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# Title page: Development of the nursing associate role in community and primary care settings across England

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# Development of the nursing associate role in community and primary care settings across England

**Abstract (50-100 words)**

Nursing associates have now been a part of the health and social care workforce in England for three years and are starting to make a contribution to managing current workforce challenges. However, little is yet known about the nursing associate role in primary and community care settings. This paper provides an overview of what is known and introduces some emerging findings from recent research. It highlights some of the benefits that nursing associates can bring to community and primary care nursing teams and some of the challenges that remain in training and embedding nursing associates within these sectors of the health and social care workforce.

**Introduction**

In the context of an increasing elderly population, the continuing challenges of managing long-term conditions and now the Covid-19 pandemic, community and primary care nursing teams remain vital in providing treatment and preventative care close to home that can help maximise independence. In this article we consider the implementation of a new level of nursing practice in England; the nursing associate (NA). We provide an overview of the literature and briefly introduce some emerging findings from recent research to help explore how these new members of the healthcare workforce are experiencing and contributing to community and primary care and some of the challenges that still remain as the role becomes embedded in these settings. It is important to note that when talking about community and primary care in this paper we have also drawn on research from the social care sector (particularly work that has been undertaken on the NA role in nursing and care home settings) as well as work completed in general practice and in district and community nursing teams.

**Background**

The nursing associate role was first proposed following the *Shape of Caring* review conducted by Lord Willis (Health Education England 2015). This work examined the future of education and training for healthcare assistants (HCAs) and registered nurses (RNs). It highlighted a skills gap between HCAs and RNs and proposed that the new NA role would fill this skills gap and could also provide a clear alternative route into registered nurse training. The NA role was specifically designed to be flexible and generic in order to best manage our changing population health needs. Because of this, NA training provides exposure to all four fields of nursing practice and ensures experience in developing the skills required to care for people 'in hospital', 'close to home' and 'at home' (Nursing and Midwifery Council, 2018a). Experience within the community, including that within social care and primary care settings, is therefore an important and essential aspect of NA training.

The first two pilot groups of trainee nursing associates (TNAs), based at 11 centres across England, commenced in 2017 and began qualifying and joining the workforce in early 2019. Two important changes took place as these pilot cohorts were undertaking their two-year training. First, the Nursing and Midwifery Council (NMC) became the legal regulator for the role and the "Standards of Proficiency for Nursing Associates" (Nursing and Midwifery Council 2018b) were developed. Second,

the next cohorts of TNAs commenced under the apprenticeship programme. This has important implications for their status. TNAs are primarily apprenticeship employees who are released to study and this differs from traditional RN trainees who are primarily undergraduate students released into the workplace for clinical placements. This is changing somewhat as there are now some direct entry TNAs not subject to apprenticeship regulations and increasing numbers of apprenticeship degree level pre-registration nursing programmes.

**Nursing associates in community and primary care**

So what is currently known about NAs from the community and primary care sector? The national evaluation of the introduction of NAs, commissioned by Health Education England (HEE) found that approximately 14% of applicants to the early, pilot, cohorts came from the community sector with "a few recruited from general practice or social care" (Vanson and Bidey 2019; p.23). Further HEE commissioned work, focusing on TNAs in primary care and social care (Traverse 2019a; Traverse 2019b), showed that only 2% of trainees in the early cohorts came from each of these two settings. However, the number of trainees from primary care, and other parts of the independent sector (including care homes and nursing homes), has increased rapidly since changes to the funding rules in October 2020 made the cost of having an apprentice more viable for this sector (ESFA 2020).

Work commissioned by the National Institute for Health Research (NIHR) Policy Research Programme shows that, of the 59 Trusts that took part in their survey (which included hospital, community, specialist acute, mental health, and combined Trusts), 39% deployed NAs in community nursing teams, 20% in community mental health teams and 5% in community learning disability teams. It also noted that of those 59 Trusts surveyed, Community Trusts tended to have smaller numbers of TNAs than Hospital Trusts, with 80% of Community Trusts employing less than 40 TNAs compared to only 47% of Hospital Trusts employing less than 40 TNAs (Kessler et al 2021). However, this work does not capture the number of TNAs or NAs working in primary care or in the independent nursing and care home sector.

A case study commissioned and delivered by the same research team (Kessler et al 2020) looked at the rationale, processes and consequences of introducing the NA role in a single Trust that mainly delivers community-based services (though with some mental health inpatient delivery). The first cohort of NAs in that Trust were all deployed into district nursing teams, where staff shortages were particularly prevalent. This, of course, raises concerns about the possible use of NA roles to substitute for registered nursing roles in times of workforce shortages and the potential impact of this on the quality of care and patient outcomes. Kessler et al (2020) note that NAs in their case study were completing initial assessment and care planning in the district nursing teams despite the NMC being clear that registered nurses will take the lead on assessment, planning and evaluation (West 2019) with NAs contributing to (but not leading) these aspects of care (Nursing and Midwifery Council 2018b). These concerns about clarity in scope of practice have been noted in other research relating to NAs (Lucas et al 2021). The prospect of role boundaries becoming blurred is likely to increase in community contexts, where teams are under increased pressure; something we know is a particular concern in UK community nursing contexts (Queens Nursing Institute 2019). Again though, this work by Kessler et al (2020) does not explore similar concerns about the NA scope of practice and possible blurring of roles within the primary care and social care sector and such research seems long overdue.

Research by Traverse (2019a; 2019b), which involved interviews with NAs, practice managers and practice nurses in primary care and with NAs, care home managers and clinical educators in social care, suggests that the motivations of employers and trainees to invest in and commence NA training in these sectors were similar to those noted across wider groups of TNAs (Vanson and Bidey 2019; King et al 2020). These motivations included career progression, the ability to 'earn and learn' in a local setting making training financially and practically viable, a desire to do more to assist RNs, improved deployment of skills across teams and, ultimately, improved patient care. This same interview work by Traverse (2019a; 2019b) also suggests that the training helps primary and social care NAs become more person-centred and less task focused than they might have been in previous health care assistant roles and that they have increased skills in supporting patients to self-manage. It further highlights how their expanded role can free up registered nurses' time, including that of practice nurses, to engage in more complex work with patients and their relatives and carers. It also demonstrates how NAs could improve continuity of care in nursing and care homes, when their inclusion in the staff rota could lead to fewer ad hoc agency and temporary staff being deployed.

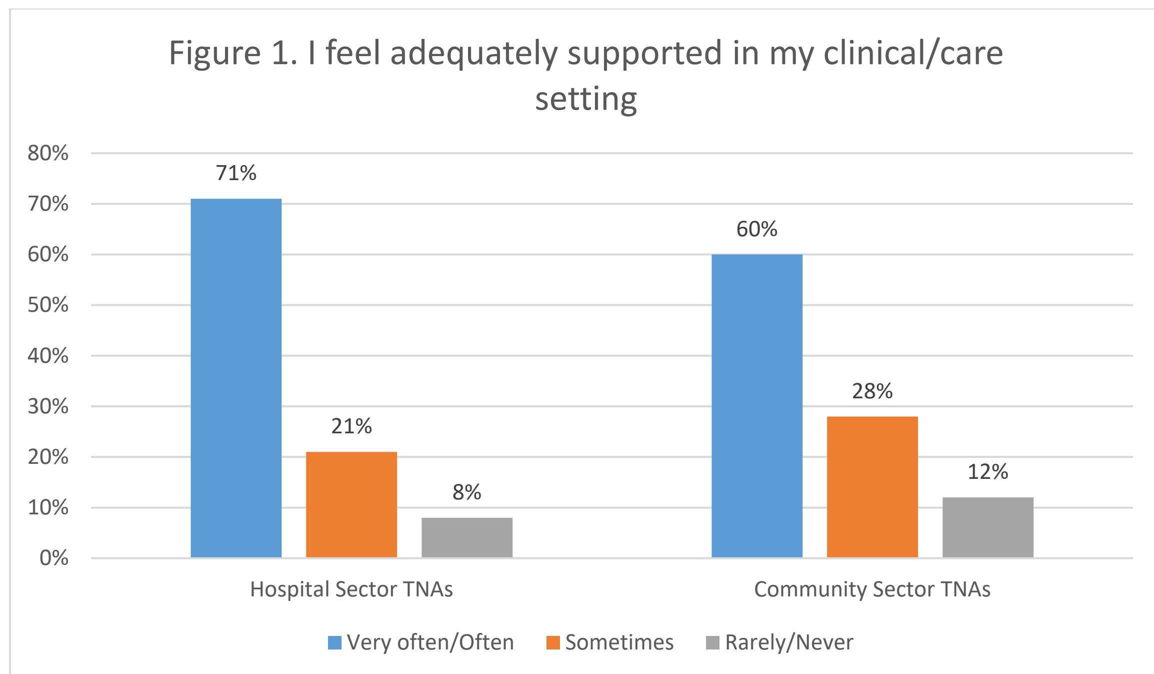
However, concerns remain that expectations of the scope of practice of NAs may go beyond that which may be considered safe for patients and staff in community and primary care settings. For example, work in social care (Traverse 2019b) has suggested that, on qualifying, many NAs move into leadership roles including "running shifts in a nursing capacity" and handling tasks such as disciplinary meetings (p.6). Such work may fall within a NAs sphere of practice if they are suitably trained and supported. However, concerns have been raised, particularly within primary care, about the ad hoc nature of support and training for nursing staff and how general practice can represent a 'risky choice' for newly qualified nurses (HEE 2016; Ipsos Mori Research 2016). Similar concerns about limited clinical oversight and training opportunities, alongside concerns about poor general management, have been identified by nurses working in the care home sector (RCN 2012). These issues will potentially impact NAs in these sectors and might be compounded by the lower numbers of NAs in these settings making the role less clearly understood and peer support less readily available. In short, NAs and TNAs in these sectors are often more isolated and such situations could leave trainee and qualified NAs, and those responsible for their supervision, professionally vulnerable and more uncertain about professional boundaries.

**Emerging findings from recent work**

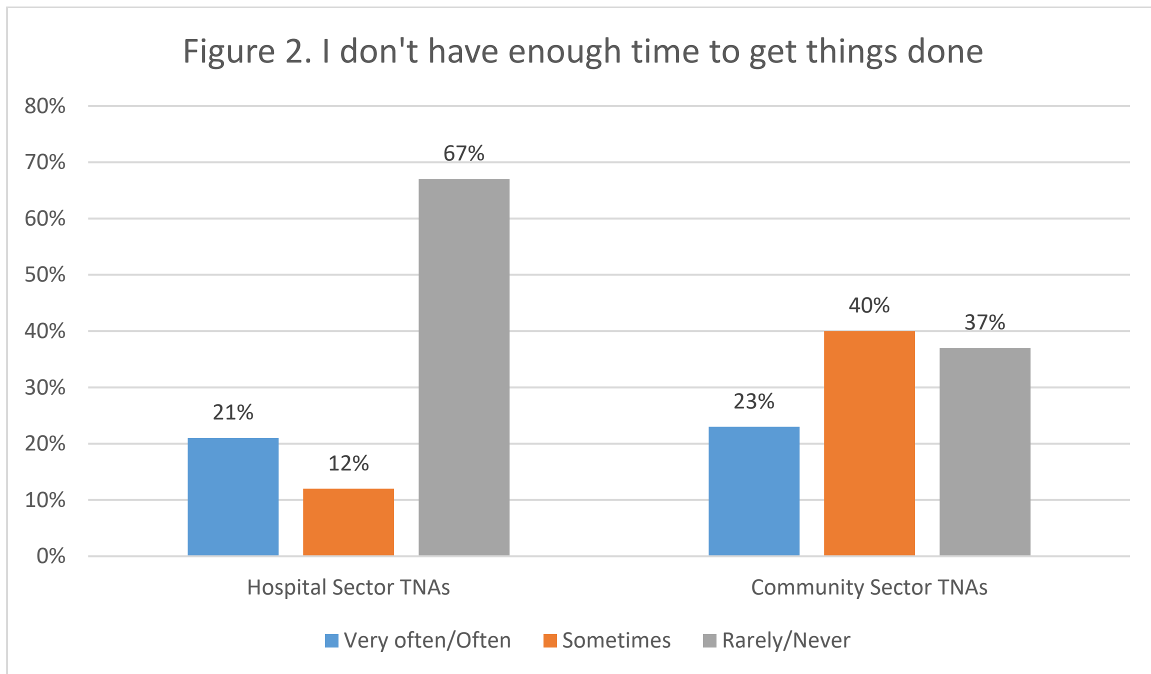
We are currently undertaking a programme of research which explores the motivations, experiences and career aspirations of TNAs. The programme has several elements of data collection with TNAs and with others involved or invested in the TNA programme. Recent survey work we have conducted within this programme with a small research cohort of sixty-four TNAs from across England, highlights some interesting similarities and differences between those based in hospital and community settings (participants in community settings involved a mix of TNAs and NAs working in general practice, district and community nursing teams, children's community nursing teams, mental health and social care). This data was collected during the early part of the Covid-19 pandemic. Recruitment of participants was facilitated through 7 universities that train NAs and by social media outlets. Data demonstrated that participants across all sectors raised concerns in relation to; the supply of personal protective equipment (PPE), being moved to different clinical settings and to whether action was taken when concerns were raised. However, some significant differences were also highlighted between those in hospital settings and those from the community sector. Community-based participants felt less prepared in relation to staff numbers, felt less safe at work,

had a higher rate of working more overtime than normal and felt less likely to have sufficient time to complete their work than those working in the hospital sector (Blinded for review).

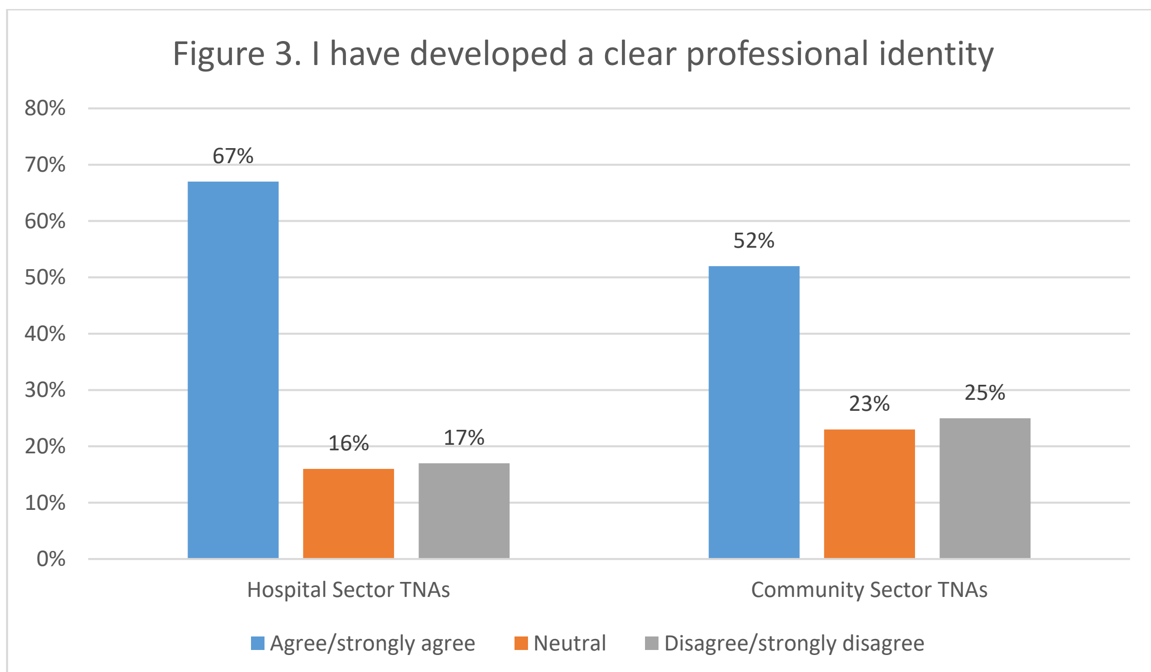
Further evidence, previously unpublished, from this same cohort highlights that those in the community sector reported lower levels of support at work than their hospital sector colleagues. Only 60% responded that they often or very often felt adequately supported compared to 71% of their hospital sector peers (Figure 1.).




Perhaps linked to this issue of support, participants from the community sector were also more likely to report not having sufficient time to get work finished. While 67% of hospital sector participants reported that they never or rarely lacked the time to get things done only 37% of those in the community sector reported this (Figure 2.).



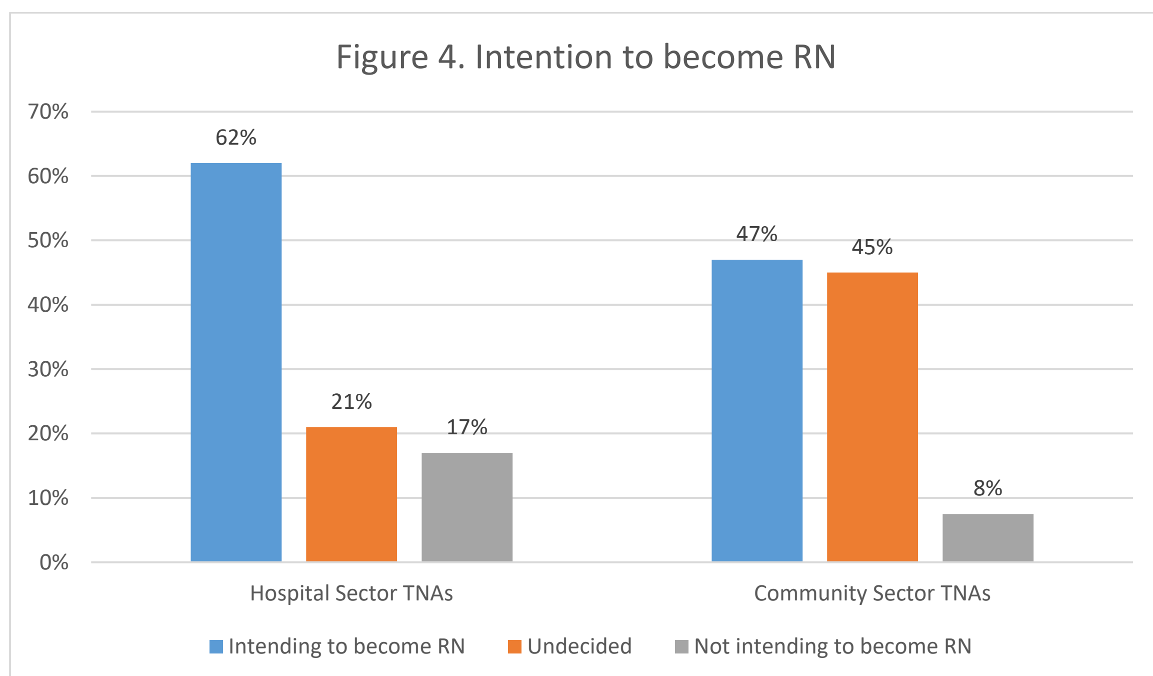

There were also differences in terms of professional identity between those in the community sector compared to their hospital sector colleagues. Those from the community identified themselves as being less sure of their professional identity. More participants from the hospital care sector agreed or strongly agreed that they had developed a clear professional identity; 67% compared to 52% from the community (Figure 3.).




While a degree of uncertainty around professional identity is to be expected when any new role is being established (Wakefield et al 2010), and has been noted among NAs (King et al 2020), why this should be more so for NAs in the community sector remains unclear. It is possible that this is because, until recently, more TNAs (and now NAs) have been trained and employed within the

hospital sector and the role in that setting is therefore better understood. However, this issue would benefit from more research.

Future career intentions also differed (Figure 4.). Those trainee and qualified NAs from the community sector showed less intention to go on to complete registered nurse training (47% compared to 63% from the hospital sector). However, very few stated that they fully intended to remain as an NA (7% compared to 17% from the hospital sector) and many more were undecided on their career path (45% compared to 21% from the hospital sector). This greater uncertainty may have particular implications for workforce planning within smaller community care employers, where NAs have been supported through their training, but then may not remain. It is of course possible that this uncertainty reflects wider feelings of discontent and exhaustion that have been identified in the community nursing context, leading to problems of recruitment and retention (Queens Nursing Institute 2019) and that have been exacerbated by the Covid-19 pandemic (Green et al 2020).




Furthermore, early findings from interviews with university stakeholders that we have recently conducted are highlighting some issues about the learning experiences of TNAs from the community sector. These include concerns around the organisation and availability of placements, opportunities for peer support, and the precariousness of access to practice-based assessors in small settings (like GP surgeries and care homes) that may only have one trained assessor - though many such sites are members of larger primary care networks, and supported by training hubs (Health Education England 2021) which can act to minimise this precarious access to practice assessors and reduce isolation from peers. We hope to complete this analysis and publish this work shortly.

Some caution should be taken in relation to what can be inferred from these previously unpublished findings because of the small sample size and a lack of analysis to determine whether the differences noted are statistically significant. They nevertheless raise some interesting issues that could form the focus of future research. It is also important to note that evidence included in this overview was collected both before and during the Covid-19 pandemic and the emerging data presented was collected during the pandemic. This obviously has implications in terms of both how community-

based NAs might be deployed and utilised and in terms of the placement opportunities available for TNAs.

**Implications for practice**

This overview of evidence has potential implications for practice. Clearly there are specific challenges related to embedding the NA role in community settings. It is important for those involved in workforce planning to understand the scope of NA practice and to have a clear vision for how NAs will fit in the broader healthcare team. For managers, it is important to engage in conversations with healthcare assistants about their aspirations for career progression, and if motivated, to harness this opportunity for development. You may also want to talk to appropriate staff about becoming workplace assessors for TNAs, or become an assessor yourself, in anticipation of having TNAs within your workplace. All employers that provide a base placement for TNA apprentices must ensure they have trained assessors.

If you do already have NAs within your setting you may wish to consider whether they feel adequately supported. Asking about this could specifically be built into appraisal or development conversations. Similarly, given the level of uncertainty in terms of career paths reported here, discussions around career development and progression could also become a regular part of on-going appraisal processes if it is not already.

Specific work could also be done on raising awareness of the NA role and particularly on what the boundaries and appropriate expectations of the role are. This could be done with support from existing NAs working in the primary, community or social care context who could bring in real life examples alongside professional standards (Nursing and Midwifery Council, 2018b). Such work would not only help to inform the wider team about the NA role but could also help consolidate the NAs own sense of professional identity.

**Concluding thoughts**

This overview paper outlines the current evidence about the NA role in community care and primary care contexts. The NA role is now becoming more embedded within community health and social care settings where, until recently, it has been slightly slower to implement compared to hospital care settings.

Early research has started to show the benefits of incorporating this new level of practice within the primary care and social care sectors. These include a shift toward more person-centred care, increased skills in supporting patients to self-manage, freeing up registered nurses time and improving continuity of care. However, there are challenges that remain. The more isolated nature of nursing within these settings can leave NAs (and TNAs) more vulnerable. Having greater awareness of the role and absolute clarity in terms of agreed and acceptable standards and scope of practice will be crucial going forward to reduce any risks to patients and staff while ensuring high quality care.

In addition, early career planning between the employer and NAs/TNAs in community and primary care settings could help ensure that expectations are more aligned and workforce planning is maximised in ways that help recruitment and retention of NAs. In primary care, such planning could fit well alongside the ten point plan for delivering the general practice nursing workforce of the future (Health Education England 2016).

Finally, concerns that are being expressed in relation to the training experiences of nursing associates from this sector would benefit from further solution-focused research.

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