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ORIGINAL ARTICLE

Healthcare professionals' views of a new second-level nursing associate role: A qualitative study exploring early implementation in an acute setting

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ABSTRACT

Aim: The study aimed to establish the views of a range of stakeholders about their experiences of the newly implemented nursing associate role in England and its potential to contribute to patient care.

Background: Second-level nursing roles are increasingly used internationally within the healthcare workforce. In response to registered nurse workforce deficits, a new nursing associate role has been introduced in England to augment care provided by registered nurses and enable career progression of support workers.

Design: Qualitative descriptive design.

Methods: Semi-structured interviews and a focus group were conducted with a range of healthcare professionals in a large inner city acute secondary care healthcare organisation in England. Interviews were guided by the Consolidated Framework for Implementation Research and analysed using Framework Analysis. The study was reported according to COREQ guidelines.

Results: 33 healthcare professionals were interviewed—directors of nursing, ward managers, nursing associates and multidisciplinary team members. Participants perceived the role was broadly adaptable to different healthcare settings and provided a positive professional development mechanism for healthcare support workers. Managers felt training commitments made implementing the role complex and costly. Participants argued the role had limitations, particularly with intravenous medicine management. Implementation was impeded by rapid pace and consequent lack of clear communication and planning.

Conclusions: The nursing associate role was perceived as an inclusive pathway into nursing but with limitations when working with high-acuity patients. Further evaluation is needed to investigate how the role has embedded over time.

Relevance to clinical practice: The role should be seen as both a stepping stone into registered nursing positions and valued as part of the nursing workforce.

Consideration must be given to how the role can be safely implemented in different settings. Findings have relevance to healthcare leaders internationally, who continue to work in a climate of economic pressure and staffing shortages.

KEYWORDS
implementation, nurse roles, nursing, nursing associate, nursing workforce, qualitative study, registered nurses, role development, workforce planning

1 | INTRODUCTION

Second-level nursing roles are used internationally within the healthcare workforce to support first-level registered nurses in their work. In countries such as Australia and Canada, workforce shortages and economic pressures mean that second-level roles have changed over time moving from the delivery of care to stable patients to an enhanced scope of practice including medication administration (Jacob et al., 2013), alongside increased educational preparation (Dahlke & Baumbusch, 2015; Jacob et al., 2016).

In the UK, a second-level nursing role—the enrolled nurse (EN)—was discontinued in 2000 and nurse training moved into university settings (United Kingdom Central Council for Nursing, 1986). Nurses in this role had reported issues with workload and stifled career progression unless converting to a registered nurse (RN) role (Royal College of Nursing, 2015). The removal of the second-level role led to a reduction in the size of the nursing workforce and an increase in the use of unregulated support workers—healthcare support workers (HCSWs)—thus impacting on overall skill mix (Ball et al., 2019). Systemic failings in some areas of care (Francis, 2013) prompted a review of such roles (Cavendish, 2013) and led to a re-examination of education and training to support high-quality care in nursing and to build the capacity and capability of the workforce heavily affected by staff shortages (Health Education England, 2015). As one part of transforming the workforce to deliver optimal care and to bridge the gap between HCSWs and RNs, a new second-level nursing role—the nursing associate (NA)—was subsequently developed. The NA role was designed both to support RNs and provide career progression possibilities for those in support roles into the nursing profession (Health Education England, 2016). The development of this role sits within a broader picture of new clinical role development designed to address funding, recruitment and retention issues in the National Health Service (NHS) (British Medical Association, 2020).

International research on the use of second-level nursing roles continues to report on the increased use of the role in a broader variety of settings including acute care (Moore et al., 2019), alongside a lack of role differentiation between first and second nursing levels (Kusi-Appiah et al., 2018) especially when demarcated by tasks (Jacob et al., 2013). Research has also pointed to the devaluing of second-level roles (Janzen et al., 2013), which are positioned as focusing on physical care through practical tasks rather than critical thinking, thus reproducing problematic gendered divisions that are still attached to care work (Clayton-Hathway et al., 2020). Previous research has reported the need for more participation from second-level nurses in research to explore issues that have persisted over decades of practice in different countries and contexts (Moore et al., 2019). The advent of the nursing associate role in England provides a useful opportunity to understand how a new second-level nursing role is viewed as it is implemented to avoid replicating some of the problems that continue to be debated in research, policy and practice.

What does this paper contribute to the wider global clinical community?

- The study is one of the first to explore the implementation of the nursing associate role and assess how the new role was viewed by stakeholders.
- The nursing associate role needs to be clearly communicated, championed and supervised and its scope demarcated to build a clear identity within healthcare organisations to avoid it being reinterpreted as a repeat of previous second-level nursing roles.
- A second-level nursing role should not only be seen as a stepping stone into registered nursing positions but also needs to be valued and allowed to exist in its own right.

1.1 | Background and context

Registered nurses (RN) and unregistered healthcare support workers (HCSW) represent the largest proportion of the UK healthcare workforce (Leary et al., 2016). There are 40,000 nursing vacancies in health and care settings in England (Royal College of Nursing, 2020), a number which has been influenced by changes to the funding of healthcare courses and a drop in European nurses joining the workforce following plans to leave the European Union (The Health Foundation, 2020). The coronavirus pandemic in 2020 has also emphasised the need for a robust and sustainable healthcare workforce and although the spotlight on healthcare professions has increased recruitment to pre-registration nursing programmes (Department of

Health & Social Care, 2020), there is still a requirement for creative solutions to the registered nurse workforce deficit.

The development of the nursing associate role intended to increase the capacity and capability of the NHS nursing workforce for patients. Nursing associates can progress onto a shortened nursing course to become qualified as a RN due to the training they have already received. The first cohorts of nursing associates started their 2-year training in 2017, and in 2019, the first qualified nursing associates were registered with the Nursing and Midwifery Council (NMC) following pilot site testing in 35 locations (National Quality Board, 2019). As of October 2019, there were 724 Nursing Associates working in secondary care in England with 114 working in general practice in December 2019 (British Medical Association, 2020). As registered professionals, NAs are individually accountable for their own professional conduct and practice. They are expected to uphold the code of their professional regulator—the Nursing and Midwifery Council (NMC)—and to work within scope (National Quality Board, 2019). This makes them different to other roles used in the National Health Service in England such as the healthcare support worker (HCSW) and associate practitioner (AP) whose roles are not registered and do not have a Personal Identification Number (PIN) from the NMC. Nursing roles in the NHS in England are often described in terms of banding, which directly relates to salary. NHS organisational structure is hierarchical and related to the salary bands. A description of the bands and commonly associated roles is given in Table 1. Nursing associates are 'Band 4' on the salary scale for the National Health Service with RNs starting at Band 5 (NHS Jobs, 2020).

Whilst several studies have been conducted on views of second-level nursing in different countries (Lucas et al., 2021), given the recency of this role development in England, research into how this role is being operationalised and how healthcare organisations have reacted and responded to its implementation is relatively limited. Initial research into nursing associate trainees' experiences largely focused on the training model. In these studies, role ambiguity and the need for role clarity (Coghill, 2018) (King et al., 2019), as well as the need for education and communication about the scope of practice of the role has been reported (Health Education England, 2019). An evaluation of the nursing associate role including expert interviews, a survey with chief nurses in England and case studies of two NHS organisations providing community and mental health care has also been conducted (Kessler et al., 2020). However, the need to understand the implementation of the role in acute secondary care settings remains.

TABLE 1 Banding of nurse roles in NHS in England

Band	Commonly associated roles
Band 2	Junior healthcare assistant
Band 3	More senior healthcare assistant
Band 4	Nursing associate
Band 5	Registered nurse
Band 6	Senior or experienced registered nurse
Band 7	Specialist nurse, advanced practitioner or nurse with leadership responsibility
Band 8	Nurse with significant management or leadership responsibility

1.2 | Aim

Halse et al. (2018) identified seven key factors for healthcare leaders and workforce planners to consider when planning the integration of the new role into their established workforce. This includes wide consultation and engagement with stakeholders at every stage to allow the benefits of the role to be realised and integrated. Given the nursing associate role is new to the healthcare workforce in England, there is a need to understand how it is perceived by second-level nurses themselves and other healthcare professionals who work with them, to ensure optimum teamwork and patient care and to meet the recommendation from the first evaluation of the role by Health Education England (2019) to: 'conduct robust research and evaluation about how qualified nursing associates are being recruited and deployed over time' to help further understand and embed the role (p.8). The overall aim of this study was to explore the experiences of a range of stakeholders of the implementation of the nursing associate role within a large, inner city, acute secondary care NHS organisation. This study was conducted from November 2019–January 2020 before the COVID-19 pandemic.

1.3 | Theoretical framework

Our study was informed by the 'meta-theoretical' Consolidated Framework for Implementation Research (CFIR). This framework was developed from a synthesis of existing theories and was developed to help understand 'what works where and why' in implementation, in this case enabling us to understand how the nursing associate role was 'assimilated into the organisation' (Damschroder et al., 2009). As Damschroder et al. explain, the implementation period is a 'gateway' into consistent and skilled use of the intervention. The CFIR framework consists of 26 constructs under five domains: intervention characteristics, outer setting, inner setting, individuals' characteristics and process. In qualitative studies, in the post-implementation phase, the CFIR can have an application both within data collection and analysis processes (Kirk et al., 2016). Table 2 outlines the constructs that form the CFIR framework.

2 | METHODS

2.1 | Study design and participants

This qualitative study used purposive sampling of a range of healthcare professionals located in one large, inner city, acute secondary care NHS organisation that provided care over four geographically disparate hospital sites. The healthcare organisation was chosen due

TABLE 2 The Consolidated Framework for Implementation Research domains and associated interview questions

CFIR Construct		Examples of associated questions
Intervention characteristics	Intervention source Evidence strength and quality Relative advantage Adaptability Trialability Complexity Design quality and packaging Cost	Can you tell us what you understand of why the NA role was implemented in [organisation name]? What do you understand was the rationale behind bringing in the NA role? What would you see as the benefit or costs to bringing the role? Do you think the NA role has had to be adapted to make it work in [organisation name]? How good is the fit of the NA role in the organisation?
Outer setting	Patient needs and resources Cosmopolitanism Peer pressure External policies and incentives	What do you think is the national need for the NA role? Do you think [organisation name] has been influenced by what other organisations have been doing to the NA role? What incentives (financial and otherwise) were offered by HEE/other Government agencies to implement the NA role? What national policies influenced the implementation of the NA role?
Inner setting	Structural characteristics Networks and communications Culture Implementation climate Readiness for implementation	How did the structure of [organisation name] influence the implementation of the role? How was the role communicated across the organisation? How is communication generally across the organisation? How has organisational culture impacted on implementation? Has culture at the level of ward or unit influenced implementation and perception of the role? How ready is [organisation name] to implement this change?
Characteristics of individuals	Knowledge and beliefs about the intervention Self-efficacy Individual stage of change Individual identification with the organisation	What did staff think about the role and the potential effectiveness or impact the NA role could have? Did you believe that you could make an impact with the role? Did you believe you could work effectively with NAs in clinical areas? How ready were you to take on the new role of nursing associate? Would you consider working in another organisation now that you are qualified?
Process	Planning Engaging Executing Reflecting and evaluating	How clear/structured was the planning for the implementation of the NA role? Tell us about your experience of how the NA role was implemented. To what extent has reflection or evaluation occurred nationally and in [organisation name] about the implementation of the NA role?

to its participation as an early implementor of nursing associates as part of the UK Government's drive to introduce the new role and was therefore in a more advanced stage of implementation than other NHS organisations.

The research was conducted between November 2019–January 2020. It involved semi-structured interviews with different groups of professionals, including nursing associates, managers of hospital wards, directors of nursing for different hospital sites and broader members of multidisciplinary teams who had worked with nursing associates. A qualitative design was considered appropriate as the study aimed to explore healthcare professionals' perspectives and experiences. The consolidated criteria for reporting qualitative research (COREQ) checklist guided the reporting of this study (Tong et al., 2007) (Appendix S1).

2.2 | Data collection

Following ethical approval, information advertising the study was communicated to potential participants via email and flyers. Potential participants included all nursing associates, their managers and relevant directors of nursing. Members of the multi-professional teams who had worked in clinical areas with nursing associates were also contacted. Although sampling was purposive, participants were self-selecting from within the potential participant group. A participant information sheet and consent form were sent or handed out to those who contacted the researchers and expressed an interest in participation. After a minimum of 48 h, two researchers (TT, DD) followed up to answer questions, confirm eligibility, provide further information or arrange a date for the interview to take place. The main reasons for non-participation included capacity issues within the workforce and a lack of knowledge or working relationships with NAs.

Interviews were conducted by three of the research team (JB, TT, DD). Two female researchers (TT, DD) conducted face-to-face interviews and a focus group within the four hospital sites. Both researchers were registered nurses, who were relatively new to qualitative interviewing, so pilot interviews were conducted before the researchers went into the field. Another academic—an experienced qualitative researcher and registered nurse—conducted telephone interviews (JB). The researchers did not know the participants before conducting the interviews. Participants were made aware of

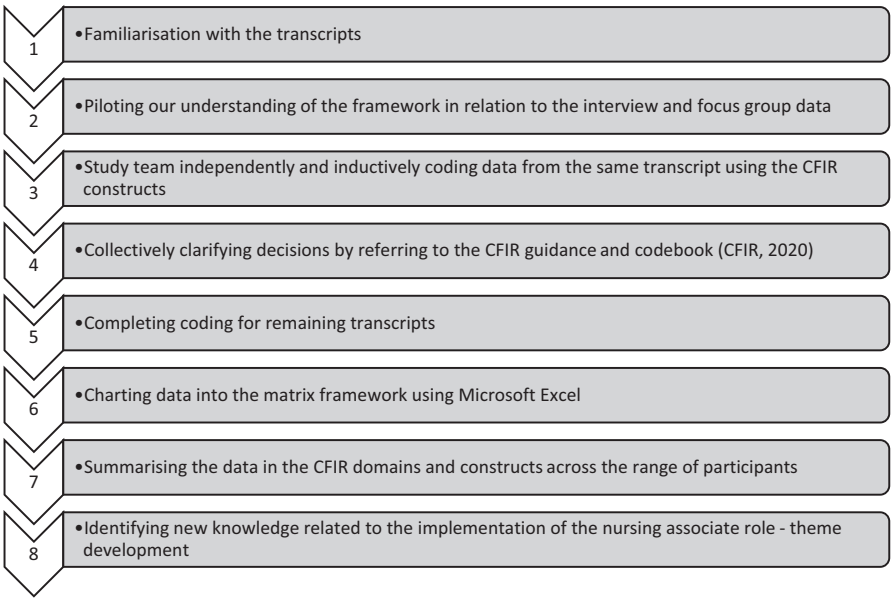

FIGURE 1 Steps undertaken for data analysis

the researchers' backgrounds and that the study aimed to explore experiences and perceptions of the new NA role conducted by City, University of London. Consent was received either via email or in person before the interviews took place. Participants were offered face-to-face or telephone interviews. Face-to-face interviews and the focus group were conducted in private rooms at the different hospital sites. Telephone interviews were conducted and recorded in a private office. No one else was present during the interviews.

The team agreed on a minimum number of interviews to be conducted for each professional group: 5 nursing associates; 5 ward managers; 2 directors of nursing; and 10 multidisciplinary team members (MDT), to access a range of participant views. The minimum was achieved in all groups apart from for the MDT, many of whom were unable to participate in focus groups or interviews due to winter pressures within the National Health Service. Following a review of the data from 33 participants, it was concluded that the sample composition, sample size and the information collected was adequate to answer the research questions (Lincoln & Guba, 1985). No repeat interviews were conducted.

As with other qualitative studies using CFIR (Stokes et al., 2018), questions were devised around all five domains of the CFIR as we began the interviews without an a priori notion of which domains would be most relevant to experiences of the NA role implementation. However, the research team used their healthcare experience to appropriately phrase the questions. The five CFIR domains and examples of the related questions are detailed in Table 2.

As advised by the CFIR guidance, broad open-ended questions were asked at the start of the interview to help establish rapport (CFIR, 2020). Follow-up, open-ended questions were used to allow participants to reflect further on their answers. Single interviews, conducted across the sample, were audio-recorded, lasted an average of 29 min and were transcribed by a professional transcription company. A focus group was also conducted, lasting 52 min and was both video- and audio-recorded to enable accurate transcription. Given the pressures on healthcare professionals' time, it was decided not to return the transcripts to the participants for comment or correction. All researchers involved in data collection checked the de-identified transcripts against the audio recordings for accuracy.

2.3 | Analysis

Data analysis was initially deductive, using thematic framework analysis (Ritchie et al., 2013) with the process guided by the approach taken by Gale et al. (2013)—the steps are outlined in Figure 1. Interview and focus group data were pooled and analysed collectively, with the role of the interviewee being given greater significance in the analysis than the nature of the data collection. NVivo Pro V12 (QSR International) was used to support the initial coding of the transcripts to the CFIR constructs, as it offered a predetermined structure for the different members of the study team (GL, TT, DD, LA) working concurrently on the transcripts. Data were then coded within a grid using Microsoft Excel, with the analysis framework predetermined by the CFIR. Once the data had been charted into the matrix framework, an inductive approach was taken to identify new knowledge related to the implementation of nursing associates in this context and themes were identified. All members of the research team were involved in the data analysis and themes were finalised through discussion and agreement where there was a diversity of interpretation.

2.4 | Ethical considerations

Written and verbal information about the study was given to the participants and consent received before interview. Participants were informed that participation was voluntary and that they could withdraw their participation at any time up to the point of

data analysis. Confidentiality was assured unless relating to a risk of harm. All participants were given an identification number to ensure anonymity. Ethical approval was provided by City, University of London, School of Health Sciences—Health Services Research & Management review committee (reference ETH1920-0097). Approval to conduct the study in the NHS was also provided by the Health Research Authority (HRA) and by the healthcare organisation's research and development (R&D) department. No participants withdrew their data.

3 | RESULTS

Thirty-three participants were recruited to the study. The sample comprised ten ward managers, nine nursing associates, five directors of nursing and nine members of the multidisciplinary team consisting of healthcare assistants, physiotherapists, advanced nurse practitioners and practice development nurses. Synthesised results are presented in the following sections, and the key themes and associated CFIR constructs are presented in Table 3. For some of the CFIR constructs, for example the outer setting, no themes were identified during the analysis; therefore, these have been omitted from the results section. In addition, the MDT participants were unable to discuss the role at length as they were mainly unaware of it. Where they have raised relevant points, they have been included in the sections below.

3.1 | Domain 1: Characteristics of the intervention

In terms of assessing the characteristics of the NA role, themes related to four constructs of adaptability, complexity, design quality and packaging and cost.

3.2 | Varied adaptability of nursing associates in clinical practice

Across the stakeholder groups, participants expressed that the NA role needed to be adaptable to fit the needs of the different clinical areas, suggesting that nursing associates need to be 'mould[ed]' to some degree to work within settings (WM2). However, role boundaries and organisational issues limited this adaptability, particularly in relation to giving IV medication, which NAs felt restricted their functionality. In clinical areas with high patient acuity, NAs commented that there were fewer opportunities to use their skills and registered nurses were more suited to the workload. Directors of nursing focused on the potential specialisation of the role, specifically in enhanced care settings. Indeed, beyond the limitations described, NAs themselves felt that the role was intrinsically adaptable and would have use in community and mental health settings as well as hospitals.

3.3 | Complexity of the new role and 'how it works' in practice

Different facets of the NA role were evaluated to be complex by different stakeholder groups. Ward managers explained that the characteristics of each clinical setting added to the complexity of implementation. Complexity also related to the perceived level of disruption, for example, where WMs needed to create an NA post and, in the process, had to lose a band 5 post. Where NAs' scope was limited, this was said to impact the workload of other staff. WMs described a number of steps they had to enable the role to work in practice. Directors of nursing in the organisation pointed to issues around the complexity of enabling staff members to take up the NA training as some wards could not manage to release HCSWs due to staffing levels, implying that the national policy to integrate the role was not sufficiently supported by central funding. Nursing associates described complexity in terms of how they felt they were wearing multiple 'hats' and 'jumping' between roles (NA9) as HCSWs, NAs and training to be RNs, which didn't give them time to consolidate their role as a NA before moving on to the next stage of the ladder.

3.4 | Design Quality and Packaging of the NA role: 'How do you identify them?'

The presentation and identification of the NA role was reported to be an issue across the stakeholder groups. NAs did not have a specific uniform due to their low numbers in the workforce and this was specifically identified as an issue by MDT members and NAs as their lack of uniform prohibited recognition and 'identification' of the role (NA4). Alongside the physical presentation, WMs and NAs described there was 'inconsistency' in terms of 'how the role should look, will look' (WM1) with a lack of a clear job descriptor about what NAs could and could not do. They felt this affected the impact the role had on the wider workforce and their motivation to embrace it within the wider teams.

3.5 | Costs of implementing the new NA role

The cost of the NA role was discussed by all the different stakeholders. For DoNs and WMs, cost related to backfill to allow for HCSWs to attend training and the challenges associated when NAs were not able to fulfil all the role requirements before they had completed their training. Across the other stakeholder groups, it was broadly perceived that the NA role was a long-term cost-effective intervention to reduce the numbers of agency staff and fill RN vacancies. Additional cost benefits related to the NA apprenticeship providing a route into the nursing profession for those who were unable to afford to go through the traditional university route. One DoN also expressed that there had probably

TABLE 3 Summary of the factors influencing implementation of the nursing associate role by themes

CFIR Domain	Theme	Quotations
Characteristics of the intervention	Varied adaptability of NA in clinical practice	'We have limitations, so we can't do certain things and it's not always possible to have all the patients who will fit in terms of me being able to look after them. So that's the difficulty, and some wards' patients, their dependability on the nurses is much more – so if they are at risk or they are very sick' (NA8) 'Having people skilled up in physical and mental health working in enhanced care for example. The nursing associate role is brilliant in that context and it's been an opportunity for us to look at roles across pathways' (DoN4).
	Complexity of the NA role and 'how it works' in practice	'What is the environment like, what's the throughput, what's the patient group, what's the demand, how many patients have IVs?' (WM1). 'What has been difficult is the numbers. The national policy was we need to get all of this number through, fine. But actually, you haven't given us the levers to make that change' (DoN4).
	Design quality and packaging of the NA role: 'How do you identify them?'	'They should have a specially identified uniform or name badge, to be placed, clearly visible for others' (MDT4). 'I'm sort of in a mishmash of scrub and trousers and it's sort of like, so what do you do and then I have to show my badge' (NA3).
	Costs of implementing the new NA role	'So, the role is good because the amount of money we spend, as a ward, on agency staff, especially late cancellations with high cost agencies.'(WM10). 'You can imagine across the whole trust, that was just for this, for our site it was still a massive cost pressure, but it was just huge' (DoN 5).
Inner setting	Implementation climate—'more accepting' of the role *Tension for change in the nursing workforce* *Compatibility dependent on clinical area*	'When you bring these sorts of roles in and it's not just about those individuals, it is about the workforce around them being ready for them and embracing them' (DoN4). 'The fact that we are looking at our grassroots staff and giving them a pathway for development because that hasn't existed at all, I think that's fantastic' (WM1) 'I think it depends what area they're in as well because if you're in somewhere like intensive care, it might not be the most appropriate area for a nurse associate […] But across the general areas, I think they're a good addition to the workforce because generally the people that have done the course have had a lot of experience of being a HCA first' (MDT1)
	Readiness for implementation of the NA role: 'it was slow' *Leadership engagement* *Available resources to support the role implementation* *Access to knowledge and information about the NA role*	'Descriptions, competencies and there isn't a uniform etc I think they're coming soon. I don't know if they have been implemented yet […] It was slow.' (WM9) 'We're lucky we had a very flexible leadership who were willing to embrace it, very good education academy who just went for it.' (DoN4) 'We're only now just getting these PDN roles to support' (DoN1) 'I think that the role of the ward manager is an incredibly challenged one and whilst email information and using intranet and face to face conversations about the nursing associate, and the lack of real detailed policy description as well has been probably an element of concern' (DoN3)
Characteristics of individuals	Knowledge and beliefs about the NA role: 'a stepping stone'	'The ultimate goal is to be a registered nurse, which I felt being a nursing associate would be a stepping-stone into the nursing full registration.' (NA2) 'For me, whilst there a number of concerns that I have about the nursing associate programme, I do see it as an opportunity to actually grow our local workforce either through ensuring that we can provide mechanisms for our current support workers or nursery nurses to actually step onto the nursing associate programme and secure a foundation degree programme, or perhaps in the longer term to actually look at direct recruitment from our local communities.' (DoN3)
	Individual stage of change: 'getting used to it'	'When we started, they [nurses] just couldn't be bothered but they're getting the hang of it now. I think because it's like mother, child. So, "OK, you do that, you're supposed to do that, you don't do that, OK" […] So, they're getting used to it now.' (NA2) 'Well, I can understand the difference from being healthcare support worker from just reporting to the nurse or the sisters, I can actually know why this is happening and act on it without, I will tell her but if I can fix it myself then I will do it and I can know evidence base behind that, that one I, I've learned a lot.' (NA8)

(Continues)

TABLE 3 (Continued)

CFIR Domain	Theme	Quotations
Process	Role planning: 'had to get the ball rolling'	'I think there are always opportunities for us to have got more ready, to have actually had a specific allocated team with people in post and directly project managing the implementation of the nursing associate programme' (DoN 3). 'I felt when they first started, they came in very quick and I thought it was a little bit disorganised because, that's how I felt because I think with the initiative, it, all of a sudden, we knew it was happening but I felt like [organisation] all of a sudden took them.' (WM6)
	Executing the NA role in practice: 'it will take a while'	'Today we're quite fully staffed and there aren't enough HCAs, so I'm having to take on my, well HCA role [...] Well it's sort of a back step [...] all that training, all that learning, if you're not really using it' (NA3). 'They practice on their own. They do everything on their own, within their limit. If they need anything, that they can't do, they escalate it to the nurse in change and the nurse in charge will do that for them' (WM10)

been an 'emotional cost' in terms of the introduction of a new role and the questions it might have raised for ward managers around ensuring safety (DoN1).

3.6 | Domain 3: Inner setting

The inner setting within the CFIR includes the structural and cultural contexts for the implementation. In this study, stakeholders focused on how the implementation climate of the healthcare organisation had transitioned to become more accepting of the role and how the organisation lacked readiness for its implementation.

3.7 | Implementation Climate: 'more accepting' of the role

Overall, receptivity to the NA role was mixed and DoNs questioned the readiness of the organisation and the staff within it to embrace the new role. Nursing associates felt that some nursing colleagues were anxious about the implementation: 'Band 4 s coming to take the nurses' jobs sort of thing' (NA2). This was partly due to a lack of understanding, which led to nurses asking lots of questions of NAs about their role and remit. Some NAs felt that this did change over time with colleagues being more supportive and 'more accepting now' (NA2) and that nurses 'appreciate our support' (NA4). This view was endorsed by ward managers who felt that, despite some initial reservations, 'everyone is on board now' (WM9). However, NAs described how opinion remained split and they were still thought of as a 'cheap nurse' (NA6). DoNs also recognised that this remained an issue.

Two of the six sub-constructs aligned with a positive implementation climate in the CFIR were also identified by participants as influencing the NA role implementation. Participants reflected that there was tension for change with a clear need for the role in the workforce and that the role was compatible with the organisation because NA staff had experience from within the organisation already.

Tension for Change in the nursing workforce: Directors of nursing reported that both within the healthcare organisation and the NHS more broadly, the make-up of the nursing workforce required change. Reduction in nursing students had meant fewer nurses had joined the workforce. The removal of the bursary for nursing degrees had also affected recruitment levels meaning that there was a clear need to look at innovations. This was also identified by ward managers who described the lack of a 'development pathway for grassroots staff' (WM1) coupled with a constantly increasing vacancy rate for nurses and lack of application for posts in the NHS.

Compatibility dependent on clinical area: WMs and MDT participants felt that there were certain areas where the role was a good fit within the organisation, such as medical and surgical wards or older people's services but in other areas, such as intensive care, it was seen to be unsuitable for NAs to work because of the limitations of the role. However, despite these restrictions, the role was generally well received by teams because NAs' experience and knowledge were already embedded in the organisation.

3.8 | Readiness for Implementation of the NA role: 'it was slow'

In terms of the tangible indicators of the organisation's decision to implement the intervention, ward managers and DoNs expressed that the organisation was not ready for the role because NAs could not 'function at the level that they're trained at' (WM1) and lacked guidelines in terms of how they function within teams. However, DoNs suggested that there would never be an ideal time for implementation and that this problem was not unique and affected the health service as a whole.

Three sub-constructs were identified within the themes related to the organisation's perceived readiness for the role. *Leadership engagement* and *available resources* to support the role implementation focused on the role of practice development nurses (PDNs) in supporting and supervising the role, which was seen by WMs and DoNs as critical for embedding and clarifying the role in the organisation, although potentially the resource was insufficient to support a 'huge

culture change' (DoN1). In terms of *access to knowledge and information* about the NA role, several WMs considered that the speed of the implementation and its 'pioneering' aspect (WM8) meant that 'the detail wasn't there' in terms of information about the role (WM1). This was reiterated by DoNs, who felt that more 'detailed policy description' was needed for the role (DoN3). All the nursing associates interviewed described the impact of a lack of knowledge about the role amongst staff as they had to explain their role to colleagues. Interviews with MDT members confirmed that this is how they had found out about the role. Knowledge about the role was also impeded by a lack of perceived visibility for the role given the relatively small numbers of NAs, as one NA explained, 'we're just a drop in the ocean' (NA4).

3.9 | Domain 4: Characteristics of the individual

The fourth domain within the CFIR relates to individuals involved in the implementation and their attitudes and behaviours.

3.10 | Knowledge and beliefs about the NA role: 'a stepping stone'

All WMs, NAs and some MDT participants saw the NA role as a positive innovation that could provide a pathway and 'stepping stone' (WM6) for support workers to develop their careers. This fitted well with the staff development aspect of WM roles and all the DoNs spoke with some level of enthusiasm for the potential of the role, particularly from the perspective of a socially inclusive agenda and an opportunity to grow the local workforce either from within the organisation or the community.

All NAs discussed the value they saw in the role and the new focus on their knowledge of why action was taken, critical thinking, being able to work with more independence and increased responsibility. Whereas NAs believed in the value of their work, some WMs expressed some personal concerns that this was a long-term solution to RN vacancies. Some saw it as recreating the 'enrolled nurse' role that they had experienced earlier in their careers.

3.11 | Individual stage of change: 'getting used to it'

WMs reported that they had to adapt to the role over time (WM4). One WM commented that they had not seen any benefit thus far in the NA role implementation. It was not clear that all WMs were progressing to enthusiastic use of the intervention but there was a general sense of optimism that there would be expansion and continued use of the role. Ward managers felt that it was the HCSWs who had experienced the greatest change from the introduction of the new role and described them as 'invigorated' as they wanted to get on to the NA programme (WM1). NAs themselves discussed how they had enhanced skills, were able to offer 'upgraded care' (NA5) and had 'improved confidence' (NA2) and how it made them want to recommend the route to others. However, whilst they had moved ahead, NAs felt the progress was slow and not unanimously shared by nursing colleagues who were still 'getting used to' the role (NA2), or indeed by every NA, as adapting to change was an individual journey. Participants from the ward manager and MDT groups explained that there was a 'big jump' between the HCSW role and the NA role (MDT6) and sometimes 'in their mentality' some NAs were still HCSWs (WM9).

3.12 | Domain 5: Process

In terms of the implementation process, in this study, participants particularly focused on the planning and execution of the NA role.

3.13 | Role planning: 'had to get the ball rolling'

Across participant groups, there was a sense that the introduction of the role was a 'rush' (WM7) and they just 'had to get the ball rolling' (WM1). Most of the ward managers felt that they were not prepared and were 'thrown in at the last minute' leading to a 'sink or swim outcome' (WM3). Directors of nursing held similar views in terms of the lack of preparation time and its impact on the initial quality of the implementation. However, both managers and directors felt this to be usual within health care and expressed pragmatic views of needing to 'design it as we went along' (DoN2), although reflecting that a 'more structured way' of planning roles would be beneficial (DoN4).

3.14 | Executing the NA role in practice: 'it will take a while'

There were mixed views of the role execution, with some NAs and other professionals feeling that they were able to execute the role and could 'feel the difference' of working as an NA (NA6). However, across all professional groups, including around half the NAs, there was criticism that the NAs were not 'fully functioning' or working at full scope (WM1). Indeed, sometimes the NA role was seen as unhelpful by WMs because of its limitations and it became a 'burden on nurses' rather than a support as planned (WM5). Although the role was planned to enable HCSWs to enhance their skills, this was sometimes not being executed in practice due to staffing issues coupled with the lack of a clear job descriptor within the organisation.

Overall, there was an understanding that the role might take 'a year to embed' (WM1) and that it would improve over time. Success was seen to be dependent on NAs being 'utilised appropriately in the clinical areas' (MDT6). Indeed, as one DoN explained, there was a relatively small number of NAs working in practice and they worked best in areas 'that designed what they needed' (DoN3). Two WMs

also commented on the NA intervention against its planned objective as a pathway into nursing stating that NAs may not be ready to go straight into nursing training and required time to 'consolidate' the role first (WM8).

4 | DISCUSSION

This is one of the first qualitative studies of the new nursing associate role in England and the first, to our knowledge, to use the CFIR to explore how the role has been perceived by healthcare professionals. Given the challenges reported with second-level nursing roles internationally over recent decades, the use of a meta-theoretical implementation science framework has enabled us to systematically explore a range of constructs that stakeholders perceive as impacting the implementation of the role.

In terms of the characteristics of the NA role, within the hospitals in this study, the role was limited in acute care by its scope (particularly by not being able to give IVs) and because some wards/areas were not able to accommodate Band 4 s. Previous research from Australia and Canada has identified that adaptability is thwarted by restrictions on second-level nursing roles (MacLeod et al., 2019; McKenna et al., 2019). However, the NA role was broadly perceived by participants to have the potential to be adaptable across settings into mental health and community settings as has been set out for the role (NHS Employers, 2019). Furthermore, the role may have developed through the COVID-19 pandemic wherein further understanding of its utility in critical care settings, for example, will have been gained.

Concerns about how to identify and differentiate the NA role were frequently raised by participants. These concerns related to a lack of consistent physical identification for the role (i.e. uniform) and the need for clear job descriptions within the organisation. Studies of other second-level nursing roles have reported similar issues with role identity (Janzen et al., 2013) and organisational failings with job descriptors have been identified in a review of nursing roles (Kusi-Appiah et al., 2018). Other studies have reported that trust and value developed over time helps to cement identity for these nursing roles within healthcare teams (Huynh et al., 2011) (Melrose et al., 2012).

The cost and complexity of the NA role implementation were identified as entangled for ward managers and directors of nursing. The complex process of taking HCSWs through training into the NA role and then into RN training had knock-on effects in terms of staffing and thus in terms of costs. NAs also discussed that the transitions between the roles and the multiple hats that had to be worn during this process added to the complexity. Although a longer-term cost benefit was generally perceived to have influenced the role development, shorter-term cost pressures were discussed both in financial and emotional terms. As Halse et al. (2018) argue, the introduction of a new role in the healthcare system given financial pressures is challenging and it is difficult to balance training to build capacity as it can place the rest of the workforce under strain.

The second domain of the inner setting of the healthcare organisation focused on the implementation climate within the organisation and its readiness for implementation in relation to the NA role. In terms of the climate, there was mixed receptivity from staff, with anxiety about the role especially evaluated to come from RNs. Previous research has highlighted that second-level nursing roles might be seen as a threat to first-level nursing, especially if scopes are poorly differentiated (Kusi-Appiah et al., 2018) and where professional identity has been gained through graduate status and a focus on critical thinking skills (Anderson, 2017). Indeed, analysis of the introduction of professional roles in health care has identified that such roles can be seen as devaluing current roles with an emphasis placed on cost savings rather than patient care (The King's Fund, 2020). Whilst stakeholders identified a need for change across the professional groups in terms of gaps in staffing and in the career pathway for healthcare support workers, whether the NA role was fully compatible with organisational needs was debated.

With regard to the healthcare organisation's readiness for implementation of the NA role, a lack of knowledge and information about the role was highlighted by participants as negatively impacting their understanding. Previous research into the use of the new physician associate role in the healthcare system in England has identified that preparing the existing workforce about the role with information and a vision of its use within the organisation is a positive facilitator of integration (Roberts et al., 2019). Indeed, the issue of communication has already been raised in evaluation of the trainee scheme for nursing associates where it was argued that a programme of effective communication to educate and inform existing colleagues of the scope and practice of the NA role was required (Health Education England, 2019). The use of practice development nurses to support the NA role was identified as a positive resource for supporting the implementation and something that would help to further establish it.

The domain of characteristics of individuals highlighted individuals' beliefs about the role. Across the participant groups, there was enthusiasm and support for the development of healthcare support workers who were largely seen to have developed positively and grown in their new NA role. The power of the role to grow and develop a local workforce was particularly acknowledged by DoN participants, reflecting a broader survey of chief nurses in England who saw the NA role as an opportunity to 'grow-their-own' nurses (Kessler et al., 2020) . However, views of the former UK second-level enrolled nurse role also impacted some views of the nursing associate role. Given that enrolled nurse position was devalued and had poor prospects (Kenny, 1993), this lasting impact again suggests the need for communication that clarifies the NA role.

Participants' views on the process of the implementation of the role focused on planning and execution. There was an overall consensus the organisation and its staff had to quickly adapt to the role and work out how to use it and make it work without much time to plan. This arguably had an impact on how the role was executed. Some NAs commented that they had to work below their level and

were not able to fully take on the role in practice due to patient needs and staffing shortages, which proved frustrating. Given the recency of the role implementation, participants felt it would take longer to embed. Indeed, overall, participants reflected that the role would take time to integrate fully into the workforce, reflecting interim findings from research into the NA role conducted within community and mental healthcare settings (Kessler et al., 2020). The process of embedding the role was felt to be assisted by educators, echoing the findings of a review of new workforce roles that emphasises the importance of clinical educators in work-based learning (Halse et al., 2018).

4.1 | Limitations

This study took place in one large healthcare organisation in an inner city context in England and thus transferability to other settings may be limited. Whilst participants were drawn from a range of wards and clinical areas within the hospital, overall a relatively small number of professionals were interviewed. Furthermore, the study did not look at how the NA role was perceived in settings outside of the secondary care environment. This qualitative interview study used purposive sampling to recruit a sample that varied by healthcare professional group. However, recruitment was challenging—particularly amongst MDT members—this can be partly explained by the finding from this study that there was poor communication about the role and issues with its identification affecting knowledge of the role and thus the ability for MDT members to voice an opinion. Overall, due to the recency of the role and the small numbers of NAs throughout a large organisation, some participants felt their views were partial because their interactions with NAs were limited. This points to the need for a 'critical mass' of the role to impact across an organisation (Wood et al., 2011).

The use of the CFIR framework offered several advantages, most notably that it allowed us to focus on constructs most apposite to our findings (Stokes et al., 2018) and make sense of the data (Warner et al., 2018). However, participants' knowledge and time impacted on our ability to ask the full range of questions. We found that participants did not specifically comment on some constructs such as reflecting and evaluating on the NA intervention. Furthermore, participants were unable to draw conclusions about the 'relative advantage' of the role because there was little to compare it with and there was an awareness that the recruitment of more RNs was not an option.

5 | CONCLUSION

This study provides one of the first analyses of the nursing associate role in England in an acute care setting. In this study, the nursing associate role was well received in terms of its ability to provide an inclusive pathway into nursing and to build the careers of healthcare support workers but the speed of implementation and issues with communication and information affected the understanding of the role across the organisation.

The interview data highlighted the interconnection of individuals' views on the implementation, and the range of voices allowed us to understand the different perspectives of the stakeholders. It was apparent that the characteristics of the healthcare organisation had a significant impact on the implementation and studying these through the lens of the CFIR allowed us to understand the complexity of implementing and embedding a new role. Further evaluation is needed to investigate the role more thoroughly over time, as well as examining how it operates in different settings. This is especially important in the wake of the COVID-19 pandemic, which may have impacted on the embedding process.

6 | RELEVANCE TO CLINICAL PRACTICE

The nursing associate role needs to be clearly communicated, championed and supervised and its scope demarcated to build a clear identity within healthcare organisations to avoid it being reinterpreted as a repeat of previous second-level nursing roles. The role should not only be seen as a stepping stone into registered nursing positions but also needs to be valued and allowed to exist in its own right. The safe limits of the registered NA role are clearly defined and as such, consideration should be given to the most effective contexts for NA practice. These findings, based on the development of a new nursing role, have relevance to all healthcare leaders when planning and implementing new clinical roles in the workforce, particularly in a climate of economic pressure and staffing shortages.

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CONFLICT OF INTEREST

The authors report no conflicts of interest.

AUTHOR CONTRIBUTIONS

Supervision and funding acquisition: DS and JB. All interviews: TT, DD and JB. Data analysis: All authors. First draft of the article: GL and JB. Manuscript finalisation: All authors. Reading and approval of the final manuscript: All authors.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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