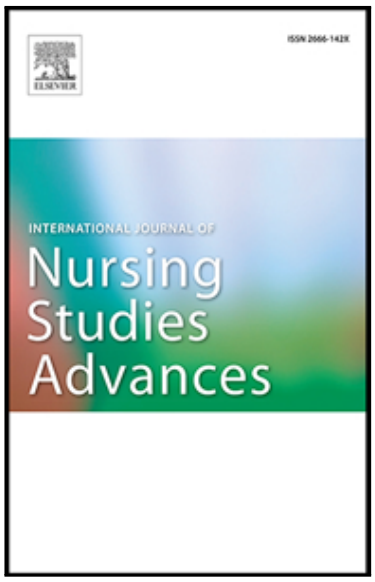

‘The Emperor’s New Clothes?’ Healthcare professionals’ perceptions of the nursing associate role in two UK National Health Service hospitals: A qualitative interview study

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‘The Emperor’s New Clothes?’ Healthcare professionals’ perceptions of the nursing associate role in two UK National Health Service hospitals: A qualitative interview study

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Key words:

Health Care Organisations; Health Care Policy; New Nursing roles; Nursing Workforce, Scope of Practice, Staffing Deficit; Staff Retention

What is already known?

- Poorly defined role parameters, unmet training needs, excessive role expectations and unreasonable workloads impede the introduction of new roles in practice.
- There is limited evidence to guide the implementation, evaluation, and optimal utilisation of the new nursing associate role.
- The views and experiences of nursing associates are largely unexplored.

What this paper adds

- There is a discrepancy between the identity of the nursing associate role as envisaged in the policy agenda, and its reality in practice.
- Staffing shortfalls and burgeoning workloads led to a blurring of nursing workforce roles
- Role holders were perceived to predominantly function in a nurse capacity to meet unmet needs.

‘The Emperor’s New Clothes?’ Healthcare professionals’ perceptions of the nursing associate role in two UK National Health Service hospitals: a qualitative interview study

Abstract

Background
The introduction of nursing associates in England (UK) in 2017 as a professional ‘bridging’ role aimed to mitigate chronic staffing shortages, enable career progression of healthcare assistants and release registered nurses to provide more complex care. Limited evidence exists about the alignment between the identity and purpose of nursing associate roles described by the UK independent regulator, the Nursing and Midwifery Council, and the expectations, obligations and team dynamics encountered in practice.

Purpose
Investigate the perceptions of nursing associate roles through the views and experiences of role holders, registered nurses and healthcare assistants.

Setting
Two National Health Service (NHS) Hospital Trusts in London, England (UK).

Methods
For this registered service evaluation, data were collected via in-person, semi-structured interviews. Verbatim transcripts were coded inductively. An adapted framework analysis method, suitable for use with Excel, was applied to support the identification of cross cutting themes. We used the Standards for Reporting Qualitative Research (SRQR) checklist for this study.

Results
Eleven registered nurses, five nursing associates and five healthcare assistants participated. Their experiences seldom reflected the policy vision of the nursing associate role in practice. Several likened the nursing associate role to the fable of the ‘Emperor’s New Clothes’ in which expectations and reality diverge. With this defined as the over-arching theme, four sub-themes were identified: (1) preparedness of organisational infrastructure to support this role; (2) credibility of the role in practice; (3) perceived organisational “blindness” to the ambiguities of the role and (4) increasing task orientation and segmentation in care delivery.

Conclusion
There is a discrepancy between the identity of the nursing associate role as imagined in the policy agenda and its reality in practice. There is a need for more protected and well-defined training, clear role boundaries and accessible career progression pathways. Moreover, honest dialogue at an organisational and policy level must continue, so that the challenges and opportunities of the NA role are properly realised.

Tweetable abstract

Emperor’s new clothes! Experiences and views of new nursing associate roles in NHS (UK) acute hospitals @CarolynSpring3

Introduction

The global nursing deficit is a worldwide health emergency linked to insufficient investment in nurse education, inadequate long-term workforce planning, unsustainable reliance on international recruitment and failure to co-ordinate policy and planning intra- and internationally (Buchan & Catton, 2023). Strategies to address this deficit include encouragement to return to practice, supporting recruitment and retention, appointing overseas nurses (Peters, 2023) and increasing use of second-tier nursing roles (Lucas, 2021).

The nursing structure in the United Kingdom (UK) prior to 2000 comprised two levels, the state registered nurse (SRN) and the state enrolled nurse (SEN). The latter was phased out in the 1990s, reducing workforce numbers and increasing the skills gap between registered nurses and healthcare support workers, who are unregistered, but undertake a standardised training to achieve a care certificate (Glasper, 2016). Systemic failings of care (Francis Report, 2013) led to a review of such roles (Cavendish, 2013) and a re-examination of education and training (Health Education England, HEE, 2016).

The second-tier nursing associate role introduced in 2017 by HEE aims to alleviate shortfalls from 43,000 unfilled nursing vacancies in the national health service (NHS) in England and Wales. Designed to be both a standalone role and a new route to attain registered nurse status, it seeks to bridge the skills gap mentioned, by progressing unregistered and unregulated healthcare assistants (HCAs) into graduate level nursing roles and enabling registered nurses (RNs) to undertake more complex care (HEE, 2016).

Following pilot testing in 35 English sites, trained nursing associates gained registration with the UK nursing regulatory body (Nursing and Midwifery Council, NMC) in 2019. Apprentice nursing associates (ANAs) now complete an NMC-approved pre-registration Foundation degree, comprising a salaried two-year vocational education programme integrated with clinical practice (HEE, 2016). Following this programme, nursing associates can further achieve nursing status via completion of a shortened nursing course (Table 1 for current NHS nursing workforce structure).

Table 1. NHS nursing workforce structure, England and Wales

Healthcare/nursing assistants	
Band 2	junior healthcare assistant (HCA)
Nursing associates	
Band 3	senior healthcare assistant / nursing associate apprentice (ANA)
Band 4	registered nursing associate (RNA)
Nurses	

Band 5	registered nurse (RN)
Band 6	experienced nurse
Band 7	specialist nurse, nurse with leadership responsibilities, advanced practitioner, ward nurse
Band 8	nurse with significant leadership or management responsibilities, matron

Qualified proficiency standards for registered nursing associates (NARs) span six platforms, differing from those for registered nurses (RNs) in leadership responsibilities (NMC, 2019) (Table 2).

Table 2. Nursing and Midwifery Council (NMC) roles, registered nursing associates and registered nurses

Registered Nursing Associate	**Registered Nurse**
6 Platforms	7 Platforms
Be an accountable professional	Be an accountable professional
Promoting health and preventing illness	Promoting health and preventing illness
Provide and monitor care	Provide and evaluate care
Working in teams	Leading and managing nursing care and working in teams
Improving safety and quality of care	Improving safety and quality of care
Contributing to integrated care	Coordinating care
	Assessing needs and planning care

By March 2024, more than 10,000 nursing associates were on the NMC register in England (NMC, 2024). The intention was to train 5,000 ANAs in 2024/25, increasing to 7,000 a year by 2028/29. It is anticipated that over 64,000 NARs will be employed in the NHS by 2036/37 (NHS England, 2023), and the NMC has recently approved an expansion of the role into Wales following a request from the Chief Nursing Officer for Wales. (UK)(NMC 2024). The NMC *Standards of Proficiency for Nursing Associates* identify the general criteria and expectations for the role (NMC, 2018; Table 2), but do not include guidelines for specialist areas, such as critical care, and there is significant discretion to tailor the position to area-specific requirements. The independent regulator (Care Quality Commission, CQC) is similarly not prescriptive about role deployment (CQC, 2019).

The barriers and facilitators to the implementation of new roles in health care are well documented. Poorly defined role parameters, unmet training needs, and lack of understanding of the new role are known to impact workplace integration (Robert et al, 2019). Excessive role expectations and unreasonable workloads also hinder employee transition (Kim & Shin, 2020).

Embedding new roles in practice can be facilitated by clearly delineated roles and responsibilities between different levels of staff seniority and expertise (Henshall et al, 2018), and effective supervision and leadership (Hasle et al, 2018). Career development pathways and timely access to appropriate education and training can also support post holder development and retention (Attenborough et al, 2020).

Currently limited evidence exists to guide the implementation, evaluation and optimal utilisation of the role. Initially, evaluation focused primarily on training and development programmes for ANAs (Traverse, 2018 & 2019) rather than how the role was performed and perceived in practice. Later studies identified challenges relating to role ambiguity, role clarity and establishing a career pathway as an NAR (Kessler et al, 2020 & 2022; King et al, 2020). Insufficient planning, poor communication, and a lack of organisational preparedness were also identified as barriers to role implementation (Lucas et al, 2021) Yet little is known about stakeholders' perceptions of NARs and the experiences of NARs or if they align with the NMC expectations for the role. Neither it is known how NARs feel about the knowledge and skills they acquire in practice and the level of support available to advance their career aspirations. An improved evidence base would allow for better understanding of the barriers and facilitators to role integration, so that these can be addressed in practice.

Methods

This study, conducted between May 2021 to September 2022, was registered as service evaluation (SE) number 543 with the NHS Trust Joint Research Office and Audit Office. Semi-structured one-to-one interviews were undertaken with three professional groups –HCAs, NARs, RNs– guided by a phenomenological approach (Neubauer et al., 2019) to support understanding of participants experiences.

Participants were recruited from different hospital sites within two London NHS hospitals. The study was promoted to potential participants via Trust newsletters and emails cascaded through matrons, practice educators and ward managers. A participant information sheet and consent form were provided to individuals expressing interest, with opportunities to request further information. Interviews were then arranged at a suitable time and date, and conducted in person in private spaces, or via MS Teams. The study aimed to include 10 individuals from each professional group. The interview topic guide is shown in Table 3.

Table 3: Topic guide for semi-structured interviews

Focus	Indicative topic for nursing associate interviews	Indicative topic for interviews with registered nurses and healthcare assistants
Introduction	Initial attraction/motivation to become RNA	Familiarity with the nursing associate role Level of interaction with nursing associates in practice
Experiences	Most/least crucial elements of the role in training/practice Emotions experienced in conducting role	Type of interactions with nursing associates Attitudes and practices of nursing associates observed in care interactions with patients
Learning/work/balance	Balance between education and practice needs Ability to apply and use taught skills in practice area/s Experience of transitioning from trainee to qualified NAR status	Opportunities and scope for nursing associates to engage in learning observed in area Approach to learning by nursing associates Match between learning and practice requirements
Team / colleagues interaction	Attitudes and approach towards role from RNs/HCAs Barriers and facilitators to collaborative working practice Designated responsibilities and tasks	Observed attitudes and approaches of nursing associates with healthcare assistants and registered nurses and the member of the wider clinical team
Professional identity	Self-perception/ perceived by others Individual nature of your role Nature of your role within the care team	Level of understanding and recognition of the professional identity of the nursing associate within the clinical area
Organisational factors	Understanding of colleagues of your role Impact of leadership/ supervision on role Impact of teamwork/individualism in care delivery	The experience of leading/supervising/supporting nursing associates The impact of nursing associates on the organisation of care delivery and care outcomes Senior Trust leadership communication relating of the nursing associate role
Professional development/future goals/longer term plans	Development of skills and experiences Intention to become registered nurse? Specialise in specific clinical area? Work in a community setting	Types of interaction regarding the ambitions and career goals of nursing associates Views of nursing associates progressing to registered nurses/specialising Appropriateness of nursing associates in high acuity settings/community settings/specialising in specific areas?

The main researcher took reflexive notes to encourage self-awareness during the study and to consider subjectivity and bias in relation to her emotional response and psychological interpretation. All interviews were transcribed verbatim and proofread several times to ensure accuracy. Participants were anonymised with a unique identification number, and their responses pasted into Excel. An adapted framework analysis for use with Excel was selected (see Table 3), guided by Swallow et al (2003).

Following re-reading for familiarity, preliminary notes were made, and phrases or sentences highlighted prior to assigning 'codes' to describe their content. Initially the data were coded inductively from the transcripts within each professional group. This involved a combined approach (Skjott Linneberg & Korsgaard, 2019), applying 'in vivo' coding directly to the words of participants and 'values' coding to understand their perceptions and views of the NAR role. 'Structural' coding was employed to establish who performed specific actions (when and where), and 'descriptive' codes were used to determine the tasks undertaken. (Table 4).

Table 4: Example of the coding process

Interview conversation extract	**Initial coding**	**Values/Valuing/ Value laden**	**Structural**	**Descriptive**
"I am *not sur*e (1) [name redacted] [the nursing associate] *is any different* from our nurses (2). She seems to do the *same* (2) *tasks (3) the meds, the IVs,* [..]*, the same workload (4). [..]* [Redacted] [NHS Trust] *probably have their reasons (5) why, for pushing this [role]. They (NAs) are seen like the band 5s [registered nurses]. [..] I don't really buy it (6) [..] Its quite convenient (7).[…] What's that old story?* Um, the king. No. *It's the Emperor. The Emperor's new Clothes (8). Yeah.* That's where it is at.	1. uncertainty 2. similarity 3. task-based 4. work volume 5. hidden/not visible 6. doubt/disbelief 7. expediency 8. Metaphor – pretence	I don't really buy it. convenient Old story Pushing Emperor's new clothes	same tasks on ward same workload in the clinical area	Meds IVs [intravenous therapy]

Codes were iteratively processed, added and revised, and finally condensed to summarise key points. Then, responses from NARs HCAs and RNs were contrasted between and within cases. Finally, using an iterative approach, themes were determined through recurrence and

alignment of relevant codes. Preliminary themes were discussed with all authors within the study team, and revisions applied to the wording of themes.

Table 5. Adapted framework analysis method

1	Familiarisation – immersion in the data	Listening to the recorded interviews and reading. Highlighting the emergent data listing key words, experiences, recurrences and divergences in views and experiences.
2	Developing a framework for analysis	Inductively coding the data into recognisable elements Revision of coding of data based on re-readings Developing themes arising from recurring views and experiences Labelling data into categories within and across professional groups
3	Indexing and identifying subthemes:	Codes were grouped into themes and distinct subthemes within each of the themes. Following completion of indexing, the indexed documents were reread and developed into thematic charts.
4	Charting the data into a framework	Use of Excel's reviewing tool bars to comment and colour code cells to chart the data and compare the experiences of the three professional groups and identify wider concurrence and divergence between and within professional groups to help achieve agreement of theme wording.
5	Mapping and interpretation	Checking and comparing themes and subthemes against the original transcripts, notes and audio recordings to see if any additional changes or merging was required. Agreeing final framework, themes and subthemes.

Results

Twenty-five participants expressed an interest in participation and four of whom subsequently declined. These included one RN who dropped out based on lack of familiarity with the NAR role and two HCAs and one NAR who chose not to take part due staffing issues in their work area. Twenty-one participants were interviewed, including 11 RNs, one ANA, four NARs and five HCAs. Participants in all groups had different age ranges and ethnicities; however, the RN group included a greater number of white nurses in senior bands (Table 6). Individuals working within both adult and children's areas were interviewed. Their clinical areas ranged from general surgery and medicine to critical care and emergency departments. The interviews averaged 49 minutes (range 34 to 81 minutes).

Table 6. Characteristics of study participants

Gender (n)	
Men	4
Women	17
Age range of participants (n)	
20-29 years old	4
30-39 years old	6
40-49 years old	5
50-59 years old	4
60-69 years old	1
Professional role and NHS banding of participants (n)	
Junior Healthcare Assistant Band 2	1
Senior Healthcare Assistant Band 3	4
Apprentice Nursing Associate Band 3*	1 (newly qualified - completing to Band 4 <5 weeks during the study inception)
Registered Nursing Associate Band 4	4 (5 months to 19 months registration experience).
Registered Nurse Band 5	2
Experienced Registered Nurse Band 6	2
Specialist Registered Nurse leaders (Ward Manager) Band 7	3
Registered Nurse senior leaders (Matron) Band 8	4
*Achieved nursing associate registration in duration of study	
Ethnicity of participants	
Participants from minority ethnic backgrounds 59% and those identifying as white 41%. Percentage of white nurses in senior nurse bands 7-8 (71%)	

A core theme and four sub-themes were identified. Quotes are provided to illustrate each of the key sub-themes. The core theme of 'the Emperor's New Clothes' was derived from registered nurses (Bands 5, 6,7 & 8) and healthcare assistants (Bands 2 & 3) using this phrase in relation to the nursing associate role, referring to the 1837 Danish fable by Hans Christian Andersen (Box 1).

Table 8. Key themes and sub-themes

'The Emperor's New Clothes'
1. Preparedness of organisational structure to support NAR role
1.1 Variable support for training and development in clinical practice
1.2 Sink or swim' – NARs determine their own passage
1.3 Presumption of supervision and support structure not fully evidenced

1.4 NAs experiences tempered by professionals' expectations in practice
2. Credibility of the NA role in practice 2.1 Steppingstone for progression not a distinct professional identity 2.2 Blurring of roles in practice
3. Perceived organisational "blindness" to the ambiguities of the NAR role 3.1 Inadequate identification and acknowledgement of NAR roles 3.2 NARs adapted to meet expectations of performing a hybrid nurse role
4. Task orientation – trend towards 'taskification' within care

In the context of this study, the phrase signified that, in relation to NARs, the organisation, like the Emperor, may 'see what they wish to see' –a tailor-made effective bridge between HCA and RN roles–, rather than openly acknowledging the limitations in scope, implementation, and effectiveness to meet clinical need. The NARs' role expectations were not readily borne out in practice, so like the Emperor, their perception of how they appeared - what their uniforms should confer- often differed from the views of other professional stakeholders. Additionally, the four subthemes emerged were: 1) preparedness of organisational infrastructure to support NAR role; 2) credibility of the role in practice; 3) perceived organisational "blindness" to the limitations and ambiguities of the role and, 4) increasing task orientation and segmentation in care delivery. (Table 8).

'The Emperor's new Clothes'

The overarching theme refers to participants' feelings of having believed in, or even having been 'duped' about the defined professional identity of the NAR role, when in practice it seems to be more intangible. Indeed, tensions about the similarities in NAR and RN roles, together with scarce human resources to implement the NAR role effectively, impacted on the confidence about the credibility of NAR roles. The institutional propensity to "see what they wished to see" instead of these tensions was challenged.

"I wonder that there is a wilful blindness here [...] a whole mass of uncertainty. [..] I think the role has evolved to fill a sort of vacuum and things are thawed out as time

progresses". [..] They'll say, [..] "oh it is agile", but [..]. Whose it agile for? Agile for the budget, that's who, not for all us lot. No. So, […] stick your [..] head in the sand, [...] fingers crossed, eyes shut […] hope for the best." RN 13 Band 8.

I love my role. I do go above, yes, and beyond. [redacted Ward Managers name] knows that. Why would they say, "oh yes, she's a nurse"? Choose to see that? I don't think so" NAR 2, Band 4. (11 months qualified).

The NAR role was described using words such as 'charade', 'illusion', 'fantasy' and 'fiction' and hence likened by several participants to the Danish folktale.

"*There is a sense of what you could call the Emperor's New Clothes about nursing, you know, that if NAs are good enough to do all this work. [..] What's the difference? What is it that nurses have? What have the nurses got that makes them better paid or higher status or, you know, a bit sort of superior? It became slightly hard to say what it was, apart from their uniform"* RN 16 Band 7

The tasks, duties and responsibilities of NARs were not well understood. Only one NAR reported receiving a job description. NAR role holders did not feel their role was distinct from other nursing roles, rather, to fit the specific ward needs they sometimes functioned largely as an HCA, monitoring patients and undertaking personal care and mealtime assistance, or more commonly, undertaking tasks within the scope of a registered nurse, often without direct supervision. A senior nurse voiced that the current requirements to enter nurse education programmes played a part in sustaining this illusion:

"This role is a pretence grade. You don't need people with degrees. They have made a rod for their own back, and they have got round it by getting in another position - it [the R NA role] is a nurse role" RN 13 Band 8

1. Preparedness of the organisational infrastructure to support the NAR role

Four sub-themes relating to organisation preparedness were identified from the interviews: (1.1) Variable support for training and development in clinical practice (1.2) 'Sink or swim' – NARs determine their own passage. (1.3) Presumption of supervision and support structure not fully evidenced and (1.4) NAs early expectations tempered by experience in practice.

1.1 Variable support for training and development in clinical practice

Although widely welcomed by participants as a debt-free door to NMC registration, apprenticeship training milestones relied on limited staff educators:

"They just don't have the time to teach or supervise me. [..]. So, I would do the same tasks as a healthcare assistant. Again, and again. I did get some balance [..] from my own initiative. Yeah, learning had to come from me". NAR 2 Band 4 (11 months registered)

Not all RN participants valued this self-advocacy and proactiveness in learning; some admired ANAs resolve and initiative, while others viewed it as a result of a lack of organisational leadership:

"It is such a top-down lack of knowledge, and it feels like a bottom-up drive [..] I wonder if that is what they are aiming for. Is it getting the nursing associates to push us to fight their way, emerge into their own sense of identity? But I think it is a top-down approach that needs to be taken. That is what is missing for me. Nobody is even willing to look at the job descriptions". RN 11 Band 8

This uncertainty, on the other hand, fostered flexibility to access learning opportunities beyond those mandatory for registration, aligned to the requirements of the specific clinical area:

"*I've had experiences on my placement, whereas a lot of people haven't had that experience. [..] Things like inserting catheters, which isn't in the proficiencies. It's another one of those lines of learning and tasks, that's blurred. But I have accomplished this*". ANA 3 Band 3 (in process of registration).

There were instances when it was apparent that the education and training provided did not match ward requirements. An NAR in a paediatric setting commented: "*I was the only [apprentice] NA in a in a children's setting, [..] Even though a nursing associate is duly trained, we look after people of all ages, the actual foundation degree was 95% adult based".* NAR 5 Band 4 (5 months registered).

Efforts to strategically embed a supportive pathway for the role were sometimes frustrated through lack of leadership, interest, or competing directives.

"I started the process, putting a business plan forward [..] to say where the nursing associate could be included and how many we could have on the wards to make it viable and truly effective. And what happened? The new [Leader in my area] came in and would not even read my strategy. And [..] just said "no that idea will not work". And that was the last I heard of it" RN 11 Band 8

1.2 'Sink or swim' – NARs determine their own passage.

It was often stated by RNs and HCAs that NARs appeared to be left to 'sink or swim' or 'left to their own devices'. Both RNs and HCAs identified that several were 'buoyed up' or 'coped' due to knowledge, skills and experience gained in previous healthcare roles:

"*I felt like they were just thrown in the deep sea, and okay, just learn how to swim. There wasn't clear guidance [..] or information from the beginning. [..] It was "so here they are, use them".* RN 17 Band 6

"*It's been a tough call [..] she knows the ropes, she started together in [..] in 2015, no, 2016. She's got these ambitions, yeah, and her experience, here, and in ENT [Ear, Nose and Throat], she's keeping up, She'll survive, I know it. She won't sink. We go back, you see" HCA 7, Band 3.*

Prior experience was sometimes incorrectly assumed; an ANA, who gained registration early on in the study, advised that it was 'all uphill' as she had to constantly reiterate her unfamiliarity with tasks requested to gain the appropriate guidance. To 'soldier on' was frequently used by participants to describe how NARs fulfilled their roles. Senior nurses noted how the workplace experiences of NARs were particularly challenging and attested to their resilience:

"*When they are thrown into an A & E environment or an ICU environment that became very difficult. They coped, but you could noticeably feel the stress pooling out of them. [..] But they soldiered on*" RN 18 Band 8

1.3 Presumption of supervision support structure not fully evidenced.

For participating HCAs and NARs, RN support and supervision of NARs was variable. Some reported excellent supervision, whilst for others, it was given intermittently or reluctantly, or even largely absent, as noted by two NARs:

"*There seems to be a lot of discretion around people who've worked here longer or have some HCA experience and there's less supervision for us, but also generally, the supervision here is in fact quite poor".* NAR 4 Band 4 (9 months registered).

The demands of the ward, RN inexperience and low confidence could impact the willingness and capacity of RNs to supervise their practice:

"*Well, the nurses will sometimes [..] say, well, I have my own set of patients. Why do I have to look after her? I don't need to be supervising other staff members. Why does [the RNA] get so much leeway? What after all the other things I've done? Or they are in that position of wait, I'm not experienced here, I need support so why the hell am I supporting someone else?* NAR 2 Band 4.(11 months registered).

Confusion also prevailed on whether and when NARs should be expected to work independently. This uncertainty appeared to be linked to a lack of clarity stemming from limited direction towards defining role responsibilities:

"I don't think there was sort of ownership on who defines the [RNA] role during practice. [..] It could get very blurred. It was not clear whose job it was to say, oh no, they shouldn't be doing that. Or yes, they should be doing that" RN 15 Band 5

1.*4 NARs experiences tempered by professionals' expectations in practice.*

Early high expectations of the role amongst NARs were tempered by their experiences in practice. Their early optimism and expectations were not always retained. Registered nurses reported a presumption amongst colleagues that the Band 4 NAR role was 'less safe' than the Band 5 RN and that the expectations of wards receiving NARs were 'not usually high'. Three senior RNs interviewed were resolute that an RN was preferable to an NAR on the ward. Their rationale was linked to workplace capacity, not individual ability:

"*I don't think we have the staffing resources to do this successfully"* RN 16 Band 7

The NAR role was sometimes seen to diminish rather than expand nursing resources. A ward manager described the impact of NARs on other staff groups:

"So, the RNs workload is now increased because you must supervise that NA [..] Why would you want an NA when you could have an RN? It feels dishonest." RN 20 Band 8

Concerns were also voiced over the economic rationale and long-term sustainability for changes to the workforce skills mix:

"*Workforce planning - I am also talking about financial structures here, have not been really carefully thought through. How are we funding this role? We cannot rely on HEE [Health Education England] funding. [..] We are making sacrifices now which seems unfair. Band 5 [nurse] posts are removed to put in Band 4 [RNA] posts, we are not removing HCAs to have [R]NAs. We are reducing the balance of skill, losing RNs, but not getting any additional money. Can this continue in the longer term*?" RN 20 Band 8

Some participant NARs voiced the need to "demonstrate" or "prove" their worthiness in the clinical team and some nurses observed that when NARs were introduced to their clinical areas, coworkers' expectations changed:

"*Perhaps [..] areas should be a bit more open minded. Initially one of the [specialist] areas said no, no, no. But now they have sent an HCA into the nursing associate programme*

and they are doing very well" [..] They will probably all say "oh they won't be capable enough to do this", but they have proved us wrong" RN 19 Band 8

2. Credibility of the NAR role in practice

The credibility of the NAR role in practice has three sub-themes, the role was perceived as (2.1) a steppingstone for progression not a distinct professional identity; and participants observed a (2.2) blurring of roles in practice; wherein (2.3) NARs adapted to performing a hybrid role.

2.1 Steppingstone for progression not a distinct professional identity

The intended 'bridging' between HCA and RN roles did not align with the RNA's transience in practice. For some NARs, receiving a salary during training encouraged them to progress towards nursing registration without a significant debt. The NAR role was commonly viewed as a 'steppingstone' journey, rather than a destination. A senior nurse observed:

"Oh, they are all stepping up to be an RN. [..] That is the sort of sentiment among all of them. So I guess, I don't know whether we will have NAs anymore" RN 21 Band 7

In fact, staying as an NAR for long seemed undesirable or unrealistic to RNs due to the limited prospects for professional development. Such a situation posed a challenge for RN leaders in terms of motivating the NAR workforce should they chose not to top-up to nurse education:

"To have a continuous development plan [..] is a challenge because there is no clear pathway out there to help you develop those skills. [..] I can't see that there is anywhere for them to go, anywhere to aspire to [..] You might not want to be a nurse, that's fine - but then you are static, stuck" RN 19 Band 8

The sentiment of the NAR role as 'a means to an end' was widely recognised. The desirability of this route to nurse status was affected by the introduction of the alternative Nursing Degree Apprenticeship scheme in 2016 in England, which led to such status earlier:

"They had seen it [NA] as a direct step towards nursing. Later […] they felt a bit duped [..] and those of them who would have had the qualifications for the [registered nurse degree] apprenticeship wanted to do that." RN 11 Band 7

The unanticipated preceptorship requirements for NARs to remain in post for at least six months to a year prior to application for top-up nurse education was also unwelcomed: *"I now have to do a year's worth of preceptorship before I can move up. And I think if it wasn't for that, maybe I wouldn't be a nursing associate anymore and I'd be a registered nurse.* NAR 5 Band 4 (5 months registered).

2.2 *Blurring of roles in practice*

In practice, professional roles along the care continuum appeared considerably blurred. NARs' duties overlapped with those practiced by RNs, with HCAs in turn completing tasks typically performed by NARs. Although this flexibility made it possible to meet clinical demands, the blurring of duties was sometimes questioned and not always welcomed.

A difference in the way that RNs and NARs were observed to practice was in the provision of "hands-on" care. NARs were perceived to work more collaboratively, with HCAs, in performing personal care - particularly with patient washing, toileting and assisting during mealtimes. However, the notion that NARs simply bridged the gap between HCAs and RNs was considered overly simplistic, with responsibilities and tasks flowing across the spectrum of HCA, RNA, and RN roles:

"*The policy, it must take a very narrow view of the HCA and nursing associate role to assume that there is always a gap. It does not see it as a sort of mosaic of experience, it sees it as something else, a sort of linear continuum. That is an impossibility, anyway, policy does not understand the complexities of either role"* HCA 7 Band 3.

HCAs questioned the NMC's allocation of care planning (Table 2 above) as the sole responsibility of nurses:

"Fantasy! [NARs] are planning, assessing, reviewing [..] instructing, in fact, and making revisions, as they go about like [..] them [RNs]. To say otherwise is utter [..] rubbish and [..] unfair. If they waited for a nurse to go and do it, well, it would just [..] stand still and the patients would never [..] go home." HCA 8 Band 2

Interestingly, HCAs also reported 'acting up', that is, carrying out tasks commonly performed by NARs: "*I now work like a nursing associate. I can do the ECGs, I can do the blood scan, I can do a cannula. I can do many things other HCAs cannot do*" HCA 6 Band 3.

Systemic service pressures such as the acuity of patients, the complexity of care, shortfalls in staffing, or the lack of a formal job description, shaped the ebb and flow of care role parameters, circumstances often not willingly accepted:

"[T]he key issue is the acuity of patients that nursing associates can or can't care for. I think they are pushed to do more than they are comfortable with because of shortages of staff [..] [T]here is a real blurring of the lines, it is "so you want to register; so you will do as you are told and get the work done" [..] *Within our professional groups [..] boundaries have diminished or disappeared sometimes*" HCA 7 Band 3

"The last thing on anyone's minds over the last two years is where the nursing associate fits in. It is just that we are happy to have extra hands. We are just firefighting." RN 18 Band 8

Sometimes tensions arose from expectations on NARs to work beyond their scope of practice and they acted to police the boundaries of their role

"*It's about [..] being brave and standing up for yourself to actually [say] no, that is not within my scope. [..] [I]t has caused tensions and [..] I've upset some people [..] but [..] I'm not touching [..] stuff that I should not be touching*." NAR 4 Band 4 (9 months registered).

A mechanism debated and actioned by NARs to diffuse such tension was consistent with the concept of 'quiet quitting' (Boy & Surmeli 2023) – a reduction in labour to fulfil required responsibilities without spending any additional energy, time, or passion required for optimal care:

"[W]hen I went to help as nurse in charge a few shifts ago, I made sure my stuff was done first. So historically, what I used to do is try to make sure everyone was happy, and everyone had what they needed, including my own patients. So I've been doing this thing of quiet quitting where I'm not going above and beyond, which is amazing, because I'm not getting as stressed as I used to, but horrible because I'm not doing everything I could for my patients and colleagues". NAR 4 Band 4 (9 months registered)

Concerns about working beyond role boundaries were voiced by RNs, uncomfortable with the workload and scope of responsibilities undertaken by NARs.

"You don't want the [R]NAs to feel short changed. I can't really expect an [R]NA to take on all these patients, can I? [..] Let her take the whole bay? [..] Since Covid it is like "she can manage the whole bay" [..] We can't just throw them in the deep end and expect them to be fine. We are talking such an enormous workload" RN 21 Band 7

Such frequent role blurring also fostered uncertainty across all professional groups in terms of how to differentiate NAR and RN roles, ("*They [doctors] didn't have a clear concept of what the [RNA] role was, and reverted to what a nurse does")* RN 11 Band 7 (Participant 11)

3. Perceived organisational "blindness" to the ambiguities of the NAR role

This theme refers to the disinclination of the study organisations to openly acknowledge the low role specificity of the NAR post and the impact of this ambiguity in the workplace. It

includes two sub-themes; (1) inadequate acknowledgement of NAR responsibilities (2) NARs adapted to meet expectations of performing a hybrid nurse role.

3.1 Inadequate acknowledgement of NAR responsibilities

NARs in both Trusts reported they were included in the electronic roster as registered nurses and frequently worked unsupervised. Virtually all interviewees felt that the pay structure for NARs was 'dishonest' or 'unfair' for their work, and they should instead receive the same pay as band 5 RNs. Several RNs called for more 'honesty' – or a 'spotlight' – on what was happening with the role in practice (*"It should be made clear, [..] we are training you to be a nurse through this route"* Band 8 Registered Nurse. Participant 13), while some NARs spoke of feeling slighted or exploited (*"I felt sometimes, abused, like I was used just as cheap nurse"* NAR 1 Band 4 (19 months qualified).

Lack of recognition of the volume of work undertaken by NAs was often voiced. Some HCAs and RNs argued that the extent of NARs' responsibilities were 'unacknowledged', with some senior RNs comparing NARs to the now-defunct State Enrolled Nurse (SEN) positions:

"*On the whole people see it as unfortunately going back to the days of when we had SENs. [..] Over time resentment grew, especially from the enrolled nurses who saw they were doing pretty much what the registered nurses were doing but were being paid less for it. [..] I can sense that is how it will go in the future because it is like, just cheap labour, basically [..] and what is fair here?"* RN 13 Band 8.

3.2 NARs adapted to meet expectations of performing a hybrid nurse role.

NARs appeared to adapt in practice to meet the expectations of working beyond their intended scope of practice. They cited instances where they validated *their* care decisions and actions in patients' notes as those instructed by a RN. NARs, who openly suggested that they worked in a RN capacity, felt conflicted and questioned the validity of this practice but continued in performing the required care.

"I [..] feel, currently, admissions and discharges should not be done by us nursing associates. Like we can coordinate them and discuss it with the nurse in charge. But that final discharge [..] should be done by a nurse, surely?" NAR 4 Band 4 (9 months registered)

4. Task orientation – a trend towards 'taskification' within care

The term 'task' was consistently used across professional staff groups to describe routine care practices and to explain who undertook care activities. Senior RNs expressed concern that

extensive focus on completing tasks in managing care, a process termed 'taskification' (Blanco-Mavillard et al, 2022), resulted in ill-defined responsibilities and potentially threatened patient safety if critical thinking and decision-making were not prioritised. A ward manager commented:

"*I wanted [the NA] to focus on the patient care, really understanding what is going on with deteriorating patients [..] There is too much task comparison between wards where they [NAs] come from and what we are doing here. This is not helpful. My ward is really kind of different in that we get quite a lot of aggressive violent patients. We have to look beyond allocation of tasks. Think "when should I escalate"?* [raise concerns] RN 19 Band 8

The emphasis on task completion was perceived by some to take priority over building supportive professional relationships in practice:

"*For me it feels unpersonal (sic) […] like its finish that one, that task, [..] Then what's the next? What's happening? whose waiting? [..]. I think, managers should ask, [..] has anything [..] disturbing happened?, anything upsetting happened? [..] Those [..] are the kinds of questions that you want to be (sic). But no. It's 'whose bloods are done?', 'who is washed'?"* NAR 1 Band 4 (19 months qualified).

Patient-centred communication also sometimes seemed to be absent in a task-focused care environment, which led to moral distress:

"*The holistic caring, the talking, the listening, well that is not highlighted, and critical thinking is not highlighted [..] "It seems to be all about [..] getting on with tasks. The onus on a good bedside manner, really communicating with patients, fostering this dialogue is missing – in [all] our Bands [..] There is care and there is caring care. I think what has happened here is due to low resources, yes, shortages of people, of everything, and this is very sad." RN 11 Band 8.*

Discussion

This study revealed a mismatch between the identity of the NAR role as envisaged by the education and regulatory bodies in the UK, and its implementation and reality in practice. Although intended as a bridging role between HCAs and RNs, the NAR seemed to predominantly function in a RN capacity. Yet, NARs desire to use the role as a steppingstone to RN status was not readily attained. As early adopters, the NARs did not experience role consolidation or the availability of specialisation in their role, factors which may reduce its credibility as a career destination. Concerns voiced by RNs that the NAR role could replicate the limited career prospects associated with the defunct NHS state-enrolled nurse position are

echoed in King et al's 2020 study which identified apprehension that NAR post could be similarly restrictive.

The two NHS Trusts seemed to adopt a flexible approach to the implementation of the NAR role. Different clinical areas had different requirements and views on what NARs could do, fuelled by the individual RNA's perceived competencies and willingness to accept tasks. The often-voiced 'Emperor's New Clothes' metaphor suggested a 'blind eye' regarding the organisational reluctance to critique or review the role in view of the flexibility it afforded. Yet the ambiguity perceived from the blurring of role responsibilities generated uncertainty and anxiety in practice, a finding mirrored in King et al's (2020), Coghill (2018) and Lucas et al's (2021) evaluations of ANA and NAR experiences.

Fotaki and Hyde (2015) identify that '*blind spots'* develop in organisations as a defence mechanism for coping with problems arising from attempts to implement unrealistic strategic and policy objectives. In our study, nurses may have found themselves defending or turning a blind eye to the discretionary usage of NARs in practice simply to fill gaps in services and keep practice operating safely. Yet this very usage may have increased feelings of unsafety in the participants. Moreover, it is possible that NARs felt obliged to provide care beyond their scope of practice.

Accounts of NARs apprenticeship experiences indicate learning and development opportunities required to achieve their registration appeared to be negotiated and hard won. Nevalainen et al (2018) identify lack of management support as an impediment to formal and informal work-based learning in health organisations. However, in this study, the challenges encountered point to a need for both higher education institutions and Trusts to create a practice environment where 'learning' and 'working' are not perceived as competing priorities, but as integrated and part of a foundation to support and facilitate continuing professional development.

NARs acculturated to fit in and meet practice demands and some employed 'quiet quitting' to manage distress by covertly setting boundaries. In 'quiet quitting' employees act exactly within their job descriptions, but without passion and work commitment. Inadequate management, emotional exhaustion, disengagement and depersonalisation underlie this withdrawal. This study suggests it may be a strategy to delineate roles. Other authors propose quiet quitting can trigger a toxic organisational culture and must be seen by leaders as a sign of moral distress (Boy & Surmeli 2023). Jameton (1984) identified that 'moral distress', arises '*when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue*

the right course of action'. Those who experience moral distress can withhold care, which can impact on duration of patient stay, increased complications and mortality rates (Lamiani et al., 2017).

Boy & Surmeli (2023) propose that improved alignment of staff needs, motivations and expectations is required to support professional development and staff retention. Although it is well established that managers should provide close supervision and monitoring to support clarity, embeddedness and accountability for new roles, (Lucas et al 2021) (Busca et al (2021), Kim & Shin (2020) Halse et al (2018), this is only feasible if there is sufficient organisational readiness and capacity to enable it. A clinical environment of increasing patient acuity, burgeoning workload and limited resources (Dunn et al. 2023) is unlikely to facilitate role implementation and sustain the required levels of support for NARs. The preoccupation with 'tasks' in the two NHS Trust may signal a 'firefighting' response (McKeown et al, 2019) where efforts to contain service pressures do not address the underlying shortage of resources fuelling these challenges.

A tension seemed to exist wherein the difference between 'nursing' and 'nurses' per se was not recognised. The rationale presented by most study participants that NARs deserved more recognition and pay as they 'did' the same 'tasks' as nurses may fail to recognise that the expectations from multiple stakeholders (i.e., the UK NMC, their own profession, other health and non-health professionals, and the public) for nurses regarding their decision-making and understanding of holistic and pre-emptive care would be different than the expectations of NARs(Steven et al, 2023). Perhaps concerningly, these differences were not readily apparent in this study. At the heart of all this is a discussion about what extra contributions nursing workforce professionals bring to their roles over and above the performance of set tasks, which others may perform just as well or better. Further exploration and definition of these aspects of caring are required, including any externalities and unintended consequences.

Limitations

This study has several limitations. It was undertaken in two London (UK) acute Trusts with high rates of nursing vacancies, at a time when staff were still recovering from the COVID-19 pandemic. The responses might have been given with social desirability in mind. In addition, we do not know whether participants claiming that responsibilities of NAs were unclear had read any documents available to support role realisation. A balance in representation across and within professional groups was not achieved. The higher concentration of predominately senior nurses reflects who came forward for interview. Senior managers, education leaders,

or other organisational perspectives were not examined, nor were organisational guidelines or NAR implementation strategies.

Conclusion

The views and experiences of NARs, HCAs and RNs in this study raise some doubt around the effective implementation of the NAR role. Perceived organisational expectations about the scope of practice of NARs differed from those held by NARs, who largely aspired to progress to become RNs. NARs were commonly perceived by HCAs and RNs to be working as substitute nurses. This fluidity around the application of the NAR role appears to contribute to a sense of invisibility and lack of professional identity.

Efforts must now be made to prioritise NARs professional development rather than simply engaging their capacity to plug gaps in service delivery. However, unless consensus exists in terms of the duties and responsibilities of NARs, efforts to develop the role to support post-holders' progression will have limited relevance. Furthermore, as the role gains momentum and extension in practice, further research and evaluation is needed to ensure that pre and post registration education and practice support meets and balances personal professional and service needs.. Finally, it is essential that the psychological and moral distress associated with the gap between experiences and expectations is listened to and addressed.

Conflict of Interest

None.

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Data not available / The data that has been used is confidential

Due to the confidential nature and potentially sensitive nature of the questions asked in the study interviews participants were assured that the data collected would remain confidential and would not be shared.

Declaration of interests

☒ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.