Clinical Practice

Discussion

Nursing associates

In this article...

● Why the nursing associate role was introduced
● Problems with clarity and definition of the role
● Why the role needs clear boundaries

What does the future hold for the nursing associate role?

Authors

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Abstract

The nursing associate role was proposed as a way of alleviating the nursing shortage in the UK. However, reasons for its development and the role itself were poorly defined and, despite the first nursing associates being on the nursing register for a year, this has yet to be addressed. As a result, employers, nursing associates and other members of the multidisciplinary team are often confused about what the role entails. Nursing associate responsibilities vary between employers and nursing associates are being recruited to replace registered nurse posts, therefore, masking serious staffing issues that put patient safety at risk. We suggest that nursing associates should be encouraged to develop in a role that is more clearly defined and individuals doing the role should not suffer as a result of poor policy making.

Citation


Talking points

Reasons for development of the nursing associate role were poorly defined

There is much confusion about the role among employers, nursing associates and other members of the multidisciplinary team

Replacing registered nurse roles with nursing associates masks staffing issues, which can potentially compromise patient safety

In this year since nursing associates (NAs) joined the Nursing and Midwifery Council (NMC) register and, for some, the reality seems to be a hard one. A role introduced on vague reasonings such as to “bridge the gap between registered nurses [RNs] and support workers” (Health Education England, 2015) was never going to have an easy ride. Su Hickman, a trainee nursing associate and co-author of this article, has written very clearly about the experience of some NAs and trainee NAs with whom she had been in contact, reporting that the role is misunderstood and post holders are open to abuse (Hickman, 2020). This means a poor workplace experience and the ‘leaky bucket’ that is the nursing workforce becomes even harder to fill.

Defining the gap

How can the situation for this workforce be improved? Many issues seem to stem from the nature of the ‘gap’. This gap has never been clearly defined and so it is not clear what gap the NA role is trying to fill. There is, of course, a very large gap in the RN workforce in the UK – there are over 40,000 vacancies in England alone (Mitchell, 2019). This has led to confusion and the predictable replacement of RN posts with NAs (Lintern, 2019; Lintern, 2017).

Claims that NAs are there simply to fill RN vacancies jobs might be the aim of policy makers or a way for employers to bring down agency spend, but rarely seems to be the view of actual NAs or trainees. For this reason, there needs to be further clarity on the role – namely, what it is and what it is not. Is it simply a reinvention of the enrolled nurse (EN), a role phased out due to limited career prospects and exploitation by some employers, on the recommendation of the Briggs (1974) report?

Patient safety

Organisations replacing RN posts with NAs need to think carefully about the risk to patients and the workforce. Research
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“The job description at present is employer-dependent: what nursing associates can do in one organisation they may not be able to do in another”

suggests adding workers without RN qualifications may not improve patient safety (Aiken et al, 2017). Studies have explored the impact of roles similar to the EN but the evidence is not supportive of the role in terms of patient safety or the experience of the workforce (National Nursing Research Unit, 2009). Yet, when this evidence has been presented, it has been soundly dismissed. Indeed, the eminent workforce researcher Professor Jane Ball was called “pathetic” on social media by Lord Willis, a champion of the NA role. Such behaviour is unlikely to win arguments, hearts or minds. Instead, it has simply fuelled concerns instead of addressing them and has also meant that registered and trainee NAs on the front line, rather than policy makers, have borne the brunt of this scepticism.

EN-type roles were often introduced at a time of high demand for nurses and poor workforce supply, such as during outbreaks of disease or war (Abel-Smith, 1975), but crisis should not drive workforce planning. The NA role has been rushed through to try to alleviate the nursing workforce crisis but, in so doing, much ambiguity about the role exists and there has been no time for it to develop its own professional identity.

Professional identity

Professional identity is important. It is how we perceive ourselves in our occupational context and how we communicate this to others. A strong professional identity is especially important to a newly created role but, unlike other professional groups, the NA workforce has not had time to evolve one. It was constructed by policy makers and pushed into the workforce at speed. That speed and subsequent scepticism, along with the lack of clarity, means those doing the job are having to deal with the challenges of introducing a new role as they go along. For some, this might be a welcome challenge, but for others it is demoralising. It is then for employers and NAs themselves to make the new role work – not something for the fainthearted.

Workforce policy is not high on most people’s list of “must reads” but it is becoming increasingly important that nurses and nursing support workers have a view on it. It affects the jobs nurses do, how they are employed and even what kind of jobs receive funding. Not questioning decision makers’ policy can have long-term effects, which eventually filter down to frontline individuals. It is demoralising for any workforce to be termed “the Aldi of nursing” on social media or blamed for the loss of registered nurse roles. NAs are as likely to suffer from poor workforce planning policy as any other group.

Training to become an NA comprises an apprenticeship that takes two years to complete. There is much talk of it being ‘topped up’ but that can require 18 months at the expense of the individual or another four years on a nursing degree apprenticeship. Those who cannot afford to self-fund or cannot get a student loan are left in limbo. And why bother becoming an NA at all? Why not go straight into the nurse apprenticeship?

A role in its own right

It might be better to promote the NA as a role in its own right, rather than a mere stepping stone to a full nursing degree. There is demand in the system for workers and if we think more carefully about how the nursing workload is distributed and risk is managed, there might be other opportunities. Hickman (2020) suggested NAs could perform different functions that contribute to not only providing care but also supporting the workforce. For example, they could take on roles similar to the link role in specific areas, such as infection prevention and control on the wards, or perform a support leadership and role-modelling function for other sectors of the workforce, such as novice support workers. If NAs are here to support, why not use them in a constructive way and let them do that? The job description at present is employer-dependent: what NAs can do in one organisation, they may not be able to do in another. This is creating confusion.

Doctors also appear confused or simply have not heard about the role. When asked, only two out of six consultants working on a stroke ward knew what an NA was and where they fitted in. Given that qualified NAs must work across multidisciplinary teams, this is worrying. It suggests that more information and education is needed about the role so it can be promoted correctly and do the job it was created to do – namely, to provide the support to RNs that is so badly needed.

In 2020, there is hope the NA role will be streamlined and given clear boundaries and a remit. Ultimately, patient-centred care is what is at the heart of the NHS. To function correctly, every team member must understand and agree what the role involves, so the patient experience is a positive and successful one.

Development of the nursing associate role

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<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>2015</td>
<td>Willis review (Health Education England, 2015) proposes developing a new role to bridge the gap between the registered and non-registered nursing workforce</td>
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<tr>
<td>2016</td>
<td>HEE agrees to pilot a “senior healthcare assistant role”</td>
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<td>2017</td>
<td>First students enter nursing associate training</td>
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<td>Nursing and Midwifery Council (NMC) agrees to regulate nursing associates</td>
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<td>Nursing Times reports “hostility” to the role in Scotland, Wales and Northern Ireland</td>
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<td>Government sets target of 5,000 trainees in 2018 and 7,500 per year from 2019</td>
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<td>2019</td>
<td>First nursing associates join the NMC register</td>
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References

Hickman S (2020) The Nursing Associate Role is Misunderstood. nursingtimes.net. 16 January.
National Nursing Research Unit (2009) Policy Plus: Is There a Case for the UK Nursing Workforce to Include Grades of Qualified Nurse other than the Registered Nurse? London: NNRU.