Pioneering new roles in healthcare: Nursing Associate students' experiences of work-based learning in the United Kingdom

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In order to address urgent workforce considerations and changing demographics, in 2017 the National Health Service in the United Kingdom introduced a new role in healthcare, the Nursing Associate. Education for the new role was delivered by work-based learning in partnership with local universities. This paper reports on a qualitative longitudinal study of a study which explored the experiences of work-based learners enrolled at a university in London. Data was collected in two stages over a six-month period: 17 work-based learners participated in interviews in stage 1 and seven in stage 2. Data was analysed using framework analysis; the framework was derived from a systematic literature review about introducing new roles in healthcare. Results have resonance for work-based learning programmes in healthcare and beyond and included the importance of adequate time for work-based learning; supervision by a skilled clinical educator; stakeholder engagement; a well-defined scope of practice and an appropriate and supportive educational programme. Participants valued the input of experienced qualified staff but appreciated the capacity issues that militated against their progress, as staff were not always able to support them. Participants also identified the necessity to take responsibility for their own learning in clinical practice. University-based learning was valued more highly than learning in practice, suggesting, as has been established elsewhere, that work-based learning opportunities in healthcare can be difficult to identify.

Keywords: work-based learning, healthcare apprenticeships, nursing associate, healthcare workforce

Introduction

The National Health Service (NHS) is one of the biggest employers in the world, and the largest in the United Kingdom with 1.5 million employees (Nuffield Trust, 2019). Workforce shortages are currently the biggest threat to the NHS, with the changing demographics of

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the UK population bringing associated pressure on services (Beech et al 2019). This shortage is most acute in the registered nursing workforce with 41,000 vacancies, representing one in every eight posts (Nursing Times, 2019). In 2017, the Nursing and Midwifery Council (NMC) reported that more nurses and midwives were leaving the register than being admitted (NMC, 2017).

One way of addressing this workforce challenge is the exploration of introducing new roles in healthcare. In the past decade, two reviews, Willis (2015) and Imison et al (2016) highlighted the need for a new role to bridge the gap between health care support workers (HCSWs) and registered nurses (RNs). The recommendations of the two reports were taken forward for implementation by Health Education England, an arms-length government organization, by the introduction of a role that became known as a *Nursing Associate*. The nursing associate role was introduced in 2017 with the overall aim of improving the capacity and capability of the NHS to care for patients. The route to qualification was by work-based learning in partnership with local universities.

The new role was designed to be more flexible than established nursing roles, working across the traditional fields of nursing and throughout the lifespan in hospital, community and home-based services. The role also provided a route to qualification as a registered nurse, and, in order to overcome barriers to education for more mature entrants, was delivered by an apprenticeship model led by employers in partnership with higher education institutions (HEI). The model of delivery was an 80:20 split between work-based learning in clinical practice and university-based education.

The role was introduced at pace. Health Education England announced in July 2016, that the role would be introduced in two stages. One thousand trainee nursing associates (TNAs) were recruited in December 2016 to start in January 2017, with a further 1,000 starting in April 2017 (Coulson 2019). When the first intake commenced their course in 2017 the role was not regulated by the Nursing and Midwifery Council (NMC).

This paper reports a qualitative longitudinal study, which was chosen to track the experiences of students as pioneers on this unregulated course; following their experiences

gave us the opportunity to gain insight into how the course developed and became embedded over time, from the students' perspective.

The longitudinal study was undertaken in a university in the United Kingdom over an eight-month period. Work-based learners on a programme leading to qualification as a nursing associate were interviewed on two occasions. The data from interviews were analysed using framework analysis drawing on the seven recommendations of Halse et al (2018) for introducing new roles in healthcare. This paper reports on the experiences of students in a novel learning situation in relation to the framework provided by Halse et al (2018).

The aims of the study were to establish the experience of work-based learners studying a course leading to qualification in a new role in healthcare and to establish changes over time experienced by the students as the role became established in the NHS.

Background

New roles in healthcare

The introduction of new roles in the NHS was considered by Bridges and Meyer (2007). In the policy context of role expansion, investment and the modernisation of the NHS, Bridges and Meyer (2007) called for increased focus on the intricacies of new roles in healthcare and reflection and review as they are introduced. They also conclude that the more flexible roles are (as in the Nursing Associate role), the more they are likely to change once introduced, and this in turn causes difficulties for regulation. At the time of writing, the United Kingdom along with other countries, is under lockdown due to the COVID-19 pandemic, which struck just one year after the first nursing associates joined the NMC register. Emergency regulatory changes have been applied to established roles, such as in midwifery, radiography, medicine or nursing but have not been extended to the new role, despite its flexibility, and work-based focus during training (NMC 2020). This approach potentially reflects the novelty of the role and stage of embeddedness in clinical practice and raises issues about regulation.

Work-based learning in healthcare

In a systematic review Nevalainen et al (2018, p26) reported three main influences on nurses' experiences of work-based learning: the culture of the work community; the structure, spaces and duties of the nursing workforce; management and interpersonal relationships. Interestingly, the paper reports that lack of management support is the greatest impediment to work-based learning for nurses. The authors describe the double bind of increased need for effectiveness in clinical practice counterbalanced against the professional development needs of nurses.

Additionally, Attenborough et al (2019) report that, despite the richness of learning opportunities in healthcare environments, the identification of these opportunities can be difficult for both students and their supervisors. Threats and opportunities to work-based learning are discussed, with time and capacity militating against learning in most clinical environments. These findings correspond with the view of Eraut (2004), a workplace learning researcher, who discussed learning as being on a 'continuum of formality' (p250), informal or tacit learning being '*largely invisible*' (p249). He discusses the lack of consciousness and recognition of informal learning, describing the characteristics of informal learning as '*implicit, unintended, opportunistic and unstructured learning and the absence of a teacher.*'

Furthermore, Brown (2016) discusses the context of knowledge acquisition; the 'codified knowledge' that comes from academia through books and journals versus the 'situated knowledge' (p186) in clinical practice that dominates work-based learning. Drawing on recontextualization as a theoretical construct for learning as students learn and ultimately put the new knowledge into their own practice, Brown suggests (p188):

> *…the process of recontextualization is a whole body response to learning that changes learners as individuals, as well as the context (workplace) in which they operate and ultimately the knowledge itself.*

Focussing on the experience of medical students, Brown highlights the importance of links between clinical practice and universities; the scaffolding of knowledge; the importance of

learning conversations between staff and students; the utilisation of learning in the workplace and the sharing of practice between the university and clinical areas.

Correspondingly, using a literature-based concept analysis Manley et al (2008) define what distinguishes work-based learning in healthcare and what makes for success. Through undertaking a concept analysis, the authors suggest a definition of work-based learning in healthcare, which includes:

> *The everyday work of health care is the basis for learning, development (including evidence implementation) enquiry and transformation in the workplace (p121).*

The emphasis is on the importance of work-based learning to support the principles of life-long learning and the potential to provide significant benefits for healthcare organisations, while Chapman (2006) reports on work-based learning as a way of improving patient care, one of the aims of the introduction of the nursing associate role. Chapman identifies work-based learning as having *'improved the quality of care*, *increased health promotion, increased access to services, increased patient choice and reduced risk of infection.'* (p41). Work-based learning helped participants to feel *'emotionally engaged' (p43)* with their studies because of the direct link to improved practice.

Additionally, the position of apprentices under the relatively new implementation of the apprenticeship levy is addressed by Booth (2019). Whilst this account is situated in the retail sector, there are similar concerns about the shifting external and political factors that affect work-based learners under the apprenticeship scheme in the United Kingdom. Booth (2019) suggests that perhaps resilience in relation to this context should be part of work-based learning programmes.

The experiences of work-based learning by nursing associate trainees

There are few papers about the experiences of nursing associate trainees due to the newness of the course and role. However, Thurgate (2018) reports on a forerunner of the nursing associate, the assistant practitioner, in a paper about the experiences of those undertaking a work-based programme, recruited from the healthcare assistant (HCA)

workforce. Thurgate identifies that supporting work-based learners in the healthcare context requires different skills to supporting those who are supernumerary such as those studying nursing degrees, and that staff need to understand the difference. Overall this paper identifies the importance of a '*workplace culture which supports, accommodates and learns from the development and implementation of new roles'* (p87).

In two related papers from an early experience study of nursing associate trainees Coghill (2018a; Coghill 2018b) reports on the balance required to be both an employee or 'worker' and a student or 'learner' in clinical practice. The papers recommended raising the profile of the role with staff and patients, clarifying whether the TNAs are learners or workers and assisting managers to identify and enable learning opportunities for TNAs. The issue of protected time for learning is considered worthy of further debate.

Finally, in considering the difficulties of undertaking research in the workplace, Eraut (2004) cites: the lack of visibility of learning; how that learning is viewed, which may be as part of a person's capabilities rather than knowledge actually acquired and put into practice; and the fact that the complexity of knowledge gained in the workplace is difficult to articulate. Although the research described in our paper is about work-based learning and was undertaken at a university rather than in the workplace, Eraut's description of his research in the workplace, both observational and through interviews acknowledges the challenges of investigating the acquisition of knowledge at work.

The research reported in this paper is situated in a specific place and time, an important part of the developing story of the NHS in responding to change. At a time of workforce crisis and demographic change a new role was introduced to enhance patient care. Planning, reports and recommendations abound about introducing a new role in healthcare and the theory and practice of work-based learning. The current research aimed to investigate the experiences of those undertaking the nursing associate course through work-based learning over a period of time, viewed through the lens of a systematic review of existing recommendations about introducing new roles in healthcare (Halse et al, 2018).

There are few studies about the nursing associate role *per se*, but Halse et al's (2018) systematic review was undertaken at the time of the introduction of the new work-based learning course for trainee nursing associates. In their article addressing the challenges of introducing new roles in healthcare, the authors identified seven factors (p35) that contribute to successful implementation. These are: robust workforce planning; well-defined scope of practice; wide consultation and engagement with stakeholders; strong leadership; an education programme that mirrors patient need; adequate resources for work-based learning; and supervision by a skilled clinical educator.

Methods

This is a longitudinal qualitive interview study, to explore the experience of trainee nursing associates over time. Though commonly used in quantitative studies longitudinal methods are relatively unusual in qualitative research (Hermanowicz 2013). The method was chosen acknowledging the newness of the role and course and to enable the researchers to investigate the students' experiences of and responses to being pioneers, part of a specific change to healthcare delivery in the United Kingdom, based on policy. To assess the embeddedness of the role, the data were collected in two stages and two methods were used, group interviews at stage 1 (April 2019) and individual interviews at stage 2 (November 2019). Group interviews offered the opportunity to gather added value from the group dynamics and interaction between students, whilst the individual interviews enabled in depth exploration of the students' personal experiences and the issues raised in the group interviews in greater depth.

Stage 1 of the study was completed in April 2019. Trainee nursing associates (TNAs) studying at a university in the United Kingdom were sent details about the study by e-mail and invited to take part in a group interview. These took place in parallel with objective structured clinical examinations (OSCEs), tests of practical skills in a laboratory environment, which may have encouraged a higher response rate. Informed consent was obtained before data-gathering began. Of the 18 TNAs on the course, all but one agreed to take part, resulting in five interviews with three TNAs and one interview with two. Participants were asked these questions:

- Please describe your experience of work-based learning.

- Please describe what supports your learning in the workplace.

- Please describe your identity as a trainee nursing associate.

Work based learning (WBL) was defined at the start of each interview as 'learning that takes place in the clinical setting and not in the university'. Discussions, which lasted about twenty minutes, were audio-recorded and professionally transcribed.

Stage two of the study was initiated seven months later. All TNAs were invited by e-mail to an individual interview, and seven interviews were carried out though not all who responded were interviewed, due to time commitments of participants. Written informed consent was again obtained. Six interviews were face-to-face, and one by telephone. They were audio-recorded and professionally transcribed.

The individual interviews set out to explore further views expressed in the group interviews. The question asked of interviewees was therefore:

- What do you do to ensure that you have a good learning experience in the workplace?

This was the only question in the topic guide, apart from a number of prompts for amplification.

However, the first TNA interviewed began by emphasising that his second placement was very different from the first, and that staff had been much more supportive. He also emphasised the key role of university staff. The topic guide was therefore expanded to ascertain whether similar experiences were shared by others. The framework analysis used in this study affords this type of adjustment (Srivastava and Thomson 2009). Individual interviews lasted about 15 minutes.

Both data sets were analysed thematically, using the key factors for introducing new roles identified by Halse et al (2018), as a framework for the analysis. Framework analysis was chosen as an instrument to assess the impact of the implementation of the new role on those most directly affected. The analysis procedure followed the seven stages outlined by

Gale (2013), for framework analysis of qualitative data in multidisciplinary health research; namely transcription from audio recording; familiarisation with the data using the transcript; coding; identification of the analytical framework; applying the framework to the data and interpreting the data. Gale (2013) suggests that the framework method is suitable for thematic analysis of text, especially from interviews where lengthy transcriptions have been produced, enabling data to be analysed in context.

Quotations from group interviews are followed by a code denoting the group (G1-G5) from which they emerged, while quotations from individual interviews are identified by codes for individuals (T1-T7).

Ethical approval was obtained from the School of Health Sciences Ethics Committee at City, University of London. SREC reference number: Staff/17-18/07

Results

Data were analysed using the factors established by Halse et al (2018), which are as follows:

- Robust workforce planning;
- Well-defined scope of practice;
- Wide consultation and engagement with stakeholders;
- Strong leadership;
- An education programme that mirrors patient need;
- Adequate resources for work-based learning;
- Supervision by a skilled clinical educator

TNAs provided much more data about some of these factors than others, and virtually none about two factors: strong leadership and robust workforce planning.

Re-ordering the remaining five factors provides a more coherent narrative framework for the results, and minor re-wording captures more exactly the preoccupations of those interviewed. Thus, our themes, expanded and exemplified in the following sections, are:

- Adequate time for work-based learning
- Supervision by a skilled clinical educator
- Engagement with stakeholders

- Well-defined scope of practice
- An appropriate education programme

Adequate time for work-based learning

In each of the stage 1 group interviews, TNAs laid considerable emphasis on the lack of adequate time for learning in the clinical placement. Group discussions typically began by emphasising the lack of learning time and returned to it at least once. There was agreement between members in all groups on this subject.

The participants in this study were all employed as health care assistants (HCAs) and were therefore part of the established clinical team. They reported that this limited their opportunities for 'on the job' learning, as staff generally expected that performing their HCA duties would take precedence over any opportunities to learn.

> *Because we are still counted in the numbers, most of the time you are still doing the HCA job. Even though you see yourself as a student, you're still doing the HCA job (G2).*

> *Most of the time … we are doing what we'd do before, so we're not kind of getting more knowledge (G1).*

In particular, it was hard to find time to practise new procedures, which could have serious consequences for trainees.

> *So let's just say like, now we're doing subcutaneous injection. For me to perform it, I need to practise it, and with practice comes perfection. So then, if I don't practice, and now I have to come and do an OSCE, it's going to seem like I'm not learning. But if you're not getting the opportunity to do stuff, you're always going to fail (G2).*

However, in the individual interviews later in the year, TNAs spoke much less about time pressures than previously, and several mentioned that it was now easier to study while in the clinical setting.

> *My mentor, she told me that I don't need to be going, doing work, work, work, work all the time. She said this time, 'Take a little time - I want you to go to the office, sit in there and do a little research (T5).*

Supervision by a skilled clinical educator

TNAs reported in the stage 1 interviews that supervisors were much less available than they would have liked.

> *We don't shadow them, we don't work alongside them… They are too busy doing things (G1).*

> *I've only worked with her on two shifts [in six weeks] (G2).*

Just as the pressure of work often impeded trainees from learning, so it often impeded nurses from teaching. TNAs appreciated that it was a question of supervisors' capacity to teach and support them, rather than their unwillingness to do so.

> *You've got some good nurses, they want to teach you. But then, it's just the workload (G2).*

Some participants reported that senior ward staff recognised this problem and arranged extra support.

> *My manager has appointed three people, so it's easier for me. If this person is not there, the other person would be there, and there will always be someone (G4).*

Rather more TNAs reported a lack of support when the supervisor was unavailable, however.

> *You can't get to work with your supervisor all the time, and often you are working with someone who can't or won't help or talk to you (G6).*

Some TNAs had learnt by experience that they had to, and/or were expected to, take responsibility for their own learning.

> *I managed to get some fantastic opportunities by just asking people. Because I found that the vast majority of people, once you ask them and explain that it's a learning experience, they would let you do it (G5).*

Nevertheless, the need to do so reflected, to some degree, the unsupportive behaviour of some staff.

> *You have to put yourself forward. Which I don't mind doing, but sometimes then you just feel like, do I have to? They know that you're studying, they should help you, they should encourage you (G6).*

What TNAs appreciated about the staff who did help was the willingness to explain and to challenge.

> *Some people will actually come and call you, 'I'm going to do drugs, do you want to follow me and I'll teach you one or two things'… She's very demanding, but in a very good way, she's always challenging you, to learn (G1).*

Some also mentioned that other staff, including those from other disciplines, were helpful in supporting their learning.

> *Doctors on my ward, they're like, 'If you need any help, come to me, and then we'll sit down.' They're very helpful (G4).*

In the stage 2 individual interviews, TNAs expanded on the various ways in which staff were helpful.

> *Every single time a nurse would come on shift, 'Right, you're going to do this with me, we're going to do this, we're going to look at care plans, you're going to come with me on an assessment, you can do the notes for this person under my supervision, we'll go over anything you're not fully comfortable with…' I got to observe the doctors, the OTs, the allied mental healthcare professionals when they were doing things like Mental Health Act assessments. Pharmacists came in, secure ambulance crews... I did safety huddles as well (T1).*

Staff also helped TNAS learn practical skills, by demonstration, observation and assessment.

> *I say, 'Please, can I do the dressing while you assess me?'... She'll gladly say yes, and I will do it for them, to see how I'm improving (T7).*

Several spoke of the value of feedback to TNAs about their knowledge and skills.

> *They're quite happy for me to be shadowing them, and they give me feedback at the end of the shift… [they] ask me some questions. For example she asked me, 'So why has this patient developed this kind of pressure ulcer?' Well, I could explain to her, but not in much detail. So she said, 'Your homework for tonight is going to be a little research on this topic' (T5).*

Some TNAs spoke enthusiastically of particular learning situations, and methods of exposing them to different aspects of clinical practice.

> *I constantly manage my own caseload. So, I just take probably two patients, look after them from admission to discharge... My supervisor told me it's the best way to learn, and then I gave it a try. It was fantastic way of learning (T4).*

They especially appreciated when learning was planned, thoughtful and scaffolded.

> *For instance, you're working with a nurse and you're going to do wound care: she would explain the procedure throughout first, call it a dry run if you may, and then she will ask you your opinion about it, then ask you what kind of equipment do you need to carry out that wound care… and if you're confident to do it, she will allow you to do it. If you're not so confident, then she will ask you to just shadow and see what's going on, and then maybe the next time you can do it. Which is good (T6).*

Engagement with stakeholders

Data from the group interviews in stage 1 of the study suggested a widespread lack of engagement with stakeholders at ward level. There were plentiful reports of staff ignorance about the TNA role.

> *Most of the nurses don't even have a clue of what we are doing when we say we are TNAs (G1).*

Given that staff were used to working with those individuals in a non-student capacity, such ignorance made it easy for staff to overlook TNAs' new status as learners.

> *We went from being healthcare assistants to students in a sense. But a lot of the staff still had the mind-set of 'You're a healthcare assistant' (G5).*

On the other hand, most groups reported that once they had begun to wear their uniforms (which were several months late in becoming available), they received more recognition of their status.

> *'Since we've had the uniform it's changed, people look at you differently.' (G2).*

Seven months later, in stage 2 of the study, the individual interviewees agreed that things were much improved and that staff working supporting them in their placements were now much better informed about their role, status and learning needs.

> *Before, it was like people didn't really know about the course, so they didn't know what to expect or what to impart to us. But now… you go for the first day and the nurse will ask you, 'What do you want to achieve from this placement?' (T6).*

> *The managers know what to do more. They know more about the programme and they are very supportive… A few people still struggle with our role and how we fit in on our shifts and all that. But generally, things have improved (T4).*

Indeed, some TNAs reported that latterly, Trust and university staff had raised ward staff's awareness of the TNA role and the need to facilitate learning, suggesting that engagement with stakeholders had belatedly taken place.

Well-defined scope of practice

Those taking part in the stage 1 group interviews reported that, as well as a general ignorance of the TNA role, there was a lack of clarity among staff about which clinical tasks TNAs should or should not be allowed to do.

> *Some of the places don't know what we're allowed to do and what we're not allowed to do (G5).*

A particular problem was that staff were as yet unfamiliar with the Practice Learning Assessment Document (PLAD), the detailed record that requires staff to sign when they are sufficiently assured of a TNA's competence in a specific area of health care.

> *Some don't want to sign one [PLAD] because they say they don't know what they're signing (G2).*

However, TNAs did not report lack of clarity in themselves about the scope of their practice as students, indicating that the problems they encountered were due to lack of disseminated knowledge about the role rather than poor definition.

By the time of the stage 2 individual interviews, some TNAs seemed to be more comfortable with being assertive about their practice.

> *If I'm not comfortable to do things that I am told to do, I tend to not, I just don't do it. And especially if it's something that I'm not trained to do, because at the end of the day it's, patient safety is still my concern (T2).*

An appropriate education programme

As experienced health care workers, TNAs were well-placed to judge the fit between their studies and the needs of patients on their ward. There were no suggestions of any lack of fit.

TNAs expressed great pleasure in how much they were learning and spoke of how they were acquiring the reasons and evidence base for doing what often they had been doing as HCAs.

> *I've been doing healthcare for almost 8 years, so I've got experience. But before, I didn't know the rationale behind certain things, I was just doing it for doing its sake, per se. But now studying and then going back to the ward, I know the rationale for doing things, so it's good (G6).*

There was a strong sense in the group interviews, often made explicit, that far more learning happened in the university than in the clinical setting.
Those interviewed individually also stressed how their university studies complemented and enhanced their placement experience.

> *Whatever I learnt theoretically in the university, it made a big difference in my practical, in my clinical practice and it made me feel empowered. And it made me more professional in dealing with my patients (T2).*

Discussion

The aims of this study were to establish the experience of work-based learners studying a course leading to qualification in a new role in healthcare and to establish changes over time experienced by the students as the role became established in the NHS. The results of the investigation have demonstrated significant areas for development, mapped across the chosen framework.

Adequate time for work-based learning

One of the benefits of conducting a longitudinal study was the possibility of demonstrating change over time. Participants reported an improvement in their access to learning opportunities between stage 1 of the study and stage 2, partly due to qualified staff recognising the need for protected learning time, possibly due to increased awareness of the role and course. This might also have been due to improved recognition of learning opportunities in practice on both the part of the student and the practice staff. Participants at stage 1 of the study compared their experience to student nurses who are supernumerary to the clinical team. However, this issue was less dominant by stage 2 perhaps indicating further embedding of the role and, given that one of the purposes of the

new role was to enhance the multidisciplinary team by easing staff shortages, there could be challenges to achieving protected learning time in practice.

Participants overwhelmingly attributed lack of time to their not having 'supernumerary status'- in other words being part of the workforce or 'counted in the numbers'. In contrast student nurses have supernumerary status and cannot be 'counted in the numbers'.[2] Supernumerary status is protected as a requirement of nurses' regulatory body, the Nursing and Midwifery Council (NMC), which also regulates the nursing associate courses. The NMC does not require nursing associate students to be supernumerary while learning in practice but requires the student to have 'protected learning time', which is not defined by the regulator, and instead determined locally by universities and employers.

Although the participants in this study advocated for their student role to be supernumerary, there is evidence that the supernumerary role contributes to the theory/practice gap in nursing (Allan et al 2011). Supernumerary status may militate against students accessing the hidden curricula, i.e. that knowledge that is hidden in relation to socialisation into the profession, and into clinical practice itself, strongly linked to identity. Allan et al found that because of their supernumerary status nursing students had to negotiate their way into a clinical situation and behave in the way qualified staff expected them to. Participants in our study expressed difficulty in accessing learning in practice, but this was in relation to specific skills acquisition, rather than tacit learning. Furthermore, the authors of this ethnographic study found that mentors and senior nurses did not believe that supernumerary status facilitated learning, due to lack of immersion (Allan et al 2011).

Similarly, McGowan (2006) investigated students' views of supernumerary status and how it worked in practice. One finding was that when poorly implemented supernumerary status detrimentally affected students' confidence. Our participants were all experienced healthcare assistants with years of socialisation into practice; they expressed frustration in

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[2] At the time of the study this pertained. At the time of writing however (April 2020) temporary emergency measures had been brought in by the UK government to address the Covid-19 crisis situation in the United Kingdom. This included bringing student nurses in years two and three of their programme into the workforce as student employees, with protected learning time rather than supernumerary status in line with nursing associates. Notably the apprenticeships of many nursing associate trainees have been paused to further enhance the workforce.

not having access to training or education in explicit skills-based knowledge, delivered at work and placed towards the more formal end of Eraut's continuum of formality in learning (Eraut 2004). Thus, they valued the university-based aspects of the programme, feeling that this gave them access to knowledge in a way that was inaccessible in the workplace.

Supervision by a skilled clinical educator

Our participants were often supported by professionals other than nurses to learn, notably doctors, which may reflect the apprenticeship-style of specialist medical training and empathy with the students' position in seeking out support and supervision. Participants acknowledged the pressure educators in practice are under, as described by Moffett et al (2019) in an article about clinical educator well-being. Reynolds et al (2020) suggest a model for creating teachable moments (T-moments) in practice than encourages reflection and maximises learning opportunities, acknowledging the constraints of clinical practice, and the importance of those who facilitate learning being capable of putting themselves in the learners' position. Although there was some evidence of this approach to learning and teaching being implemented in stage 2 of the study this was not always our participants' experience.

The role of clinical educator, mentor or supervisor in the implementation of work-based learning in clinical practice has been demonstrated to be pivotal to learning and strongly linked to the development of professional identity, though in a systematic review Gibson et al (2019) also found that student experience was mixed and this concurs with our findings. A poor experience might, for example, be detrimental to the development of professional identity, and the characteristics of the individual supervisor or assessor in practice along with their capacity (through workload) to be available to the learner are important factors.

Engagement with stakeholders

Lack of awareness of the role and of the TNAs' changed status as learners was an issue for participants in stage one of the study; this mirrors the findings of Thurgate's work with Assistant Practitioners (Thurgate 2018). The rapidity of implementation of the course, and subsequently the introduction of the role, militated against understanding and support for

the students as work-based learners. By stage 2 of the study this had improved, but as pioneers of a new course leading to a new role there were no role models in the workplace. The impact of wearing a uniform on both the TNA and those working with them appeared to be an important part of identity formation, which is identified in different contexts in the literature. Poppe (2013) explores the power of the uniform as an identity-marker and important marker of esteem among paramilitary foresters and rangers in Burkina Faso. Her interviews demonstrate impact on those at the lower end of hierarchies similar to that on participants in this study. Similarly, Desta et al (2015) establish that uniforms can lead to increased confidence and improved performance in nurses. Moreover, the identification of the wearer (as a student, a learner) is important and this was established by our participants. Uniforms in clinical practice are not without controversy though. Derived from nuns' habits and designed for nursing work (dirty work) the Chief Nursing Officer for England spoke out against the outdated images of nurses in uniform (NHS England, 2019), but to denote the difference between a worker and a learner in the workplace uniforms appear to serve a useful purpose. Our longitudinal study captures pre-uniform and post-uniform responses and establishes the significance of uniforms to the participants.

Well-defined scope of practice

In the experience of our participants, scope of practice, or the role of the trainee, was not well established, although there were signs of improvement between stage 1 and stage 2 of the study; participants' perception was that there had been more information about the role available to supervisors and managers. Lack of clarity in scope of practice can impact on the effectiveness of the role (Price et al 2015), though it was not possible to judge how effective the role of nursing associate was at the time of the study. Price et al (2015) investigated the effectiveness of the Assistant Practitioner role in radiography, rather than the work-based learning undertaken by trainees. Nonetheless Price established that a minority of managers had considered the workforce implications of introducing the Associate Practitioner, or the support required. Moreover, scope of practice may be clearly articulated in policy and regulation but without adequate workforce preparation and communication this will not be understood in clinical practice. Indeed, participants noted positive changes over time aligned to increased communication about their role.

An appropriate education programme

There was evidence at both stages of the study that the TNA's appreciated their programme and felt it supported their work-based learning in clinical practice. In particular, the programme provided participants with a rationale for their actions and the evidence base for their interventions and this was strongly supported. TNAs felt that more learning happened at the university than in the practice setting. While this could be due to difficulties in recognising and articulating learning in the workplace (Attenborough et al 2019; Eraut 2004), Tynjälä (2008) suggests the importance of integrating tacit knowledge (from practice) and explicit knowledge (from academia):

> *The development of vocational and professional expertise must be seen as a holistic process in which theory cannot be separated from practice- or practice cannot be separated from theory…..Participating in real life situations is a necessary but not a sufficient condition for the development of high level expertise. Only deep integration of theoretical, practical and self-regulative knowledge creates expertise* (p145).

The TNAs in our study reported integration as suggested by Tynjälä (2008), but their satisfaction with the work-based element of the course, though improved over time, remained low, at least for some participants. How this might influence the effectiveness of students once qualified is currently unknown. It is therefore difficult to comment on the overall appropriateness of the programme apart from the student perspective.

In a study investigating how professional identity is influenced through experiences on a work-based learning programme run through the apprenticeship system Booth (2019) discusses improved self-confidence and belief in participants' capability to carry out their roles as being important factors.

Fit with the framework

Out of Halse et al's (2018) seven categories, five were reflected in both stages of the study. National strategic leadership and robust workforce planning did not resonate with our participants, yet participants' experiences were related to both of these categories, for example robust workforce planning could have addressed the issue of awareness about the

role in practice generally and provided more capacity for support and teaching in clinical areas. The lack of data about these factors is hardly surprising, as these factors operate at national level rather than at ward level, whereas our purpose in this analysis is to consider these factors from the point of view of TNAs on the front-line.

They did, as reported in the results, appreciate the positive involvement of ward managers and other senior ward staff in supporting their learning, but that it is a different sort of leadership from that indicated in Halse et al's (2018) systematic review. Similarly, TNAs in stage 1 of the study had strong views about the lack of supernumerary status and unanimously reported that TNAs themselves had to take responsibility for their learning in clinical settings, as staff were unable or unwilling to do so consistently. This implies that workforce planning had not accounted for the introduction of the new role.

The strong leadership required to embed the role in practice was not necessarily absent, and it is clear that the role was introduced after reviews, stakeholder involvement and policy development. The role was launched by the Minister for Health and was high profile in both professional and national media. However, the national profile and importance of the role was not raised by participants and may reflect the pace of introduction, underpinned by stretching targets. The analysis revealed that the experiences of those most affected by policy change, in this case the TNAs, do support the introduction of the role.

Conclusion and recommendations

Our participants' experiences demonstrate the importance of preparation of the workplace for work-based learning for specific roles, and how these developed over time. As pioneers the TNAs had committed themselves to training for a role which, at the time they were studying, did not exist in actual clinical practice. Despite this, their obvious enthusiasm for learning and their descriptions of how the explicit knowledge gained through the academic component of the course supported their tacit practice knowledge is apparent and endorses the programme and approach to some extent. The TNA's valued skills acquisition above tacit knowledge that they had gained through years of socialisation into healthcare. They appreciated the constraints on educators with competing pressures in practice to teach them due to clinical commitments, but equally felt frustrated that knowledge about their

role was not sufficiently developed to enable qualified staff to support them fully; this improved between stage one and two of the study. Furthermore, stakeholder engagement was necessary to support their developing identity, this was achieved through increased input with educators and provision of a distinctive uniform to give a visual cue about their status. The lack of role models for a new role linked to an understanding of their scope of practice also developed over time and should improve as the role becomes embedded in the workforce. Overall the importance of skilled educators committed to learning, both in clinical practice and in universities was evident in both stages of the study.

A limitation of the study is that both the group interviews in stage 1 and individual interviews in stage 2 were rather short, as TNAs had to fit them in during days at the university, when their timetable was already tight. The stage 1 group interviews were well attended because they were held immediately before or after OSCEs; individual interviews were held during a period allotted to private study, and only seven were achieved (several other TNAs had originally agreed to be interviewed, but they were absent due to illness or family commitments, and did not reply to follow-up e-mails). Those interviewed in stage 2 believed that their improved experience was common to all TNAs, however.
A further limitation is that of any small-scale study of a national phenomenon such as the introduction of a new role. It may be that the clinical settings where our informants were placed were not typical of those elsewhere, either in their initial inability to offer enough support, or their ability to learn fairly quickly how to do so, or both. It is not now possible to replicate the study elsewhere, because inevitably perceptions of and understandings of the role and of TNAs' learning needs will have changed since our research was carried out.

This study does, however, add to the evidence-base about introducing new roles in healthcare, endorsing Halse et al's (2018) findings from the literature existing at the time the role was introduced. This paper demonstrates the impact of an initiative aligned to government policy to increase the clinical workforce on individuals on a work-based learning course, which was introduced at pace. The paper highlights the importance of preparation of the qualified workforce that supports learning in practice. By studying the implementation over time, with increased understanding of the role, we were able to demonstrate the cruciality of this preparation. This is an important contribution to the

evidence-base that informs and influences curriculum design and development in higher education on courses delivered in partnership with employers through work-based learning.

This also suggests important areas for investigation in work-based learning that is delivered in partnership with higher education institutions. Future research could explore the lack of parity of value between university-based learning and the learning from practice as perceived by learners. It would also be useful to hear the perspective of those supporting learning, mapped against the framework, and in particular the role of adequate information-giving in helping qualified staff to understand and carry out their role in supporting learners. More ambitiously (because of the longitudinal nature of the studies), it would be interesting to explore to what extent understanding the rationale of familiar duties, much appreciated by TNAs, enhances the care that TNAs give after training compared with before; and the extent to which their own experiences of being relatively unsupported at the beginning influence their own commitment to and skill at supporting future learners themselves.

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