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Patterns of Employment amongst Nursing Associates: Evidence from the Electronic Staff Record

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Patterns of Employment amongst Nursing Associates: Evidence from the Electronic Staff Record

Max Warner*, Ian Kessler+, Jill Manthorpe+ and George Stoye*+¹

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1. Introduction

Since early 2019 the NIHR Policy Research Unit in Health and Social Care Workforce has been evaluating the introduction of the nursing associate role in health and social care, using a range of methods, including surveys of Chief Nurses, Trainee Nursing Associates (TNAs) and Nursing Associates (NAs), and in-depth interviews with policy makers and practitioners (see for example, Kessler et al., 2020, Kessler et al., 2021a and b, and Kessler et al., 2022). This report adds to the work by drawing upon the Electronic Staff Record (ESR), the monthly payroll of all staff directly employed by NHS Trusts, to describe the personal and employment characteristics of all TNAs and NAs (henceforth T/NAs) employed by NHS Trusts in England over time and how they compare to other staff groups.

More specifically, we undertook three pieces of analysis using the ESR. First, we considered the demographic characteristics of T/NAs, and compared them to the demographic characteristics of nurses and health care assistants (HCAs). Second, given that the NA programme was a national initiative we examined regional and Trust patterns in the take-up of the role. Third, we followed cohorts of T/NAs over time, tracking whether T/NAs previously worked in the NHS, movements between Trusts and whether they stayed in the NHS over time. The ESR enables us to follow movements between different staff groups over time, to track progression between TNAs and NAs, as well as the progression from NA to registered nurse. This allows us to start to understand NA career progression: whether the role is one where people wish to stay working; whether they see it as a stepping-stone to registered nurse status; or whether they tend subsequently to leave the NHS.

The report is organised as follows. In Section 2, we discuss the T/NA role in more detail and summarise previous research on this staff group. In Section 3, we introduce the data and discuss the methodology for the analysis in this report. In Section 4, we analyse the demographics of T/NAs, before examining the regional and Trust distribution of T/NAs in Section 5. In Section 6, we consider the employment origins and career progression of T/NAs. Section 7 discusses the implications of these results.

2. Background and previous work

The nursing associate is a role regulated by and registered with the Nursing and Midwifery Council. To qualify and register as an NA requires two years of training as a TNA. Typically delivered through an apprenticeship, the training comprises three main elements: a period in higher education; on-the-job learning; and a series of placements in different health and care settings. Upon completion of their training, TNAs receive a Level 5 qualification and can work as

an NA in the NHS.² TNAs are usually employed by NHS Trusts on Agenda for Change band 3, while NAs are employed on band 4. Positioned in this way, the role sits between nurses employed on band 5 and above, and HCAs typically starting at band 2.³

The NA role was introduced in 2017, with 2,000 TNAs initially hired. Since then, new cohorts of TNAs have been taken on each year, with most staff generally recruited at the start of the academic year (October) but with some Trusts also hiring TNAs at other points in the year. By March 2021, there were 4,337 qualified NAs on the NMC register (Nursing & Midwifery Council, 2022). This means that NAs account for a very small part of the NHS workforce. Thus, they work alongside the 96,000 HCAs and around 320,000 registered nurses employed by NHS Trusts.

The primary goal of the introduction of the NA role was to act as a 'bridge' between healthcare assistants and registered nurses (Health Education England, 2015). However, research work has highlighted several additional aims underpinning policy and practice, including supporting new care delivery models; freeing nurses to focus on more complex work; providing a new route into registered nurse training; and widening participation in the health workforce (Kessler et al., 2020). Indeed, with policy targets on nurse recruitment, a key aspect of the role is the pathway to becoming a registered nurse, with the NHS advertising the NA position as a 'stepping-stone' into this role.⁴ Having completed the Level 5 NA qualification, a registered nurse degree apprenticeship would take just two top-up years instead of four years for a normal nursing degree apprenticeship.

Commissioned by the Department of Health and Social Care (DHSC), and commencing in Spring 2019, the NHIR Policy Research Unit in Health and Social Care Workforce has undertaken a series of studies evaluating the introduction of the NA role in the NHS.⁵ This work has included surveys of and interviews with T/NAs, Trust directors of nursing, and Trust case studies. In general, the evaluation has highlighted the uneven but steady take-up of the NA role by Trusts, principally as a means of facilitating the career development of their existing healthcare support workers. Indeed, this work has found that most T/NAs view their new role as a stepping-stone, being keen to progress into registered nurse training, whilst also raising questions about how firmly the NA role is establishing itself. Uncertainty remains about the NAs' scope of practice, but the role has been introduced in a range of clinical settings – for example, district or community nursing teams and A&E departments, as well as general medical and surgical wards. Moreover, NAs seem to be increasingly undertaking sophisticated

² T/NAs are also employed by social care providers. Qualified NAs might move from social care to the NHS and from the NHS to social care.

³ Trusts vary in the balance between Band 2 and 3 HCAs. Many acute Trusts continue to have a predominately Band 2 HCA workforce. Mental health and community Trusts are more likely to have a high(er) complement of Band 3 HCAs

⁴ <https://www.healthcareers.nhs.uk/explore-roles/nursing/roles-nursing/nursing-associate/nursing-associate>

⁵ Examining the introduction of the Nursing Associate role in health and social care (<https://www.kcl.ac.uk/research/nursing-associates>)

clinical tasks, relieving pressure on registered nurses, and allowing them to concentrate on more complex cases.

The Unit evaluation built on initial studies undertaken by research consultancy Traverse (2018 and 2019), which mainly concentrated on the training and learning experiences of the first two waves of TNAs recruited in 2017. Other research work on T/NA roles has been limited, qualitative in nature, and principally focused on the training experiences of TNAs. This work has revealed the challenges faced by TNAs, especially their capacity to balance responsibilities as a learner and a worker (Coghill, 2018) and to secure the requisite supervision and learning opportunities (Robertson et al, 2021). TNA career aspirations have also been explored, pointing to greater uncertainty about progression into registered nurse training (King et al, 2020) than highlighted in the Unit's work. Other studies on the NA role have outlined the stresses faced by postholders during the Covid pandemic (King et al, 2022) and examined the views held by other healthcare professionals about the role (Lucas et al, 2021).

Cumulatively these various research studies have established a picture of why and how the T/NA roles have been introduced and used, and with what consequences for various stakeholders, including the postholders themselves, their co-workers and patients. However, in the main, the data collected have been qualitative, based on interviews and focus groups, and where surveys have been conducted, they have generated self-report, largely attitudinal data about how respondents view, perceive, and experience the T/NA roles. In this report, we use the administrative data in the ESR to complement these studies, so seeking to strengthen and deepen our understanding of the T/NA workforce. In particular, we focus on the demographic characteristics of this workforce -and especially how these compare to the characteristics of staff in other key healthcare roles – on the regional take-up and distribution of T/NAs and on how postholders move into and through these roles.

3. Data and methodology

Our data source for the analysis in this report is the Electronic Staff Record (ESR). The ESR is the monthly payroll of all staff directly employed by the NHS in England. It includes all staff directly contracted to NHS organisations but does not include staff: in primary care, such as GPs; in contracted-out services, such as facilities management in some hospitals, employing porters or cleaners; or provided by an agency, sometimes the case with nurses and HCAs. This means that whenever we use the term 'in the NHS' in this report, we mean directly employed by NHS Trusts in England and therefore captured by the ESR.

Each month, the ESR provides information on the contracted and worked hours, grade and pay band, and a detailed breakdown of pay for each staff member. It also records a range of demographic and job characteristics. Demographic characteristics include age, gender, self-reported ethnicity and nationality for each staff member. Job characteristics include the NHS

Trust in which each staff member is employed, occupation codes, areas of work and job roles. We identify T/NAs in the ESR using occupation codes. These occupation codes were only introduced in December 2018 and so we cannot directly identify these groups prior to 2019. We define nurses and HCAs in a similar way, using a combination of occupation codes, Agenda for Change (AFC) bands and staff groups.⁶

In this report, we focus on three cohorts of staff. We first took a snapshot of all nurses, NAs, TNAs and healthcare assistants recorded in the ESR in August 2021. This is the latest month in which we can currently access complete data in the ESR. It provides a snapshot of the characteristics of staff most recently employed in these staff groups. For NAs, we also created a cohort of those who were NAs in April 2019. This is when the first cohort of TNAs, who started their two-year training in April 2017, would have qualified as NAs. For TNAs, we created a cohort of those who were TNAs in October 2019. Since the TNA training generally aligns with the academic year, this was the first full TNA cohort that can be drawn from the available data.⁷ It includes those who had just started their training in September or October 2019 (i.e. in Year 1 of their training), and also those who started in the previous year (i.e. in Year 2 of their training).

For data sensitivity reasons, we round all counts of staff numbers to the nearest 10. NAs and TNAs are small groups of staff, particularly when we consider early cohorts. As a result, when we calculate percentages for these groups, we round both the denominator and numerators to the nearest 5. If there are fewer than 10 staff members in the numerator, we suppress the percentage and do not report it.

Our analysis includes all NHS Trusts. The relatively small number of T/NAs working in the non-acute sectors (e.g., community, mental health and learning disability) means that many of the statistics would be suppressed if we split by Trust type, particularly for our early cohorts.

4. The demographic profile of NAs and TNAs

Table 1 shows the average demographic characteristics of NAs and TNAs, and how these compared to nurses and HCAs, employed in August 2021. In this month, there were 3,700 NAs and 4,700 TNAs employed by the NHS.⁸ This compared to 380,000 nurses and 94,000 HCAs.

⁶ If a staff member has multiple staff group assignments, we assign them to the most senior group (in terms of standard AFC bands), in the following order: nurse, nursing associate, trainee nursing associate, and healthcare assistant. All other staff groups are ignored for the purpose of this classification. This means that in our analysis each individual staff member can appear in at most one staff group in a given month, so we do not double count.

⁷ The October 2019 TNA cohort was also the last cohort that started training before the beginning of the Covid-19 pandemic, which may have disrupted the recruitment of subsequent cohorts of TNAs.

⁸ The number of NAs in our analysis (3,720) is slightly lower than the number of NAs on the NMC register in March 2021 (4,337). This is because some NAs work in social care and other organisations that are not NHS trusts, which are not included in our analysis.

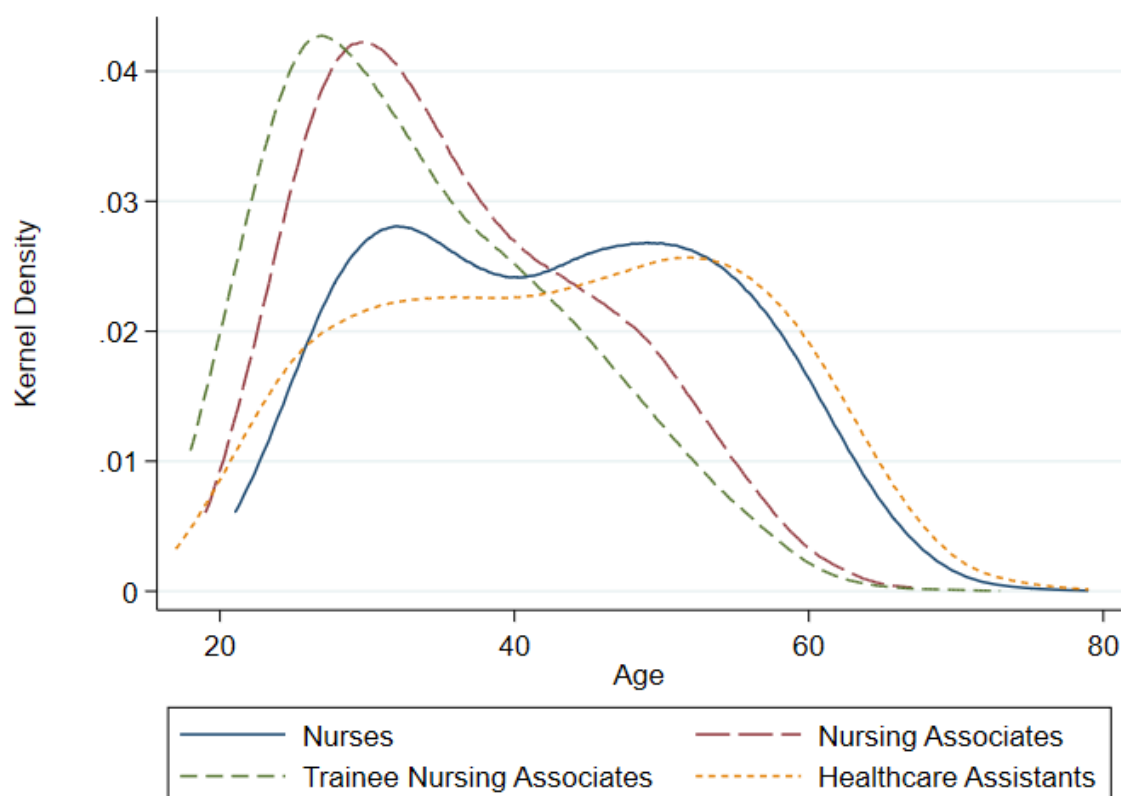
Table 1. Summary statistics of each staff group in August 2021

	Mean Age	% Female	% White	% British	Count
Nurses	42.9	89.6%	73.8%	82.9%	376,910
NAs	36.3	86.8%	79.7%	85.9%	3,720
TNAs	33.9	87.3%	75.9%	83.8%	4,740
HCAAs	43.4	83.9%	72.3%	81.4%	94,420

The largest demographic difference between staff groups was in age, with NAs and TNAs much younger on average than nurses or HCAs. In August 2021, the average NA was aged 36 and the average TNA was aged 34. This compares to an average age of 43 for both nurses and HCAs, a difference of seven and nine years, respectively. To examine these age differences further, Figure 1 shows the age distribution of staff members in each age group. This shows that the age distributions for NAs and TNAs are very different to the distribution for nurses and HCAs. The median age, for example, was 35 for NAs compared to 43 for nurses. The entire NA and TNA age distributions are shifted left compared to nurses and HCAs: T/NAs are much more likely to be in their twenties or thirties, while nurses and HCAs are much more likely to be in their fifties or sixties.

These age differences may reflect the career aspirations of those becoming T/NAs. Undergoing two years of training to become an NA, and a potential further two years of training to become a registered nurse, is a substantial commitment. The role may therefore attract those who have a long career ahead of them in order to receive the benefits of any investment now. It may also be that Trusts themselves only want to invest in those who will continue to work for many years, and potentially continue their training to become registered nurses. The relatively young age of NAs does suggest that if enough train to become registered nurses, the role could be used to increase the future supply of nurses. Although younger than registered nurses and HCAs, it is noteworthy that in their early to mid-30s, T/NAs are still typically some way into their working lives and careers, with extensive employment and life experiences.

Figure 1. Age distribution of each staff group in August 2021



Note: Kernel density is the smoothed share (percentage) of workers at each age.

Table 1 also shows gender differences between each staff group. In August 2021, a lower percentage of T/NAs were female than nurses, but a higher percentage were female than for HCAs. These differences, however, were relatively small: 87% of T/NAs were female in August 2021, compared to 90% of nurses and 84% of HCAs.

The table also shows differences in the self-reported ethnicity and nationality of T/NAs relative to nurses and HCAs. The percentage of T/NAs with British nationality was higher than for either nurses or HCAs. For example, in August 2021, 86% of NAs were British, compared with 83% of nurses. This difference in nationalities was mostly driven by nurses being more likely to be of non-EU nationality than T/NAs. Thus, 11.7% of nurses were from non-EU countries compared to 8.6% of NAs and 10.3% of TNAs. It is less likely to derive from nurses coming from EU countries: 5.6% of NAs and 5.9% of TNAs were from such countries, very close to the 5.5% of nurses coming from them.

The percentage of T/NAs that were white was also higher than the percentage for either nurses or HCAs. This is particularly the case for NAs, where 80% were white in August 2021, compared to 74% of nurses and 72% of HCAs. In Appendix Figure A.1, we provide a more detailed

ethnicity breakdown for each of the staff groups. This shows that T/NAs were substantially less likely to be of Asian ethnicity, or of other or unknown ethnicity.

This difference in ethnicity could be driven by a number of different factors. For example, it may be that there was less international recruitment of T/NAs relative to nurses and HCAs (as reflected by the relatively lower share of British nationals among nurses and HCAs). It is likely in part also explained by regional differences in the take-up of the T/NA roles: as we show in Section 5, T/NAs were relatively under recruited in London, the region where the NHS employs the highest percentage of non-white and non-British staff members in these groups.

5. Regional and Trust differences in T/NA take-up

In this section we consider regional and Trust differences in the take-up of the T/NA roles. Figure 2 below shows the distribution of Trust employment of T/NAs in each region of England in August 2021. Each green diamond on the Figure shows the employment of an individual Trust within a region, and the yellow lines show the mean employment of T/NAs by all Trusts within each region. Variation in the number of T/NAs employed in each Trust may simply reflect differences in the size of Trusts. In presenting T/NA employment in the Figure we therefore compare the number of T/NAs in each Trust relative to the size of the nurse workforce in the same Trust. For example, a Trust that employed 50 T/NAs and 1,000 nurses would employ T/NAs equivalent to 5% of the size of its nursing workforce. For data sensitivity reasons, a Trust with 0.0% T/NAs could either have zero T/NAs, or 1-9 T/NAs.

Figure 2. Trust and regional distribution of T/NAs as a percentage of the nursing workforce in August 2021

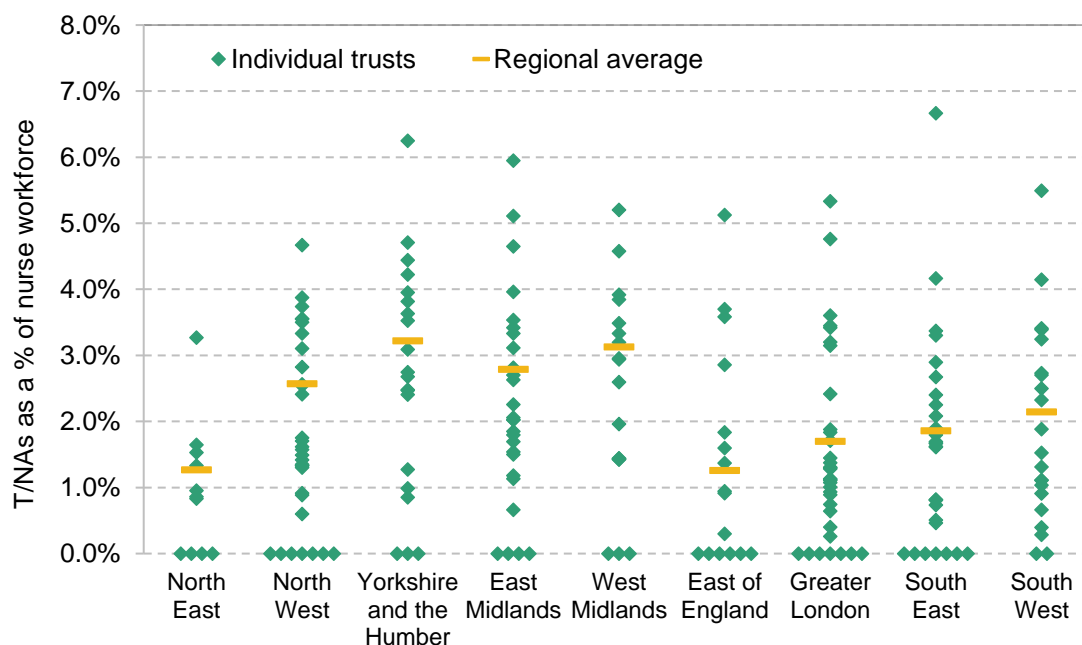


Figure 2 shows two main points. First, there are large differences in T/NA take-up between different regions. Trusts in the North East, East of England or Greater London employed relatively fewer T/NAs, while Trusts in the North West, Yorkshire and the Humber and the East and West Midlands employed more. These regional differences may represent differences between the staffing needs of regional healthcare systems. For example, Health Education England (HEE) had set different regional targets for T/NA recruitment, apparently reflecting differences in the needs of regional healthcare systems (Kessler et al., 2020). There is no public information, however, on what these targets were or how they were calculated.

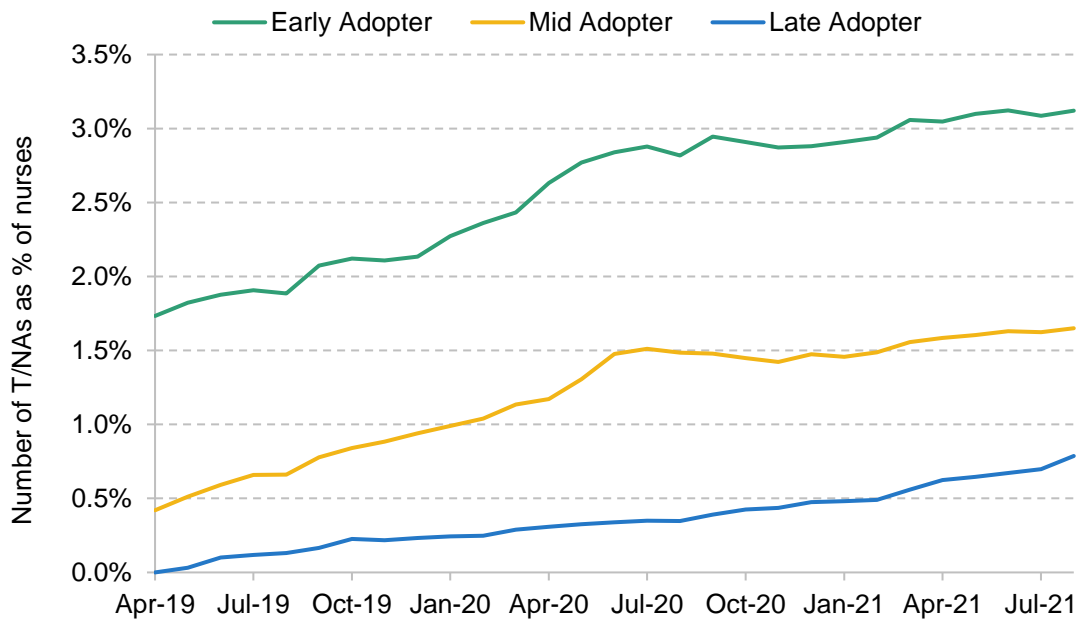
Second, there were also substantial differences in the take-up between different Trusts *within* the same region. In all regions, there were some Trusts that employed no or almost no T/NAs in August 2021, alongside some Trusts that employed a relatively high ratio of T/NAs to nurses. This suggests that Trusts differed substantially in the extent to which they introduced the T/NA role, even within each region. More specifically, with the exception of the North East, where the ratio of NAs to nurses in Trusts remains relatively close to the mean, in other regions there is a broad spread of NA/nurse ratios between the different Trusts. This within-region spread is especially marked in the South East, which includes around half a dozen Trusts with no or almost no T/NAs, but one Trust with an NA/nurse ratio close to 7%. But in the other five regions Trusts are also spread out quite widely across a low-high ratio spectrum, highlighting this variation in Trusts approach and practice.

To examine how Trust T/NA employment patterns have changed over time, Figure 3 below shows the number of T/NAs employed relative to registered nurses in each month between April 2019 and August 2021 for three groups of Trusts. The first group (in green) are 'early adopter' Trusts. These Trusts employed an above median (excluding zero) share of T/NAs in April 2019. The second group, in yellow, are 'mid adopter' Trusts. These Trusts employed a below median (excluding zero) share of T/NAs in April 2019. Finally, in blue are 'late adopter' Trusts. These Trusts employed no T/NAs in April 2019.

On average 'early adopter' Trusts employed T/NAs equivalent to 1.7% of their nursing staff in April 2019, while 'mid adopter' Trusts employed T/NAs equivalent to 0.4% of their nursing staff and (by definition) 'late adopter' Trusts employed no T/NAs at this stage. Between April 2019 and August 2021, all three groups of Trusts increased their employment of T/NAs: in August 2021, 'early adopter' Trusts employed T/NAs equivalent to 3.1% of their nursing staff, 'mid adopters' employed T/NAs equivalent to 1.7%, and 'late adopters' employed T/NAs equivalent to 0.8% on average. This shows that the differences in employment of T/NAs have persisted over time, with the percentage point difference in employment between early and mid, and mid and late, adopters actually increasing over time.

Indeed, it is not clear that 'early adopters' have hit an upper limit on T/NA employment, with a sustained upward trajectory in the ratio of T/NAs to registered nurses. The growth in employment has slowed down amongst 'mid adopter' and 'early adopter' Trusts but has not stopped. Taken together with the persistent gaps in employment between each group, this suggests that there remains either a different appetite for the NA role, or a different ability to fill the role, between different Trusts.

Figure 3. Number of T/NAs as a percentage of registered nurses over time by type of Trust



6. The career paths of T/NAs

In order to understand better the recruitment sources and career backgrounds of NAs and TNAs, we now turn to an analysis that follows these staff members over time. We examined how many of the staff employed as an NA in April 2019 (the first cohort of qualified NAs, given that training started in April 2017) were employed in different roles in the NHS in the five years before April 2019, and how their pattern of employment developed in the two years following qualification for the role. We repeated this analysis for those who were working as TNAs in October 2019, a group who would likely have started TNA training in either 2018 or 2019.

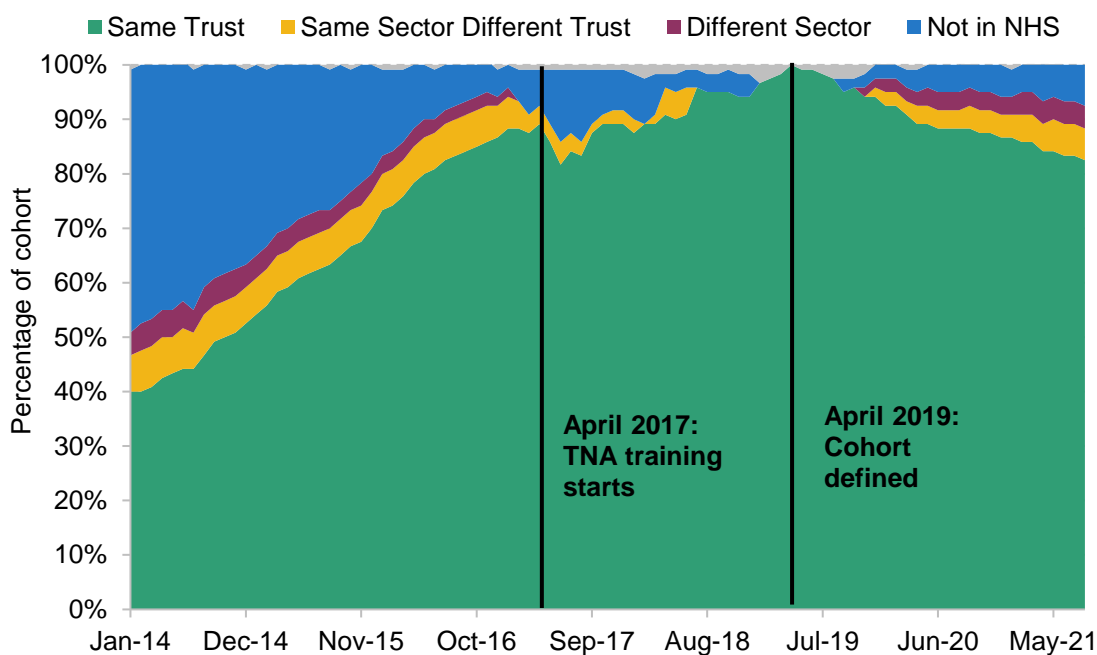
Nursing Associates

We first considered the 600 NAs who were working for NHS Trusts in April 2019. For each month, we split these staff into four different categories relative to their employment in April 2019:

- 1) they worked in the same Trust that they worked for April 2019
- 2) they worked in a different Trust than the Trust they worked for in April 2019, but the new Trust is in the same NHS sub-sector (acute, ambulance, community, or mental health)
- 3) they worked in a Trust that is in a different sub-sector of the NHS to the Trust that they worked for in April 2019
- 4) they did not work for an NHS Trust (this includes working in a sector not covered by the ESR, such as primary care, or they may have not been working in the NHS at all)

Figure 4 below shows how the type of NHS employment of each staff member in the April 2019 cohort changed between January 2014 and August 2021. By definition, all staff in this cohort were working in the NHS in April 2019. In the two years prior to 2019, almost all of the staff were already working in the NHS, indicative of the fact they were on the TNA programme. However, even in January 2016 – prior to the launch of the first TNA training programmes – 84% were working in the NHS. This suggests that the vast majority of the first TNA cohort were recruited internally from staff already employed by the NHS, likely as HCAs and other healthcare support staff. Moreover, almost all of these staff were also working in the same Trust in which they would be employed as an NA by April 2019. In January 2016, 73% were working in the same Trust in which they worked as an NA in April 2019. This shows that the first cohort of TNAs was mostly recruited by Trusts that already employed these staff.

Figure 4. Type of NHS employment over time for April 2019 NA cohort



Note: The grey area represents suppressed categories and errors from the rounding of percentages

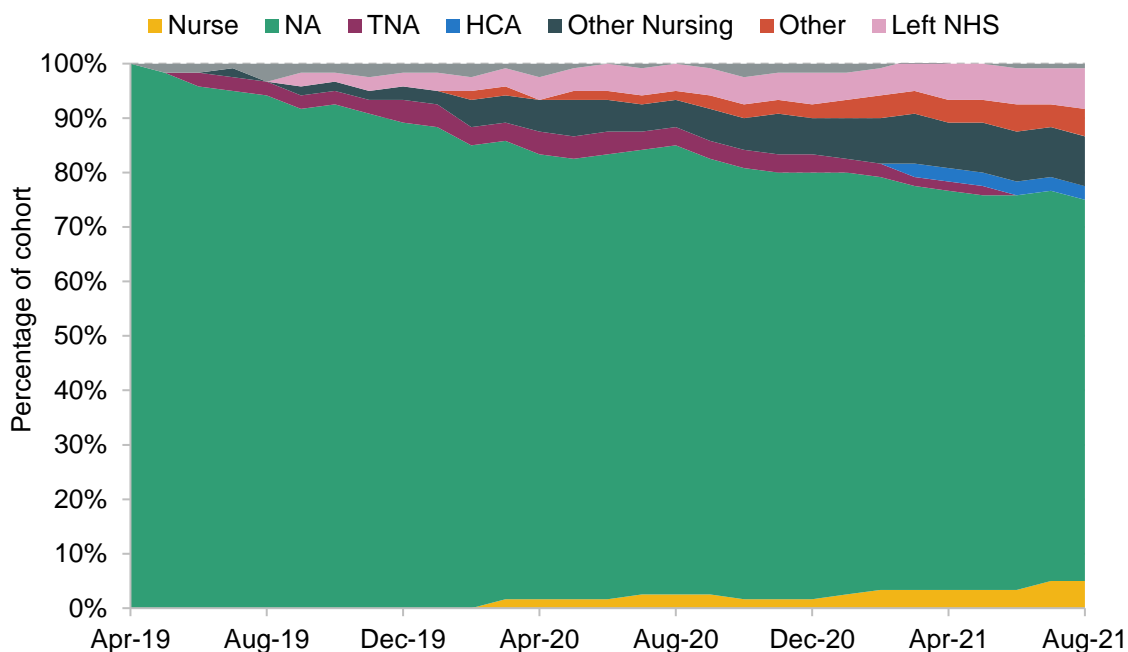
Looking further backwards in time shows that many of these staff, while already employed by the NHS before embarking on NA training, were relatively recent joiners to the NHS: for example, in January 2014 - three years before NA training started - only 52% were recorded in the ESR as employed directly by the NHS. This shows that while most T/NAs were recruited from within the same Trust, many of these staff were relatively new to working in the NHS.

The figure also shows that, once trained, most NAs remained within the NHS, and often within the same Trust. By August 2021, 93% of people employed as NAs in April 2019 were still working in the NHS, while 83% were still working in the same Trust. This possibly indicates that Trusts are good at retaining these staff. It also suggests that there is a limited system-wide labour market for NAs within the NHS, with NAs struggling to find jobs in other Trusts. It could in addition reflect that NAs were already embedded in their local communities, since most previously worked for the same Trust, and are therefore less likely to want to move location.

To explore further how the careers of these staff have developed over time, Figure 5 shows whether and how the staff group of each NA in our cohort changed after April 2019, particularly in terms of job role. This shows that the majority (70%) of those that were NAs in 2019 were still employed as NAs in August 2021. It also shows that 5% of the initial cohort had become registered nurses by August 2021. This suggests that the NA role has acted as intended by providing a stepping-stone for some staff into a registered nurse role. The numbers making this leap do seem low, but this is likely due to our relatively short sample period and the impacts of the Covid-19 pandemic. To become a registered nurse an NA requires a two-year

apprenticeship, and so to have become a nurse by August 2021 would involve moving straight into nurse training on qualification as an NA in April 2019. Many Trusts asked their NAs to remain in the role for six months to a year before starting their registered nursing apprenticeship, so there may be many who are still partway through their nurse apprenticeship in August 2021 and so may subsequently become nurses.

Figure 5. NHS job role over time for April 2019 NA cohort

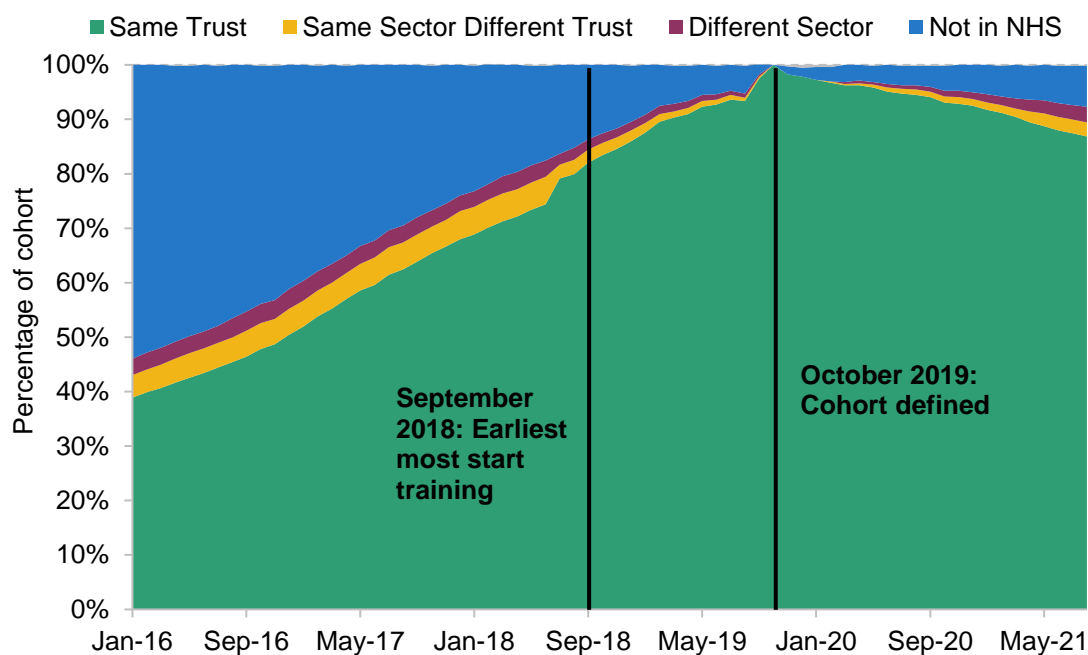


Note: The grey area represents suppressed categories and errors from the rounding of percentages

Trainee nursing associates

We repeated this analysis for the 3,980 TNAs who were working in NHS trusts in October 2019. Figure 6 splits the TNAs in this cohort into the four types of NHS employment previously used to examine the career progression of NAs (relative to the Trust in which they were employed in October 2019). To enable comparison with Figure 4 we consider NHS employment between January 2016 and August 2021. This sample period is two years shorter to reflect that TNAs in our October 2019 cohort started training either two or three years later than the NAs in our April 2019 cohort.

Figure 6. Type of NHS employment over time for October 2019 TNA cohort

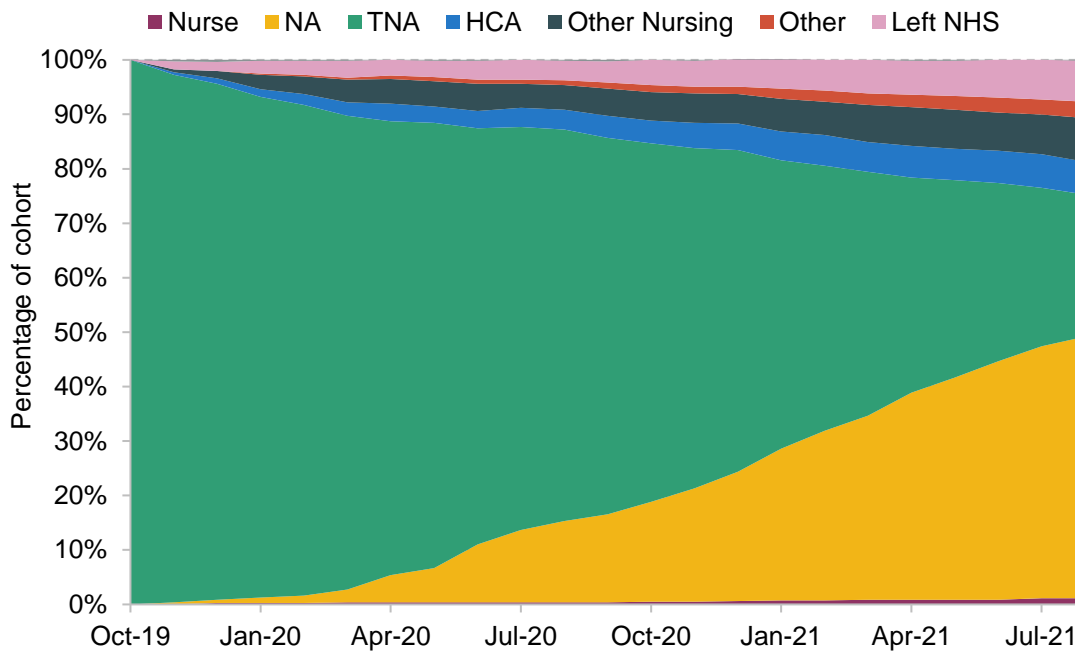


Note: The grey area represents suppressed categories and errors from the rounding of percentages

This analysis shows a relatively similar pattern to the one shown by Figure 4. In January 2018, prior to starting training, 77% of the October 2019 cohort of TNAs were working for the NHS. Going further backwards, just over half of these staff (54%) were not working in the NHS in January 2016. Of those who were working for the NHS, as with the NAs, the majority worked in the same Trust that they worked in October 2019.

Figure 6 also shows that similar to NAs, most TNAs remained working for the same Trust over time. By August 2021, 87% were still working in the same Trust, while 8% had left the NHS. This is perhaps unsurprising given that many of these workers would still have been training at the end of the period, and therefore remained in employment in the same Trust. Although a relatively small percentage, there is a steady leakage of both TNAs and NAs out of the NHS altogether. This could represent moves to the social care sector but could also suggest some personal disillusionment with the NA role over time, and from a Trust perspective, a lost resource, and investment.

Figure 7. NHS job role over time for October 2019 TNA cohort



Note: The grey area represents suppressed categories and errors from the rounding of percentages

Figure 7 shows the progression of NAs in our October 2019 cohort. By August 2021, 48% had become NAs, while 26% were still TNAs. This is consistent with training timings. Those in the cohort most likely started their training in Autumn 2019, and so would become NAs in Autumn 2021, or started in Autumn 2018, becoming NAs in Autumn 2020.

7. Discussion and conclusions

As a new registered role, bridging the healthcare assistant and the nurse, the NA profession is approaching its fifth anniversary. The first cohort of 1,000 trainee NAs began their 2-year training programme in early 2017, qualifying two years later. Further cohorts have followed, and in 2022 the NMC reports close to 7,000 registered NAs in post (Nursing & Midwifery Council, 2022). Our understanding of the role has developed over the years, with studies examining the characteristics of those performing it, why and how the role has been used by Trusts and with what effect on various organisational and stakeholder outcomes. These issues have mainly been explored from the perspective of the TNAs and NAs themselves (Traverse, 2018 and 2019; Kessler et al., 2021a; King et al., 2020; King et al., 2022; Robertson et al., 2021). Views on the two roles, held by co-workers (Lucas et al., 2021), Directors of Nursing (Kessler et al., 2020 and 2021b) and policy makers and practitioners (Kessler et al., 2021b) have also been gathered and examined. The use of ESR data in this report provided an opportunity to further our appreciation of the role and those who undertake it. In part, these ESR data complemented existing evidence by shedding light on new issues related to the NA role. However, they have also deepened understanding by providing new, perhaps 'harder' data on subjects covered by previous studies. In the main, the ESR material presented in this paper has reinforced rather than challenged the findings from previous studies, providing assurance on the accuracy of the picture being developed on the nature and consequences of the T/NA role.

The ESR data set out in the paper centred on three main issues: the demographics of the contemporary T/NA workforce; the regional and Trust distribution of T/NAs; and the career journeys taken by panels of TNAs and NAs before and after taking up their respective roles.

The most recent demographic data from August 2021, touching on personal and social characteristics of postholders, was usefully available from the ESR for HCA and RNs as well as TNAs and NAs, providing an opportunity to compare the occupational groups in these terms. Unsurprisingly all four roles were heavily feminized, but with differences in their ethnic profiles. While over three quarters of those in all four roles were white, a slightly higher proportion of NAs were from this category. With NAs typically more firmly rooted in their local communities, the distinctiveness of their ethnic profile might well reflect the regional distribution of this group of workers. There were also nationality differences between the staff groups, with T/NAs more likely to be British, and less likely to come from non-EU countries, than nurses and HCAs.

More striking were differences in the mean ages of those in the different occupational groups, with TNAs and NAs likely to be much younger, in their mid-30s, than nurses and HCAs, in their mid-40s. This is perhaps explained by the fact that HCAs and nurses were in long established roles, with postholders much more likely than T/NAs in their newly created roles, to have developed long(er) career with a higher age profile to match. At the same time, older workers

were clearly not taking up the T/NA roles, suggesting perhaps modest career aspiration relative to younger workers. Our other studies (Kessler et al., 2021a) have shown that most NAs are keen to move into registered nursing, requiring two further years of training. For various reasons the prospect of four years training to become a registered nurse is perhaps likely to be more attractive, or certainly less daunting, to younger than older workers. However, in their mid-30s T/NAs are still likely to have a career history well before taking up their current roles, with rich work and life experiences to bring to them. Indeed, with previous research suggesting around half of T/NAs have dependent children at home (Kessler et al., 2021a), commencing degree level training to become and starting in a new job role as an NA at this stage in their lives is likely to be a challenging process.

The regional and Trust differences in the distribution of T/NAs pointed to some unevenness in engagement with these new roles. In August 2021, four years after the introduction of the T/NA roles, there were still a substantial number of Trusts that employed no or very few T/NAs. Some other Trusts were particularly enthusiastic for the new roles, employing T/NAs equivalent to at least 5 per cent of their nursing workforce. There were differences in regional take-up, with more T/NAs employed in Yorkshire and the Humber and the East Midlands, and fewer employed in the North East, East of England and London.

These enduring regional differences in take up of the T/NA roles might be interpreted in various ways. They might well reflect differences in the character of regional populations and their healthcare needs, with implications for the NHS infrastructure and the size and composition of the workforce required to service them. They might also arise from variation in whether and how effectively HEE regional systems support the introduction and the development of T/NA roles in their patch. Thus, the time, resource and capacity of regional leads to focus on the role might well vary between these areas.

More striking were substantial differences in T/NA take-up between the different Trusts in each region. In all regions, there were some Trusts that employed no or almost no T/NAs, and some Trusts that employed T/NAs equivalent to between 3 and 7 per cent of their nursing workforce. It is a finding which suggests that organisational and perhaps locality specific factors remained a powerful influence on take-up of the role. With the NA role seen by some policy makers and practitioners as a means of addressing nurse shortages (Kessler et al, 2020), our findings suggest 'hot spot' labour market pressures within rather than across a given region. However, within- region variations more clearly point to different Trusts strategies or approaches to structuring and organising their nursing workforces. A Trust building up its band 4 nursing support workforce through the adoption of the long-established Assistant Practitioner (AP) role⁹, might well be less attracted to a new role at this level, albeit one with registered status.

⁹ The AP is an unregistered role

Other Trusts might be drawn to innovative nurse roles, keen to run with them as a source of 'continuous improvement'. Manchester Universities Foundation Trust, for example, was keen to adopt the AP role, while also taking-up the NA role at scale (Kessler et al., 2020).

The importance of organisation specific factors is lent further weight by our findings on the timing of T/NA adoption by Trusts. Our analysis showed that early adopter Trusts have continued to increase their recruitment of T/NAs, with no sign of an upper limit on T/NA employment being reached. For these Trusts the role is clearly not a disappointment, indeed it is continuing to prove its worth. Trusts that were late adopters of T/NAs have increased their employment since 2019, but there is no convergence yet with Trusts that adopted the role earlier. Moreover, take-up of the role by the late and even mid-range adopters remains relatively sluggish, possibly pointing to a deep-seated organisational drag.

The panel data on the career journeys of NAs and TNAs provided useful insights on the nature of the labour market for TNAs and NAs. The April 2019 panel would have been the first TNAs to have qualified as NAs and been in the new registered role for the longest. The ESR data indicated that prior to starting their training a significant majority of these NAs were not only employed in the NHS but in the same Trust. This confirms previous research pointing to the use of the NA role to provide career development opportunities for a Trust's existing, often experienced support workers (Kessler et al., 2020 and 2021b), and suggests perhaps that employment of T/NAs is not greatly increasing NHS healthcare workforce numbers. Indeed, this same research suggested the take up of the new NA role by existing staff now who were trusted co-workers, contributed to its acceptance and use. This personal attachment to the Trust is further reflected in the fact that most NAs have remained with their organisation following qualification, while also perhaps suggesting an external labour market for NAs has been slow to develop. Given T/NA nurse aspirations it was noteworthy that only a small proportion of the April 2019 panel had moved on to become registered nurses. This likely reflected the additional time need to qualify as a nurse, with some NAs still in nurse training and yet to qualify as registered nurses. Our previous research has also revealed that Trusts are often keen to encourage qualifying NAs to stay in their role for at least a couple of years to consolidate their new skills. Indeed, with competing staff development priorities, Trusts might well withhold the requisite funding for nurse training severely constraining the capacity of individuals to move forward in the short term (Kessler et al., 2020 and 2021b). As more up to date ESR data become available, we will be in a better position to explore NA career progression, and particularly the degree of movement into registered nurse roles. This movement is an important policy goal underpinning the introduction of the NA, perhaps in tension with the aim of embedding the NA as a role of value in its own right. The 'jury is still out' as to which of these outcomes will be most effectively secured.

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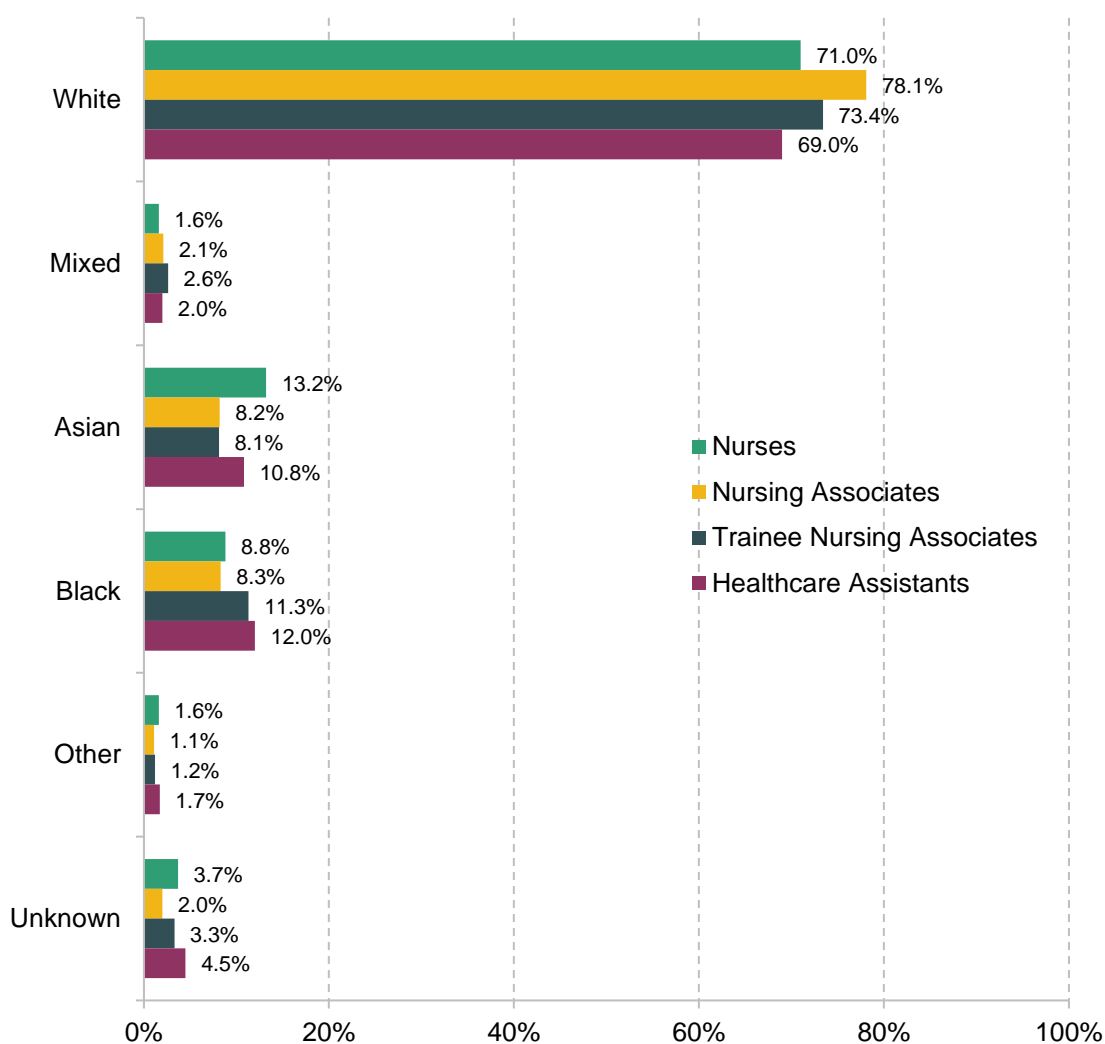
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A. Additional demographics results

T/NAs in August 2021

Figure A.1. shows the distribution of major ethnicity groupings for each staff group in August 2021. This differs slightly from Table 1 because the figure includes unknown as an ethnicity group, while Table 1 excluded those with unknown ethnicities to calculate the percentage of white staff.

Figure 8. Figure A.1. Ethnicity distribution of each staff group in August 2021



NA (April 2019) cohort

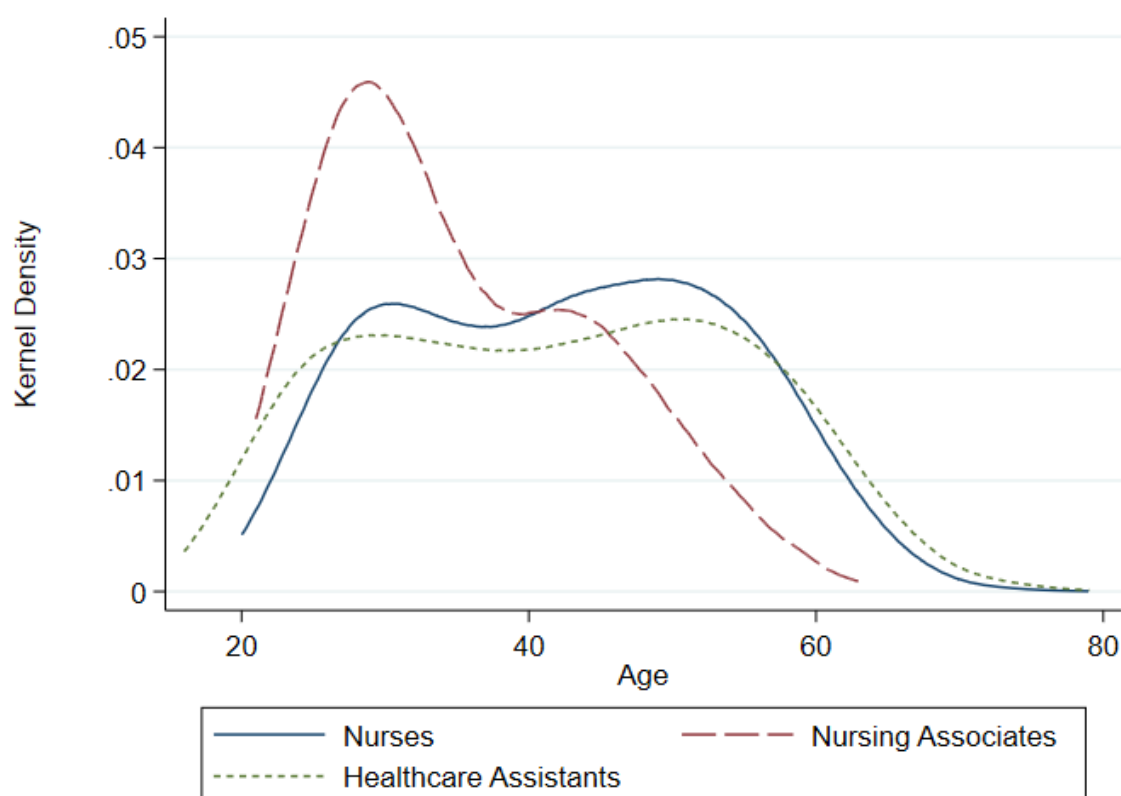
Table A.1. shows the average demographics of the April 2019 NA cohort, as well as the demographics of nurses and HCAs in April 2019.

Table 2. Table A.1. Summary statistics of each staff group in April 2019

	Mean Age	% Female	% White	% British	Count
Nurses	42.5	89.7%	77.1%	84.2%	363,850
Nursing Associates	35.4	86.7%	82.9%	86.3%	600
Healthcare Assistants	41.8	84.1%	73.4%	81.7%	102,510

Figure A.2. shows the age distribution of the April 2019 NA cohort, as well as the age distribution of nurses and HCAs in April 2019.

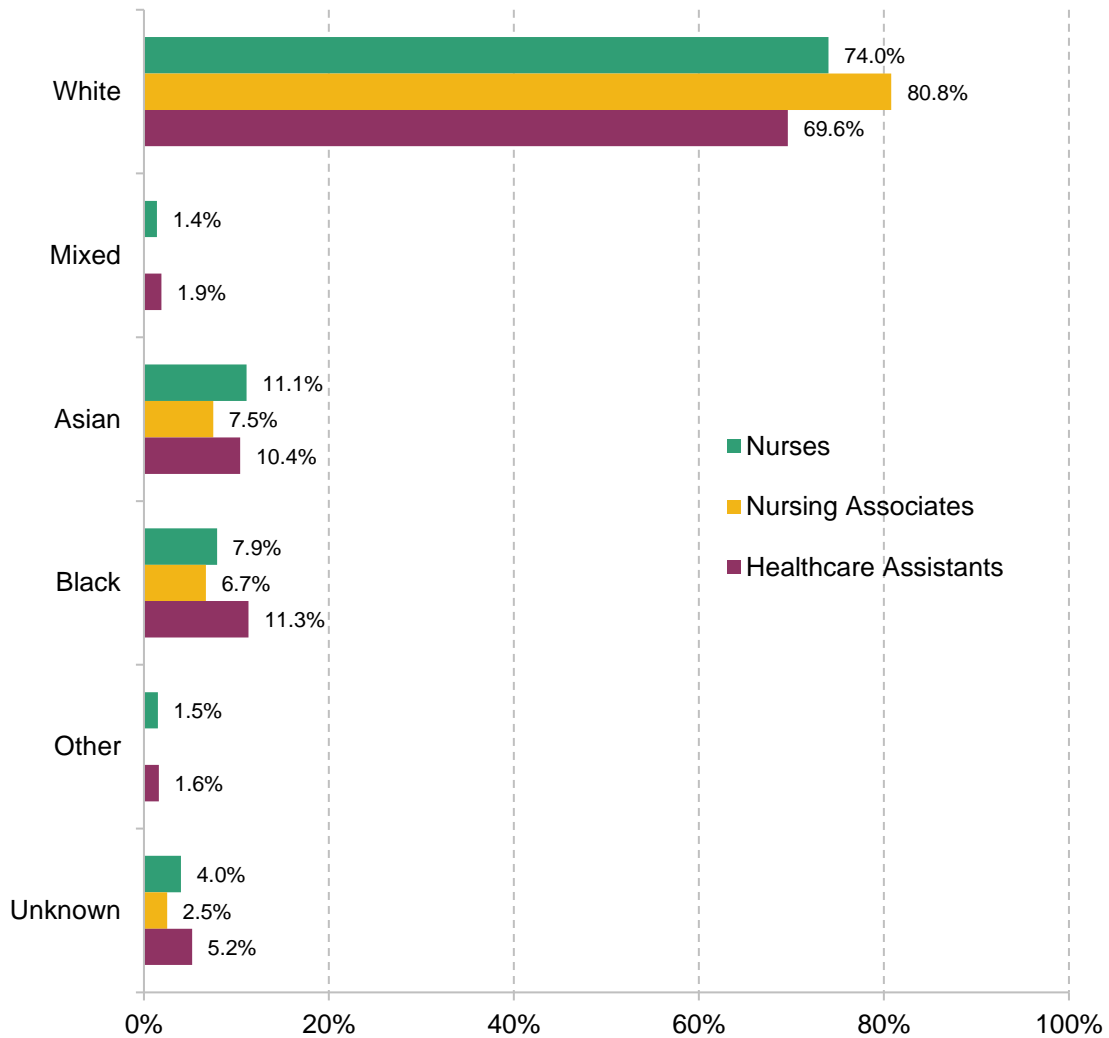
Figure 9. Figure A.2. Age distribution of each staff group in April 2019



Note: Kernel density is the smoothed share (percentage) of workers at each age.

Figure A.3 shows the ethnicity distribution of the April 2019 NA cohort, as well as for nurses and HCAs in April 2019. This differs slightly from Table A.1 because it includes those of unknown ethnicity.

Figure 10. Figure A.3. Ethnicity distribution of each staff group in April 2019



TNA (October 2019) cohort

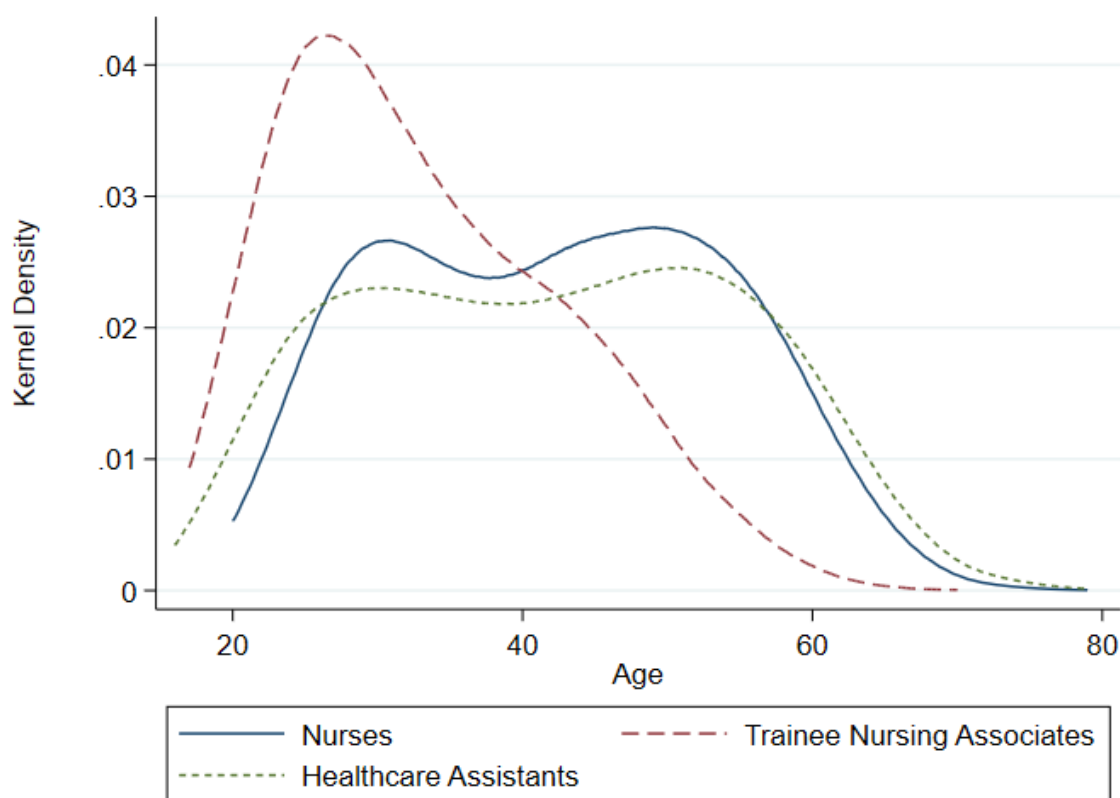
Table A.2 shows the average demographics of the October 2019 TNA cohort, as well as for nurses and HCAs in October 2019.

Table 3. Table A.2. Summary statistics of each staff group in October 2019

	Mean Age	% Female	% White	% British	Count
Nurses	42.4	89.6%	76.1%	83.6%	369,500
Trainee Nursing Associates	33.3	86.8%	77.7%	84.0%	3,980
Healthcare Assistants	42.0	84.3%	73.1%	81.3%	104,640

Figure A.4 shows the age distribution of the October 2019 TNA cohort, as well as the age distribution of nurses and HCAs in October 2019.

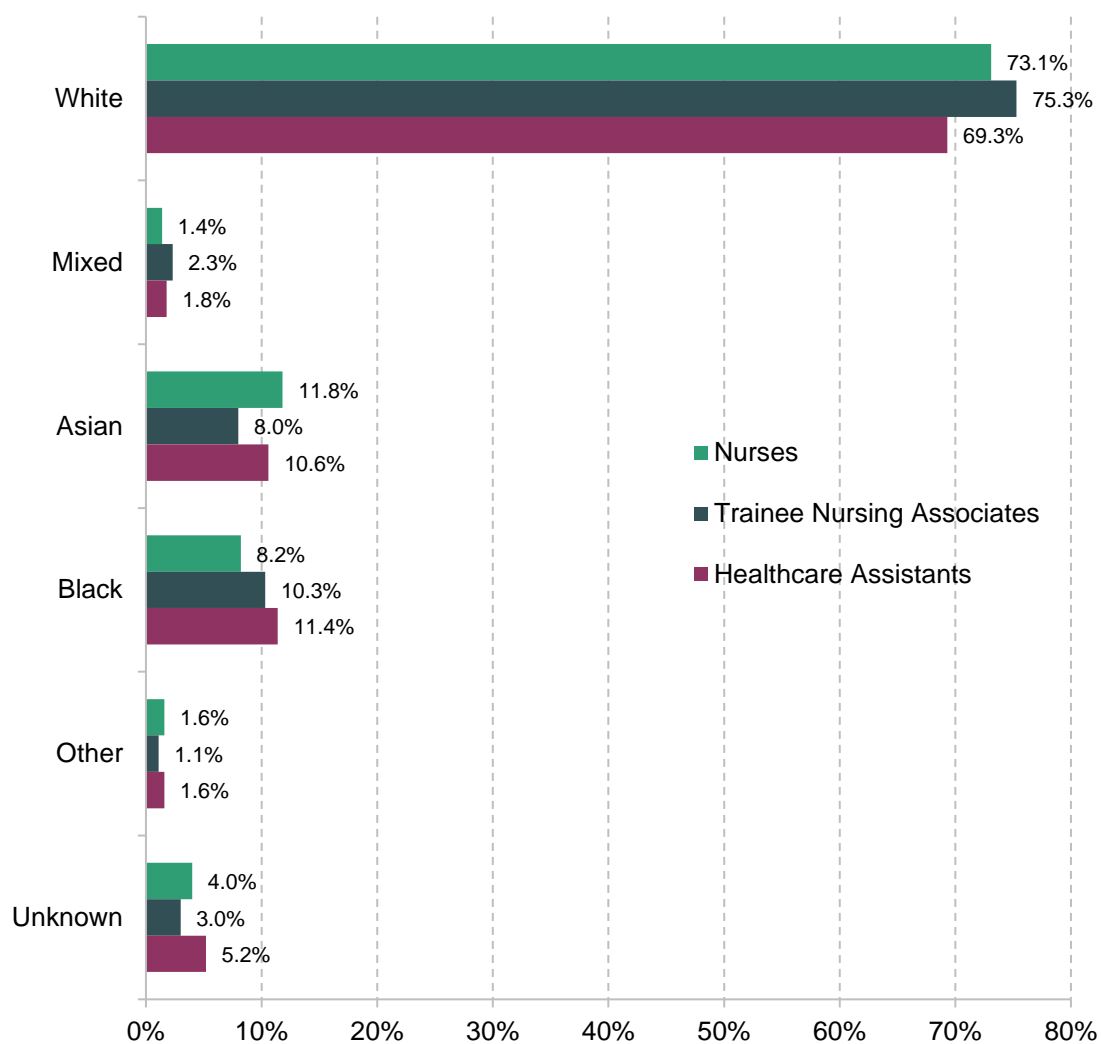
Figure 11. Figure A.4. Age distribution of each staff group in October 2019



Note: Kernel density is the smoothed share (percentage) of workers at each age.

Figure A.5 shows the ethnicity distribution of the October 2019 TNA cohort, as well as for nurses and HCAs in October 2019. This differs slightly from Table A.2 because it includes those of unknown ethnicity.

Figure 12. Figure A.5. Ethnicity distribution of each staff group in October 2019



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