Nursing Associate Consultation

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the NHS Health Education England's Nursing Associate Consultation: Building capacity to care and capability to treat - a new team member for health and social care: Consultation.

2. RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 52,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

3. RCGP thanks Jennifer Aston for her contributions to this submission.
Our response to the consultation questions

Q1. What are the most important issues that need to be addressed in deciding whether to establish a new care role working between a Care Assistant with a Care Certificate and a Registered Nurse?

4. RCGP considers that the following issues are critical and must be answered before the decision is made on whether to establish a new care role working between a Health Care Assistant (HCA) with a Care Certificate and a Registered Nurse (RN) (i.e. a Nurse Assistant (NA)):

- The specific tasks and activities that NAs will undertake must be clearly defined.
- Clear training standards must be set (they should be mapped to RN standards) and their enforcement ensured. The length of training and entry requirements should balance a need for skilled NAs with ensuring that an appropriate number of NAs complete training.
- Clinical trainers, facilitators and mentors for NAs must be identified. It should be clear whether NAs will be trained in-house or external clinical teachers. It should also be clear how the trainees be supervised and supported during training.
- It is important to ensure that training providers have the right skills and capacity to deliver skilled NAs.
- NAs should be regulated to ensure a national UK standard.
- The curriculum should avoid being too general to be useful in primary and secondary care. Consideration should be given to separate primary and secondary specifications.
- Funding should be identified for infrastructure to support the training (practice facilitators/ back fill etc.)
- It is not clear whether there is a target number of NAs for both primary and secondary care – this makes it difficult to assess the likely impact.
- Clarity is needed about how the role of assistant practitioners (AP) aligns with NAs.
- There should be scope for existing Health Care Assistants (HCAs) to accredit prior existing training towards NA training.
- The availability of indemnity insurance needs to be considered for the new role.

Q2. What contribution to patient care do you think such a role would have across different care settings?
5. In primary care, NAs would be most valuable working as part of the Nursing and Primary Health Care teams. Many HCAs, with appropriate training and support, are already carrying out a wide range of activities such as those listed in the Royal College of Nursing/RCGP HCA competencies. What current HCAs lack, is the academic qualifications to enable them to access nursing courses. Consideration should be given to supporting existing HCAs to top-up the academic qualifications or we will exclude many potentially excellent NAs for foundation nursing degrees.

6. If the curriculum is to prove useful for NAs wanting to work in primary care, there must be a focus on health prevention and promotion. Within primary care, NAs could carry out work including:
   - Supporting activities such as smoking cessation, weight management, Cardiovascular risk assessments and motivational behaviour change which could greatly contribute to care.
   - NAs trained in clinical measurement such as blood pressure, blood tests, diabetic foot checks, spirometry and audiology could and save RN or GP time.
   - NAs could, if appropriately trained, carry out a wide range of wound care from suture removal to managing complex wound including four layer bandaging.
   - NAs could safely administer many routine injections such as B12 and Influenza under PSDs.

Q3. Do you have any comments on the proposed principles of practice?

7. A set of nationally enforceable standards needs to be written with clear mapping against the RN standards so the employers and educators are clear where the boundaries for HCAs, NAs and RNs are.

8. Given how difficult it is for RNs to move from hospital to primary care it would be hard to have a truly generic NA as is suggested in the paper. If NAs are expected to work across population groups and care settings there is a risk that their ability to do anything useful will be reduced.

9. It would be useful to identify where NA training overlaps with RNs training to be clear how the NA role fits alongside existing roles. If this is not done RNs may be undervalued and becoming a RN may not seen as a worthwhile ambition. Focusing too much on flexibility may fail to deliver safe competent people. It is vital that the boundaries of competence are clearly set within an enforceable framework so that the
role is used to support and enhance RNs, rather then NAs providing nursing more cheaply.

10. Nursing is complex, so if NAs are to have more responsibility than existing HCAs it needs to be very clear what additional core training they will have, especially with regard to the softer aspect of care (emotional and psychological).

Parameters of the role

Q4. Do you have any comments on the aspects of service the proposed role would cover?

11. Consideration need to be given to the very different working context in primary care as compared to secondary care.

12. In primary care, NAs would be working on their own in a room behind a closed door. This requires an added element of trust which is very different to the open working environment on a hospital ward.

13. NAs working in the community would also need additional loan working skills.

14. As mentioned above the boundaries need to be very clear so that employers and indemnifiers know what is appropriate for NAs to be responsible for or patients will be put at risk.

Q5. Do you have any comments on the proposed list of knowledge this role requires?

15. There needs to be more clarity on how the educational standards for NAs differ from RNs. It is not clear about as the paper appears to suggests that training for an NA will be at the RN level (level 5). It appears to suggest that NA training is an unregulated apprenticeship like the state registered nurses was.

16. If the learning outcomes are that of a RN, it would suggest that the NA would be trained to do everything a RN can, but without any regulated title. It is essential that the differences in the curriculum are made clear or there will be a two-tier arrangement. Those wanting to train need to understand what benefits there are for NA as opposed to RN training (via a foundation route).
17. Addressing the question of how an NA becomes an RN may help to identify what the differences are between the two roles.

18. The lack of clinical nursing educators needs to be addressed before any of this can be delivered. This is especially problematic in Primary care.

Q6. What do you think the title of this role should be?

19. Nursing Assistant should be the term used because it clearly denotes working under a registered nurse, whereas associate suggests an equal but different role. Using the term associate would cause confusion with Physician Associates.

20. It is important that the title includes the term nursing to denote that the role that it is part of the nursing family. The term Nursing Assistant gives the clearest description of where the role sits between an HCA and an RN.

21. A consistent title can only be enforced if that role is regulated.

Q7. Please comment on what regulation or oversight is required for this role and which body should be responsible.

22. The NA role should be regulated by the National Medical Council in the same way that enrolled nurses were. As the role involves carrying out nursing activities, this is the most appropriate regulator.

23. A role with direct patient care and increased responsibility at this level should be regulated so that national standards can be set and enforced to protect patients. Nursing activities should be regulated by a regulator who understand and sets nursing standards (ideally NMC).

24. There needs to be a clear definition of role boundaries and the delegation of duties so that the limits of the role are understood by all concerned. The current delegation of duties is quite clear, but any new role will need things spelled out in a clearly understandable way. It is important to maintain the uniqueness of a registered nurse and not threaten the role by extending the NA role too far or ending up with a two-tier training.
25. Nurses will obviously play an important role in training the NAs so consideration needs to be given to ensuring there are enough appropriately trained nurse facilitators or mentors.

26. Regulation of the role would necessitate adequate funding to ensure that the set standards are met and maintained. It will be important to ensure that a risk assessment is carried out depending on the work context. Where NAs are working independently (e.g. home visits or in separate consulting rooms) there will need to be clearly identified protocols for accessing advice or support to ensure that NA are able to practice safely.

Further views

27. This new role needs careful planning to ensure that NAs are properly prepared for taking on nursing activities.

28. Consideration of the oversight and responsibilities needs more detail.

29. It would be helpful to have more details about funding of the training. This is especially relevant to general practice where there would need to be consideration of financial support for training. Some training grant or tariff or arrangement for backfill needs to be taken into consideration because of the different funding arrangements in general practice. General practice is facing a funding shortage and does not have the additional resources to be able to train future NAs without additional resources.

30. General practice is under-supplied with nursing mentors and practice educators so consideration would need to be given to funding and supporting additional clinical educators.

31. The new role needs to be regulated if it is to be use to its full potential in General Practice.

32. The new role needs to incorporate the skills necessary for General practice or have a separate equivalent training branch to ensure that Primary care can benefit from this new role.