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Robertson, S. orcid.org/0000-0002-5683-363X, King, R., Taylor, B. et al. (5 more authors) (2023) Trainee nursing associates in England: A multisite qualitative study of higher education institution perspectives. International Nursing Review. ISSN 0020-8132

https://doi.org/10.1111/inr.12868

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Received: 16 January 2023 | Accepted: 14 July 2023

DOI: 10.1111/inr.12868

International Nursing Review WILEY

ORIGINAL ARTICLE

Trainee nursing associates in England: A multisite qualitative study of higher education institution perspectives

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Abstract

Aim: To explore the experiences of university employees on the development and implementation of the nursing associate programme.

Background: As part of wider policy initiatives to address workforce shortages, provide progression for healthcare assistants and offer alternative routes into nursing, England recently introduced the nursing associate level of practice. Little research has yet considered university perspectives on this new programme.

Methods: An exploratory qualitative study reported following COREQ criteria. Twenty-seven university staff working with trainee nursing associates in five universities across England were recruited. Data, collected via semi-structured interviews from June to September 2021, were analysed through a combined framework and thematic analysis.

Results: Three themes developed: 'Centrality of partnerships' considered partnerships between employers and universities and changing power dynamics. 'Adapting for support' included responding to new requirements and changing pedagogical approaches. 'Negotiating identity' highlighted the university's role in advocacy and helping trainees develop a student identity.

Conclusions: Nursing associate training in England has changed the dynamics between universities and healthcare employers, shifting learners' identity more to 'employee' rather than 'student'. Universities have adapted to support trainees in meeting academic and professional standards whilst also meeting employer expectations. While challenges remain, the ability of nurse educators to make adjustments, alongside their commitment to quality educational delivery, is helping establish this new training programme and thereby meet government policy initiatives.

Implications for nursing policy: The international movement of apprenticeship models in universities has the potential to change the status of the learner in nursing educational contexts. National policies that encourage this model should ensure that the implications and challenges this change of status brings to learners, employers and education institutions are fully considered prior to their implementation.

KEYWORDS
education nursing, health workforce, nursing associates, second-level nursing, staffing, United Kingdom

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INTRODUCTION

Nurses are recognised by the World Health Organization as making a central contribution to national and global targets to a range of health priorities; however, the global shortage of nurses is well documented (World Health Organization, 2020). This shortage has been recognised in the United Kingdom where, in England alone, there were 43,619 registered nurse job vacancies in December 2022 (NHS Digital et al., 2023).

In England, one solution to this staffing shortage has been to implement a policy introducing a new second-level nursing qualification—the nursing associate (NA). This new level has a status and function similar to 'Licensed Practical Nurses' (LPNs) in North America and Finland, and 'Enrolled Nurses' (ENs) in Australia, New Zealand, South Africa and several European countries. Research with diploma EN course coordinators from Australia (Jacob et al., 2016) suggested that changes introduced to education when moving to diploma level resulted in many similarities between the roles of ENs and registered nurses (RNs), often leading to organisational confusion about the extent of the scope of EN practice and restricting ENs abilities to fully utilise their skills. McKenna et al. (2019) highlighted similar confusion about EN scope of practice among ENs themselves in Australia after new national competency standards were introduced in 2002. Similar role confusion between RNs and LPNs has been noted in Finland (Lavander et al., 2018) and in the United States (Lankshear et al., 2016). Such international evidence regarding this level of practice has implications when considering how policy on the introduction of such a new role might be implemented in ways that can help mitigate these issues.

In England, this new level of NA practice was recommended following the Shape of Caring review (Health Education England 2015, 2015), which considered the career and training needs of healthcare assistants (HCAs) and RNs. In the UK, HCAs provide fundamental patient care, such as assisting with hygiene, mobility, and monitoring of vital signs, and work under the instruction of RNs. Several policy assumptions underpinned this new level of practice, including facilitating the career development of HCAs, filling an identified skills gap between HCAs and RNs and providing another route to becoming an RN.

Training for NAs is completed over two years, using a work-based learning model that requires employer and Higher Education Institution (HEI) partnerships (Attenborough et al., 2020). Pilot training sites commenced in 2017 with the first NAs qualifying and joining the workforce in 2019. Successful trainees enter onto a newly formed part of the Nursing and Midwifery Council (NMC) register (the NMC is responsible for regulating the nursing profession in the UK).

In line with international and UK government policy trends to expand higher-level apprenticeships (Hughes & Saieva, 2020; National Centre for Vocational Education Research, 2019), from 2018, NA cohorts are funded mainly through an apprenticeship model; a collaborative arrangement between employers and training providers where learners spend the majority of time learning in the workplace (Hughes & Saieva, 2020). This has important implications. First, it means trainees are clinically based employees, with time release from the workplace for university study (equivalent to one day a week) and for alternative placements. In this sense, NA training differs from second-level nurse training in North America, Australia and New Zealand, where trainees are students, not employees. Second, apprenticeships have specific Education and Skills Funding Agency requirements to be met in addition to the academic and NMC standards for NA training programmes (NMC et al., 2018). This creates multiple layers of assessment that students, HEIs and employers administer and adhere to.

There is an emerging body of research considering the perspectives and experiences of trainee NAs (e.g. Coghill et al., 2018; Kessler et al., 2021a; King et al., 2020; Vanson & Bidey, 2019) and employer stakeholder perspectives (e.g. Lucas et al., 2021; Kessler et al., 2020, 2021b; Robertson et al., 2022a). However, despite the educational complexities this new level of practice brings, there has been only limited research, reviewed below, on HEI perspectives and experiences of developing and delivering this new training programme. It is this research gap, this missing piece of the picture, that this paper begins to address.

BACKGROUND LITERATURE

While many trainee NAs already have considerable clinical experience, often gained through working as HCAs, they have been shown to encounter significant academic challenges. These are mainly related to being older than most UK university students, with more personal time demands such as childcare and family life, and limited prior educational experience (Coghill et al., 2018; Kessler et al., 2021a; King et al., 2020). Despite this, a longitudinal qualitative study tracking the work-based experiences of NAs training at an HEI in London suggests university learning was highly regarded and that there was a good fit between the academic programme and trainee NAs garnering knowledge to improve patient care in clinical settings (Attenborough et al., 2020).

The national evaluation of the pilot NA programme (Vanson & Bidey, 2019), which combined surveys, interviews and analysis of programme data, included HEI stakeholders. This evaluation showed the policy timeframe for developing the NA training curriculum had been very demanding. Consequently, HEIs amended existing curricula and programmes and/or formed strong partnerships to make required changes and run the pilot to meet policy implementation deadlines. The evaluation also highlighted diversity in trainee placement models and in how responsibility for placement organisation was negotiated between HEIs and employers. Finally, it recognised early adaptations HEIs made in meeting the learning needs of trainees. This included pre-course preparation, initial personal tutor interviews and assessment, signposting to additional support, and maintaining regular communication with the trainees when in their workplace and on placements.

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In a similar way, Taylor and Flaherty's (2020) case study provides an in-depth description of how one HEI engaged with the new issue of degree apprenticeships. They highlight complexities around higher degree apprenticeship delivery and the pedagogical innovations used to meet demands within their NA programme. These innovations reflect those noted by Vanson and Bidey (2019) but also include greater emphasis on early study skills development, a focus on integrating practice to theory, a shift from didactic content delivery to more interactive learning, and the production of a user-friendly online learning platform.

Ensuring that innovative approaches and new curricula meet required standards and expectations is challenging for HEIs. Roulston and Davies (2019) describe developing a medicines management module for trainee NAs. They highlight how limited guidance from the NMC at this time, combined with the need to satisfy multiple standards and stakeholder demands, created challenges. To address these, the authors suggest strong collaborations are required between students, employers and HEIs to help align shared outcomes and to ensure the transition of learning into practice.

The above studies provide useful insights into HEI perspectives on implementing NA apprenticeship policy during the development and delivery of the NA programme. However, the majority of these studies were completed during the pilot and early phases of NA programme implementation and were single HEI-site studies.

AIM

To explore the experiences and perspectives of those working in the HEI sector on the development and implementation of the NA training programme as it continues to embed within the healthcare sector in England.

METHODS

This section is reported according to the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007).

Study design

A descriptive, exploratory design within a qualitative interpretive framework was employed. Such approaches are appropriate when ascertaining people's experiences, perspectives and the meaning attached to these (Seale et al., 2018).

Participant selection

HEI participants were recruited through combined purposive and convenience sampling. They were purposively sampled to ensure geographical diversity across England and diversity of HEI programme structure and delivery. The convenience aspect involved initial contact with identified HEIs being made by the Head of Department in the University where the research team are based via their involvement in a national UK network of universities engaged in nursing education. The intent was to recruit a range of HEI staff involved at various levels with trainee NA programmes.

After an initial email introduction to senior academics in six HEIs, a research team member explained the study to this contact person. The contact person then provided all HEI staff involved in all levels of the NA programme with the invitation to participate and with the information sheet developed by the research team. This initial contact person from each university had no further involvement in the study and was not aware which, if any, members of staff subsequently participated. One HEI that showed initial interest did not respond to subsequent contact. Twenty-seven staff from five universities across England (two in the North East, one in the Midlands, one in the North West and one in the South East) agreed to participate and provided written consent (Table 1). All participants were given an identifier to aid anonymity.

Relationship with participants

The research team was based at a participating HEI, so some participants were known to research team members. However, these were not close working relationships. One research team member also previously worked at another participating HEI, but only one participant was known to that team member and this was not a close working relationship.

Data collection

The team drew on the limited existing literature, and their research experience of the NA programme (King et al., 2020, 2022a, 2022b; Robertson et al., 2022a, 2022b), to develop a semi-structured interview schedule. This schedule covered the following topic areas:

- Motivation, drivers and recruitment into the programme
- Training challenges and adaptations to meet these
- Clinical and placement concerns
- Career progression

There were two further topic areas with specific questions related to the COVID-19 pandemic and to trainee NAs from independent sector employers. These data will be considered in separate papers.

One-to-one interviews took place between June and September 2021 and were conducted by either RK or SR. Due to COVID-19, interviews were conducted using an online platform and were recorded. Video recordings were converted to MP3 audio files prior to transcription and data were stored in the university's secure drive. Interviews lasted 28–66 minutes (mean 48 minutes), and brief, reflexive, field notes were made following interviews.

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TABLE 1 Sample for England-wide HEI stakeholder interviews.

Identifier	Participants role
University 1	
HEI1_S1	Senior management/leadership team TNA Programme
HEI1_S2	Senior management/leadership team TNA Programme
HEI1_S3	Senior management/leadership team Department of Nursing
HEI1_S4	Senior management/leadership team Department of Nursing
HEI1_S5	Senior management/leadership team TNA Programme
University 2	
HEI2_S1	Senior management/leadership team TNA Programme
HEI2_S2	Lecturer
HEI2_S3	Lecturer
HEI2_S4	Senior management/leadership team Department of Nursing
HEI2_S5	Senior management/leadership team TNA Programme
University 3	
HEI3_S1	Associate Professor
HEI3_S2	Associate Professor
HEI3_S3	Lecturer
HEI3_S4	Lecturer
HEI3_S5	Senior management/leadership team TNA Programme
University 4	
HEI4_S1	Senior management/leadership team TNA Programme
HEI4_S2	Senior Lecturer
HEI4_S3	Teaching Fellow
HEI4_S4	Senior management/leadership team Department of Nursing
HEI4_S5	Senior management /leadership team TNA Programme
HEI4_S6	Senior management /leadership team TNA Programme
University 5	
HEI5_S1	Senior management/leadership team TNA Programme
HEI5_S2	Senior management/leadership team Department of Nursing
HEI5_S3	Senior management/leadership team TNA Programme
HEI5_S4	Clinical Educator
HEI5_S5	Learning Development Facilitator
HEI5_S6	Senior management/leadership team TNA Programme

The concept of 'information power' was applied when considering the adequacy of sample size and data collected (Malterud et al., 2016). Within this framework, our study's relatively broad, exploratory aim would suggest a larger sample is required. However, we emphasised the specificity of experiences, demonstrated a high quality of interview dialogue and utilised an exploratory analysis strategy aimed at presenting selected patterns relevant to the study aim rather than cross-case analysis that attempts to uncover the whole range of phenomena present. These factors all facilitate a smaller sample size while maintaining information power.

Data analysis

Data analysis followed an approach that combined elements of framework analysis (Ritchie & Lewis, 2003) and reflexive thematic analysis (Braun & Clarke, 2019). As noted by Gale et al. (2013), the framework method sits within the broad method of qualitative analysis termed 'thematic analysis'. The more structured approach offered by framework analysis allowed the research team to produce an initial descriptive overview of the data set that was mindful of the previous evidence that generated the topic schedule areas noted above. However, we also wished to consider 'stories about particular patterns of shared meaning across the data set' (Braun & Clarke, 2019, p. 592), to take a more reflexive view of this initial descriptive overview. We therefore incorporated a second level of analysis, using reflexive thematic analysis (Braun & Clarke, 2019). This enabled a creative approach that incorporated both semantic and latent level coding and categorising within and across the initial frame. This process was conducted as follows.

After transferring data into Quirkos© software to assist data management, one author (SR) read through interviews and began coding and categorising data, initially using the topic schedule as a framework. This early reading, coding and categorisation was considered by two other team members (RK and SL) before a second level of analysis was conducted by SR where coding and categorisation progressed reflexively to more closely consider the meanings embedded within responses. Following two further rounds of iterative discussion between these three team members, minor recategorisations were made and final themes developed and agreed. Themes were then sense-checked with the whole research team. Further critical interpretations of data within these themes were completed during the production of this paper as findings were integrated with previous research and policy.

Rigour

Rigour was maintained in the study through several processes, most of which are noted above. These include regular team check-in (peer debriefing) throughout all stages of the study, sampling for geographical and HEI staff role diversity, iterative reading and analysis of data by several members of the research team (both individually and collectively), transparency of the research process and self-critical reflection (achieved partly through regular research team check-ins) during data collection and analysis phases.

Ethics

Prior to study commencement, ethics approval was granted by the University of Sheffield Ethics Committee (Ref: 026355). The principles outlined in the Declaration of Helsinki (World Medical Association, 2018) were followed. Informed consent was gained and participants were made aware they could

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TABLE 2 Theme and sub-theme outline.

Theme	Sub-themes
The centrality of partnership working	• Nature and length of partnerships • Ability of partnerships to help problem solve • Negotiating in partnerships • Power dynamics and responsibility in partnerships
Adapting to provide sufficient support	• Adapting in response to apprenticeship requirements • Adapting pedagogical approaches
Negotiating identity	• Advocating to assist understanding • Helping generate a student identity • Personal satisfaction in supporting this new pedagogical development

withdraw at any time. University processes, linked to General Data Protection Regulation requirements, were adhered to throughout to ensure the security of data and personal information.

RESULTS

Three themes resulted from the analysis: the centrality of partnership working, adapting to provide sufficient support and negotiating identity (Table 2).

The centrality of partnership working

Participants described the relationship with employers as a journey they had been on together to develop and implement the NA programme. Given the employer-led nature of these training apprenticeships, this relationship was different for HEIs and was made easier when robust preexisting partnerships were present. Conversely, partnerships that were newer, particularly those with smaller, independent sector employers (such as care homes and general practice), often proved more difficult:

> 'Relationships were established in the original pilot partnership that meant there was real harmony for the key stakeholders involved in the development, a real will to make it succeed. Those relationships continue and are very strong.' (HEI1, S4)

> 'It's tricky, there are certain elements reluctant to get involved in the monthly meetings we have about students. The care homes and social care sector are the ones less likely to engage with us. But the larger employers, the biggest Trusts, are very engaged.' (HEI3, S5)

The HEIs were generally managing multiple partnerships with employers. Good partnerships helped resolve practical difficulties, particularly around the complex issue of organising alternative placement experiences, or trainees obtaining required clinical competencies.

However, to ensure maximum use of placement capacity within regions, arranging alternative placements also required cooperation and coordination between different employers. This could create difficulties and HEI participants highlighted how they sometimes had to act as negotiators when such cooperation, and therefore meeting trainee requirements, was put at risk:

> 'I have seen partner employers at [placement] meetings coming out, not quite aggressive, but snappish, and saying to them "this process is not easy" … And working together with them saying, "We understand, if this is your need, but it's not the other employer's need, we need to somehow come somewhere in the middle of this."' (HEI4, S5)

Fundamentally, participants had to realise a new way of partnership working as HEIs were no longer the main determining factor in student/trainee experience; the employer now has a greater say. However, HEIs retain most of the responsibility for ensuring trainees meet all the requirements for both their academic course and their apprenticeship. This new relationship took time to establish within this new context, but participants identified the effort that was required to work across HEI and healthcare provider boundaries:

> 'The biggest change for me was changing the balance of power. As the main provider of nurse education, we have the power essentially with traditional nursing students. That has completely changed [with the NA programme]. Essentially, we are now 20 per cent of the programme, the rest is employer-led, they're the ones telling us what needs to happen … I've worked really hard getting the relationship to a point where it's equal, where we've got one common goal. That's taken a lot of effort to agree a mutual way forward.' (HEI3, S5)

To reach these common goals for the benefit of all concerned, not least the trainee, required a change of mindset and the adaptation of existing processes and approaches.

Adapting to provide sufficient support

All participants spoke of making adaptations to successfully implement this new NA programme and the effort involved in this. Much related to becoming familiar with apprenticeship requirements, overseen by the Office for Standards in Education, Children's Services and Skills (Ofsted), as these were new to most participants. Prior to the

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introduction of apprenticeship opportunities in UK universities, the work of Ofsted was typically associated with school and college education providers for those under 18 years old. Most HEIs developed dedicated posts or departments to assist with this new inspectorate, often facilitating staff to develop specific apprenticeship expertise and confidence alongside new organisation of work:

> 'The work's divided up within the nursing team, we have a separate group of lecturers involved in apprenticeship delivery. We'll have in-depth expertise about the apprenticeship delivery … there's a group of us that just deal with quality assurance for apprenticeships and for Ofsted.' (HEI2, S3)

Tripartite meetings between employer, HEI and trainees, an apprenticeship requirement, created additional time demands for HEI staff. However, alongside link roles that bridged between the employer and HEIs, they were noted as being significant for ensuring consistency and supporting trainees in their clinical settings:

> 'The obvious support is the tripartite process, part of the Ofsted regulation. Meetings with the stakeholder, the academic advisor, and the student. They work really well because the student feels part of a group. … They make sure everybody's singing from the same hymn sheet.' (HEI2, S3)

Alongside adapting university systems and processes to meet apprenticeship requirements, it was suggested that trainee NAs represented a different type of student; they were often older than those entering RN training, and many had not studied since leaving school, often at 16 years of age. Because of trainees' limited prior academic experience, this required adjustments to pedagogical approaches. Participants spoke about needing greater emphasis on basic academic skills, referencing, revision, basic note taking and developing confidence. However, it was also important that approaches recognised the maturity and practical experience these trainees bring to their learning. This balance was not always easy to achieve:

> 'It's very different teaching. You don't talk at them, you have a conversation. They will take no prisoners. If they feel that you're not giving them an explanation or an answer, or don't relate it to practice, they'll rip you to shreds, without a shadow of a doubt.' (HEI1, S1)

These changing partner relations, and necessary practical adaptations, challenged aspects of the previous HEI approach to nurse training compelling participants to reflect on matters of identity.

Negotiating identity

Participants noted how developing a new level of nursing practice, through an adapted training model (apprenticeships), required forging new identities for themselves. To help this, participants often had to advocate on behalf of NA trainees to assist employers in understanding training requirements and help placement areas adapt to the parameters of this new level of practice to ensure patient safety:

> 'They [employers] underestimate the input required to support apprentices and the commitment they have to make. One thing we see, when times get busy, it's, "Well, I need you to come and do this today." "But I'm on a placement day." "Well, you're just going to have to come and do it because we employ you." That's a difficult, challenging, situation to address with employers and to overcome.' (HEI3, S2)

> "We've helped [employers] see what that role is, and they've helped us to see what isn't working. "Are they allowed to do this?" And we keep banging it into everybody, they have a scope of practice. They have a scope of practice. They have to be supervised by a registered nurse. If they've not been taught it, you cannot do it." (HEI4, S5)

Given the employer-led nature of NA training, and the prior work experience and age of many trainees, HEIs worked hard to help trainees develop a student identity. This sometimes required a renegotiation or reconsideration of the professional identity and skills NAs previously held:

> 'With the NAs, a lot came into the course doing lots of clinical skills, which nursing students wouldn't do; cannulation, venepuncture, catheterising, etc. Then, suddenly they're on the course and they can't do that. They're having to do training to say they can do what they've been doing for years. That was quite a challenge for some.' (HEI2, S1)

Despite the challenges noted, most participants reported personal pleasure in assisting learning, widening participation, and helping individuals who commenced training at a different level than they were used to with most RN students who commence training immediately following their high school education. They took particular gratification in working with trainees who would not previously have had the opportunity to progress:

> 'For me that's been a joy, seeing people grow. You see people who might have been dyslexic, they may not have been given time in school, or not

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> felt worthy, and they might be the first in their family to go to university. And I like that, I like nurturing these students and saying look how far you've come.' (HEI5, S3)

DISCUSSION

This study sought to explore the experiences and perspectives of those in the HEI sector on the development and implementation of training for a new level of nursing practice in England; the nursing associate. The learning approach within the NA programme links to wider policy drives to integrate vocational training and higher-level qualifications to meet changing healthcare workforce needs both in the UK and beyond; for example, in the United States (Decker et al., 2019) and Australia (National Centre for Vocational Education Research, 2019). Yet, such integration is not without its problems in relation to partnerships, processes and identity formation.

Nurse training, internationally, has always required strong partnerships between HEIs and healthcare providers to ensure adequate practical experiences and competencies are acquired and our first findings theme reinforces this. The apprenticeship model, chosen to enact the policy introducing the NA role, follows the principle of being led by employer workforce needs and requirements (McEwan et al., 2019). Trainees are employed and spend most of their time in the workplace with only 6 hours being off-the-job, university-based, training (Powell, 2020). This stands in contrast to previous (and still existing) nurse training programmes in the UK, and in most economically developed countries, where training is led by the education sector, and partnerships with healthcare employers are required for trainees to obtain the necessary number of practice hours to meet standards for qualification. NA apprenticeship training has therefore shifted partnership dynamics between HEIs and employers in ways that HEIs were not sufficiently prepared for (Vanson & Bidey, 2019).

The implementation of this policy using this new model of NA apprenticeship training, requires both employer and HEI partners to be clear about their roles and responsibilities in order to adequately support trainees and ensure high-quality patient care. Work exploring the introduction of the NA programme (Kessler et al., 2020) shows it can strengthen existing local partnerships. However, our findings further demonstrate that this can come at a cost for HEI staff; ensuring new training requirements are embedded in clinical settings involves staff investing significant time assisting employer partners to understand these new requirements and thereby ensuring trainee progression. HEI staff were often having to engage in emotional labour to advocate for trainees, acting as negotiators between various partners, to help ensure sufficient opportunities and competencies, and therefore required outcomes, could be met. These problems are often compounded within the NA programme where HEIs have to manage multiple and new partnerships, such as those with primary care, where less established relationships, and more restricted resources, create particular challenges and solutions from the HEI staff. We discuss trainee NAs in primary care in more detail in a separate paper (Robertson et al., 2023).

The pursuit of a policy aimed at increasing vocational training into HEIs under an apprenticeship model requires new structures and processes; that is, it requires adaptation as noted in our second findings theme. In line with previous research on the NA programme (e.g. Coghill et al., 2018; Vanson & Bidey, 2019), our participants felt unsure about the unfamiliar Ofsted standards and overwhelmed by the bureaucracy and multiple requirements that these bring alongside the familiar NMC and academic requirements. In apprenticeship programmes outside healthcare, Mulkeen et al. (2019) highlight how university administrative systems are 'playing catch-up' (p. 343) with apprenticeship requirements, and Martin et al. (2020) note similar feelings among HEI staff of being overwhelmed and inundated with bureaucracy but identify additional concerns about staff feeling pressured to be involved with apprenticeship programmes. Their participants reported 'being compelled' and 'drafted in' to deliver apprenticeship training, and while such decisions were recognised as being driven by institutional pressures, they nevertheless required staff to redefine their academic identity and what constituted a 'proper academic' in a vocational teaching context (Martin et al., 2020). The NA programme clearly generates a policy platform for widening participation in nursing (Coghill et al., 2018; King et al., 2020). In line with other apprenticeships in England (Oldridge & Booth, 2022), trainee NAs are often older and bring considerable life and clinical work experience into the HEI. Harnessing this experience, while acknowledging their often limited confidence in academic skills, requires innovation and change to the pedagogical approaches and processes used for nursing students who commence training immediately following their high school education. Despite these challenges, our findings emphasise the commitment and desire of HEI staff to make this new type of employer-led learning work by advocating for NAs in their clinical settings and adjusting learning approaches to achieve high-quality training and education.

Previous research highlights how a policy that seeks to integrate apprenticeships into higher education can create a culture clash and a challenge to existing pedagogical identity (Graham et al., 2019; Martin et al., 2020). Our findings, detailed under our third theme, concur with this viewpoint. This programme has required a shift from previously existing nurse training models in the UK, and other countries, where learning is led from HEIs. The identification of NA learners as employees in training, rather than students on placement, has implications for HEIs and trainees, particularly when clinical areas are busy. In such situations, learning can become secondary to the provision of care (Robertson et al., 2022a), student identity can be lost as HEI contact is more arms-length (Bishop & Hordern, 2017; Mulkeen et al., 2019), and the scope of practice of trainees can be stretched. While such uncertainty around the scope of practice for practical nurses and ENs has been identified in other countries (Lankshear et al., 2016; McKenna et al.,

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2019), our findings demonstrate the important role HEI staff can play in these situations in advocating for the trainees, and communicating with employer partners, to help ensure safe and effective care. Nurse educators in Australia experienced similar challenges when EN training became diploma level. This created uncertainty among healthcare employers about advances in EN skills and some resistance to change in organisational policies to accommodate the increased scope of EN practice (Jacob et al., 2016). They suggest that part of this organisational uncertainty and resistance is due to the limited exposure of clinical staff to these changes in EN education. The workplace-based nature of the NA apprenticeship programme ought to provide more rapid exposure of clinical staff to the new training requirements and scope of practice of NAs. However, evidence from a survey conducted in late 2020 (Kessler et al., 2021b) showed that well over half of the organisations expressed ongoing uncertainty in relation to the scope of NA practice and their place in the clinical team.

Limitations

There are limitations to this study. Data collection was limited to five HEIs and may not, therefore, cover all issues and solutions that have occurred when developing and implementing the NA programme across England. Nevertheless, the geographical and training model diversity obtained through the purposive sample ensures that some patterns and similarities can be identified across the HEI sector. In this sense, our work moves beyond most previous research that focuses on NA trainee concerns within single HEIs.

IMPLICATIONS FOR NURSING AND HEALTH POLICY

A level of nursing practice that bridges the skills and knowledge gap between healthcare assistants and RNs, although known by different names, is common in the healthcare systems of many economically developed countries. This study allowed consideration of how a policy that led to the new development and implementation of such a role in England, the NA, is perceived from the HEI perspective. As such our work contributes to debates about the nature of these 'new' roles and their implementation at an international level. The challenges identified reiterate the point made in a recent review of UK degree apprenticeships which noted that, even when there are sound policy initiatives, there can be a mismatch between apprenticeship objectives and their implementation (McEwan et al., 2019). Findings highlight how the implementation of new nursing programmes requires national and local policies and guidelines that clarify the expectations and responsibilities of trainees and employers in order to help trainees meet the course requirements and operate within a safe scope of practice. Furthermore, the international movement of higher degree apprenticeships in universities has the potential to change the status of the learner. This has a particular impact in nursing educational contexts when there is a shift of identity from student to employee and learning can become secondary to employer demands when there is a high workload. National policies that encourage apprenticeship approaches generally, and to nurse education specifically, should ensure that the implications and challenges that this change of status brings to learners, employers and education institutions are fully considered prior to policy implementation.

CONCLUSION

This study contributes to previous research on policy requiring the development and implementation of a new level of nursing practice in England by providing a more comprehensive and specific perspective from the HEI sector.

The apprenticeship framework, adopted for developing and implementing the NA programme, places greater emphasis on workplace-based and employer-led training. This changes relationships between HEIs and healthcare employers, shifting the identity of learners to one more closely aligned with that of employee rather than student. To help mitigate some of the challenges this brings, HEIs have found ways to adapt their structures, processes and learning approaches, thereby helping employers understand new training requirements and ensuring that NA trainees are adequately supported in meeting academic, professional and apprenticeship standards alongside employer expectations. These issues are not fully resolved, but the ability of nurse educators to make such adjustments, and their commitment to maintaining quality delivery to learners, means that this training approach is now becoming embedded within HEIs and among the healthcare sector partners that employ NA trainees. Policies that encourage apprenticeship approaches to nursing and healthcare education should ensure that the challenges this approach brings, and examples of how these have been mitigated, are well considered prior to implementing this model.

AUTHOR CONTRIBUTIONS

Funding acquisition: AT and TR. Conceptualisation and study design: SR, RK, BT, EW, MS, AT and TR. Data collection: SR, RK and BT. Data analysis and interpretation: SR, RK, BT, SL and TR. Draft paper preparation: SR, RK, TR and SL. Review, editing and final approval: All authors.

ACKNOWLEDGMENTS

This work was supported by the Royal College of Nursing (RCN) as part of the Strategic Research Alliance between the RCN and the University of Sheffield. The views expressed are those of the authors and not necessarily those of the RCN or University of Sheffield.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

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How to cite this article: Robertson, S., King, R., Taylor, B., Laker, S., Wood, E., Senek, M. et al. (2023) Trainee nursing associates in England: A multisite qualitative study of higher education institution perspectives. *International Nursing Review*, 1–10. https://doi.org/10.1111/inr.12868

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