 3 whilst doing this which I feel is not fair ... I will not be considering the administration of IVs or CDs (controlled drugs) as a band 4 as what is the difference between us and a band 5 ... just cheaper .... I do feel demoralised and was promised the top up by my employer now only seems interested in cheap labour. [79396481]

Nursing associates once qualified should be given the opportunity to complete their studies to become a band 5 registered nurse and should be encouraged to do so within all organisations. [79353935]

There needs to be more progression for Nurse Associates and employers able to facilitate this. It can feel like I am doing the same role as the RN’s as a band 4. Overall I am very happy in my role
but would like there to be more opportunities to progress and more education about the role so I am not be seen as a HCA or RN. [79354801]

- **Concerns and difficulties**

It is a shame to have done the nursing associate course that I will need to repeat lots and do another 2 1/2yrs more to become registered and as I am doing the same as the trained nurses without the same pay. [79776579]

Considering the amount of training hours and placement hours we complete as trainees the NMC need to look at easier ways of RNA’s becoming Registered Nurses rather than a further 2 years of study. [79395960]

In my situation I really want to become RN but with children is very hard to start your training and lose your income. Also looking on the Nurses how much responsibilities they got and stress I am a bit less convinced if that’s good way for future. [79354880]

Nurse associate course gave me an entry into nursing which I wouldn't have been able to do without a funded role. I love my job in primary care however the way Nurse Associates are placed in primary care means they can’t top up. Nurse associates employed in ARRS roles are unable to be funded to top up to RN at present. [79526150]

I do believe the top up for a registered nurse needs to be re-evaluated as after completing already two years of training you are now required to complete another two years and for many people this could be too much especially though with children. on a personal thought 18 months would of worked a lot better and either though this is only 6 months different that is a lot when having to juggle work as well as training and home life, and due to the fact that we a short on all types of staff in every Trust this could be beneficial to both staff already working in care as well as patients. Overall, I am greatly appreciative of the opportunity I have been given to not only better myself but better my home life and if I had to go back I would choose to do this course again even with all the difficulties we have come across. [80196978]

Boost the top up. Experienced nurse associates with valuable skills cannot afford to live on 400 a month whilst they top up - this is disgraceful. [79393301]

I hope the role continues to grow and that the top up degree is shortened as we have a lot of skills abs experience once qualified. This should be reflected. I hope the future students have a better experience of training than us as a cohort did. [79390522]

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### 7. **Reward/recognition**

- **Pay Levels**

The pay for the responsibility of a registered professional is not acceptable. [80321485]

I do believe there should be a change in pay as there are other band 4 roles who do not have such the responsibilities as we do and yet are getting paid the same. I do not think it should be band 5 pay but should be somewhere in between to reflect the training and hard work we undertake. [80164441]
Being a TNA is hard work and has too many grey areas that need clarifying. There needs to be national guidance of what we can and cannot do as an RNA. I also feel that qualifying as a band 4 just does not pay enough once qualified especially with the Trust I work in and all we basically do is an RN role apart from taking charge. It feels like it is a cheap labour route for government and it is underestimated how difficult this course actually is. The grey areas need to stop and have clarity on what the role of an RNA involves and what we are exempt to do.

- **Pay and relative job size**

  While I do see the value in a role between HCA and RN’s which is how the NA role was advertised, it is not what it has become, with all the additions many Trusts are making we are now doing almost the same as an RN yet band 3 HCA’s are not even close to the responsibility we have and are only a few hundred pound a year below us in salary.

  Consider having a different band system for nursing associates that have medication training and have a reasonable pay to reflect this. For instance, NA’s with IV training could be Band 4a and those without Band 4.

  As a newly qualified NA I feel introduction on IV administration into are role is not appropriate, this will make very little skill difference between NA and staff nurse and yet the NA pay doesn’t reflect this.

  I do not believe we should give IV or CD medications at this would not be fair to given such a responsibility on a band 4 wage.

  The course sounded an amazing route into nursing offering opportunities to caring people who may not have been able to self fund. All the opportunities which sounded amazing have slowly faded away goal posts have changed and it would seem that nursing associates may be used as a way of bridging the gap but for a lot less pay but with the same responsibilities.

  The nursing associate training is very good and is a great opportunity for those individuals that are practise base learners, like myself. However, I do think that the role is abused. I see nursing associates get used the same as a registered nurse and I find it difficult to see the difference between the 2 roles at my Trust.

  It has been good for hands on learning and being paid whilst learning but how we have been treated and toyed about has been difficult. I’m getting paid less for doing everything an RN is.

  The idea of the nurse associate is good, but in my experience in practice it is not effective. Being able to do nearly everything a registered nurse can do, minus IV medication is more of a hindrance. Getting paid a band 4 wage but basically doing a band 5 role is cheap labour. Being able to do the training through an apprenticeship route is a good bonus. Having hands on experience is good when you are able to.

  The accountability we hold and the pay we receive is disgusting! we are not cheap labour. The role has expanded and now means we do more in our daily tasks such as IV medication after a year which is essential in most areas of the hospital settings but our pay does not reflect that. Even as a senior NA after 6 years at the top of banding you still earn less than a fresh starting band 5 all for the sake of a few months at uni. Experience in the job is better than those few months in university after.
The NA role was 'sold' to be a role that 'bridged the gap'. This gap is miniscule, apart from a large gap in pay there are not many differences with workload/day to day tasks as that of my colleagues who are RMNs. [79388055]

I am a nurse on the cheap. The sooner this is acknowledged, the sooner the associate role will be respected and understood. [79390480]

I love what I can do although it seems very unfair at times that I work with band 6 midwifes on the postnatal ward who do the same job as me bar giving IVs and I'm only being paid 30 pence more an hour that my old MSW role it's seems that I have taken a huge amount of responsibility and give much higher standard of care with a much deeper level of knowledge for no financial reward. [79392909]

- **Pay and qualification**

  I really do feel the pay does not reflect our role and the responsibility we will have on qualification. [79755440]

- **Uniform**

  There should be a set uniform for each role so that no matter where a patient goes in the country they know who is who such as nurse in purple, support worker in grey. [80164441]

  The nursing associate role is great. We should wear the same uniform as a registered nurse but have different name badges. [79399702]

  Uniform is an issue as we aren’t recognised at all having the same uniform on as HCAs. [79265671]

  Needs to be a generic uniform to differentiate the nurse associate from a clinical support worker as in my particular Trust we are often not recognised by the multidisciplinary team and doesn’t give NA's recognition. There also needs to be more promotion of the role within hospitals so it is understood better. [79318906]

**Discussion and Conclusion**

The themes emerging from the comments closely map onto the issues covered in the survey, although a few new issues, for example, uniforms, are raised. There is a significant sprinkling of positive comments about the training and the NA role with respondents welcoming the opportunities provided and expressing enjoyment in their work and new responsibilities. Quite often positive comments are tempered by concerns and challenges, while a raft of remarks is more critical of the T/NA experience. With some themes the weight and nature of comments are very much in tune with the overall survey findings. In other cases, the comments are less representative of or aligned with the pattern of results. More specifically, the following points are worth highlighting:

- Unsurprisingly given our interest in surveying TNAs, a significant number of comments were received on different aspects of training. In the main they supported the survey results, bringing to the fore the challenges of the training process: the tensions between learning and work and domestic responsibilities; the lack of familiarity with academic programme and the need to develop new learning skills; variations in the level of support and supervision; the difficulties of moving to online teaching in the context of Covid; and the uneven experience in terms of protected time and supernumerary status between placements. At the same time
the value of workplace learning and especially the scope to learn and earn through the apprenticeships was stressed.

- Equally valued was the scope the NA role provided for a career, particularly for HCAs previously with few development opportunities. However, if the NA role is to remain a viable career destination, and indeed to remain attractive as a role in its own right, attention was drawn to the importance of in-role training, allowing NAs to grow within the role. As a registered role, resting on periodic re-validation, continuing professional development is likely to be of importance in the future.

- There were some concerns raised about the level of support provided for the role as well as the value attached to it, in the main reflected in a failure to fully acknowledge and utilise the NAs’ capabilities. These comments do not align with the survey findings suggesting that T/NA generally see themselves as well supported by their colleagues and managers. However, such remarks overlap with concerns raised about status within staff numbers, with some NA comments indicating that they were being driven back to the HCA role.

- The comments reinforce survey findings on the limited understanding still associated with the use and nature of the role amongst colleagues, line managers and patients and the public more generally. Weak understanding raises questions about whether and how work colleagues and others engage with the role, encouraging respondents to suggest the need for greater information about and advice on the role.

- These uncertainties about the nature of the role might be related to comments on the NAs’ scope of practice. The general survey findings indicated NAs were performing a wide range of tasks, from direct care tasks such as making beds and washing patients to more technical clinical tasks such as undertaking ECGs and wound care. However, the comments suggest that NAs were being pulled in different directions. On the one hand, attention was drawn to NAs sometimes being treated as HCAs. A hint of this trend was picked up in survey findings recording some NAs as included in the unregistered numbers on certain shifts, with NAs, as already noted, feeling their new skills are not being used. On the other hand, comments pointed to NAs feeling that, with the exception of administering IV and controlled drugs, their roles were not greatly different from RNs. Here the concerns raised related to the fairness of the pay received, given the size of their job.

- The comments confirmed the survey findings on the enthusiasm of many NAs to progress into RN training. The occasional comment called into question the willingness of Trusts to support such progression, while a few remarks touched on the length and content of the top-up RN training, given the nature and intensity of the NA training already completed.

- There was a relatively large number of comments on reward and recognition. No report on workforce issues in healthcare is complete without mention of uniforms, and a few NAs were concerned about the need for a distinctive uniform as a means of recognising their status. However, most comments on recognition centred on pay. The survey picked up quite low levels of pay satisfaction. The comments suggest this dissatisfaction is related to the size of the job they felt they were now performing and in terms of tasks and responsibilities and what they saw as its close proximity to the higher paid RN role. In justifying pay differences, the NMC Standards of Proficiency for the respective roles can readily be pointed to, but it is important to note that these comments reflect how NAs perceive their pay with policy implications for staff morale.