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Evaluating the Introduction of the Nursing Associate Role: The Livewell Southwest Case Study

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1. Introduction

Researchers at the NIHR Policy Research Unit in Health and Social Care Workforce (HSCWRU), King's College London, have been commissioned by the National Institute of Health Research (NIHR) to evaluate the introduction of the nursing associate (NA) role in the NHS and social care services in England. The NA is a new registered Band 4 nursing role typically positioned between the healthcare assistant and the registered nurse in the NHS and working with care home nurses in the social care sector. Trainees for the role take a two-year level 5 qualification[1], which involves an off-the-job college component and a number of on-the-job placements in different care settings[2]. Our evaluation is principally focused on the first two waves of NA, that is those 2,000 trainee nursing associates (TNAs) who began their training in 2017 and, on completion a two year Foundation Degree at level[3], have now qualified and, in the main, registered as a NA with the Nursing and Midwifery Council (NMC). More specifically, our evaluation is examining the organisational deployment of these initial waves of NAs, albeit with some interest in subsequent cohorts as the role extends within and across organisations. The core questions underpinning the evaluation centre on:

- How and why the NA role was introduced;

- How it is being managed and used; and

- With what consequences for key stakeholders including the NAs themselves, their co-workers, managers and patients/services users and carers.

Following-on from a series of interviews with national policy makers and practitioners[4], we are carrying out a series of organisation-based case studies, with a

[1] In the early waves, typically a Foundation Degree, and in more recent waves an apprenticeship.
[2] More detail on the training of NAs can be found in two report by Traverse, which be accessed at https://traverse.ltd/recent-work/reports/health-education-england-evaluation-introduction-nursing-associates
[3] Subsequent national waves of TNAs have been trained through the apprenticeship route, also taking two years.
[4] The findings from these interviews were written-up in a report on early findings which is available from our website. This report also provides more background on the nature and development of the nursing associate role.

view to addressing these questions. A set of 6-8 case studies were planned but were put on hold as the Coronavirus pandemic took hold; however, two case studies were completed prior to the pandemic becoming established in the UK. Livewell Southwest was the first of these case studies, and as such might be seen as a pilot case: valuable and interesting in its own right, but also allowing us to test our research instruments and sharpen our analytical framework. This report presents the Livewell case study in following sections:

- Background
- Methods
- Findings

2. Background

Livewell Southwest (henceforth Livewell) is a social enterprise, in the form of a Community Interest Company. It provides integrated health and social care services for around 270,000 people across Plymouth, South Hams and West Devon, as well as some specialist services for people living in parts of Devon and Cornwall. The organisation was established as an independent care provider in 2011, and a few years later took on the full range of community and mental health services for this catchment area, along with the adult social care assessment service, under the Care Act 2014, from Plymouth City Council. Livewell provides close to 80 different services, delivered by a total workforce of some 3,000 employees, including some 760 registered nurses and 500 clinical support staff. These services are grouped under three broad headings, comprising the following activities:

Community health services including:

- community health services for adults
- community health in-patient services
- community end of life care
- community therapies
- adult social care

Mental health services including:

- acute wards for working age adults
- long-stay rehabilitation mental health wards for working adults
- forensic in-patient/secure wards
- wards for older people with mental health needs
- community-based services for working age adults
- crisis service
- community services for people with a learning disability

Children and young people including:

- child and adolescent mental health services
- health visiting
- school nursing

In 2017, Livewell recruited two cohorts of trainee NAs as part of a broader Devon NA partnership. More specifically in January 2017 it took on 11 TNAs. These TNAs all completed the programme, with 6 of them moving straight onto nurse training, leaving 5 qualified NAs in post. In September 2017 Livewell employed a further 24 TNAs. Of these, 19 completed the programme, with 4 immediately progressing onto nurse training, leaving 15 qualified NAs in post.

At the time of the case study fieldwork Livewell, therefore, had a total of 20 qualified NAs in post from these first two waves. The distribution of Livewell's ***existing*** qualified NAs by clinical area and team or unit is set out in Table 1 and Table 2 below (these tables do not include those NAs who moved straight into nurse training). It can be seen from the tables that:

- The first cohort of qualified NAs was exclusively concentrated in Livewell's 6 district nursing teams (4 teams in Plymouth, one team for South Hams and another covering West Devon). Those first wave NAs who moved straight through to their nurse training were also from district nursing services.

- The second group of qualified NAs is more diverse in terms of workplace, with: the largest concentration (4) in acute adult mental

health in-patient wards; smaller concentrations in health visiting (2), community health care teams (2) and various recovery and rehabilitation facilities (4). The remainder of the qualified of NAs were to be found as single members of a team in a variety of services including liaison psychiatry and assertive outreach[5].

- Looking at the 30 NAs comprising cohorts 1 and 2 as set out in Table 1 below, the role seems to have been taken-up with greater alacrity in community nursing (6 NAs) than in community mental health care teams (2 NAs), while various types of in-patient wards (with 8 NAs) have also embraced the role on a significant scale.

Table 1: Nursing associates in cohort 1 and deployed area

Cohort 1 NAs	**Deployed area**
NA 1	North District Nursing (DN)
NA 2	East DN
NA 3	West DN
NA 4	South DN
NA 5	South Ham DN

Table 2: Nursing Associates in cohort 2 and deployed area

Cohort 2 NAs	**Deployed area**
NA 6	Ward A– Facility Y (Acute Female Inpatient Mental Health)
NA 7	Ward B – Facility Y (Acute Male Inpatient Mental Health)
NA 8	Ward A – Facility Y (Acute Female Inpatient Mental Health)

[5] Since 2017, Livewell has recruited two further cohorts of around 20 TNAs each. As a consequence, many teams and units will now have TNAs working alongside qualified NAs.

NA 9	Ward B – Facility Y (Acute Male Inpatient Mental Health)
NA 10	Ward C (Inpatient Functional Older People's Mental Health)
NA 11	Assertive Outreach (Community Mental Health team)
NA 12	Liaison Psychiatry (Hospital X, Mental Health ward and ED)
NA 13	Female Mental Health Recovery Unit
NA 14	South and East CMHT (Mental Health Community Team)
NA 15	Neuro unit (Neurology Rehab Adult Inpatient)
NA 16	Adult Stroke/General Rehab Ward
NA 17	Adult General Rehab Ward)
NA 18	South DN (Adult Community Nursing)
NA 19	East Public Health Team (Health Visiting Team)
NA 20	South Public Health Team (Health Visiting Team)

3. Methods

Conducted over two full days in the middle of February 2020, the fieldwork at Livewell mainly comprised focus groups with different types of stakeholder. As can be seen from Table 3 below, focus groups were convened with:

- Senior managers
- Qualified NAs from a variety of clinical settings;
- Apprenticeship degree nurses (members of the original TNA cohorts who had moved straight through to nurse training on qualifying as NAs);
- Existing TNAs; and
- NA line managers.

During the visit, a one-to-one interview was also conducted with the Placement and Development Facilitator. Two follow-up one-to-one telephone interviews were carried out respectively with the Livewell Organisational Development Lead and the Director of People and Professionalism (All three of these interviewees also attended Focus Group 1- see Table 2 below).

In total there were 11 data collection points (focus groups and interviews) involving a total of 28 participants. It is particularly noteworthy that 8 of the 20 qualified NAs were able to participate in the focus groups along with three others who had been part of the initial cohorts but moved straight onto their nurse training. The use of focus groups allowed for the collection of views from a large and wider range of participants. At the same time, the dynamic of a focus group is very different to that of a one-to-one interview, and this should be borne in mind in reflecting on the material presented in this report.

Table 3: Data Collection	
Session	**Participants**
Focus Group 1: Senior Managers	Placement and Development Facilitator
	Director of People and Professionalism
	Professional Lead
	Undergraduate Preceptorship Lead
	Organisational Development Lead
	Matron for Community Nursing Services
Focus Group 2: Line Managers ad Co-Workers	Staff Nurse (and NA mentor) women's rehab ward
	Practice Lead Complex care/Dementia psychiatric liaison
	Unit manager in patient mental health recovery unit
	Neuro rehab, unit ward manager
	Health visiting team manager
Focus Group 3: TNAs	District Nursing team east
	Complex needs team

Focus Group 4: Qualified NAs (a)	Male in-patient acute mental health ward (2 participants)
Focus Groups 5: Qualified NAs (b)	Female in-patient acute mental health ward (2)
Focus Groups 6: Qualified NAs (c)	Heath visiting team
	District nursing teams (2)
Focus Group 7: Nurse degree apprentices	Former TNAs (3)
Focus Group 8: Liaison psychiatry	Line manager
	Qualified NA
One to one Interview (face to face)	Placement and Development Facilitator
One to one Interview (telephone)	Director of People and Professionalism
One to one Interview (telephone)	Organisational Development Lead

A draft of the final case study report was sent to Livewell for comments and particularly to ensure that there were no factual mistakes or major errors of interpretation in our write-up. Livewell confirmed the report provided a clear and accurate picture of developments. We also sent a draft copy of this report to a member of our Unit's Patient and Public Involvement Advisory Group, who provided useful and insightful comments. These prompted some minor but important revisions to the original draft, mainly design to provide more background detail on the NA role, for the 'lay' reader.

4. Findings

The presentation of the Livewell case study findings is structured around the following themes linked to our key research questions:

- ***Rationale: Introduction of the NA role.***
- ***Process: Implementation and management.***
- ***Consequences: Impact on various outcomes.***

4.1 Rationale

The rationale for the introduction of the NA role can be considered at different organisational levels. At senior management level in Livewell, there was a series of narratives underpinning the introduction of the NA role, complemented by a more refined set of rationales at the

service and team level. These lower level rationales assumed particular significance at Livewell with the second cohort of NAs rolled-out to a myriad of care settings and the organisation's senior management keen to allow the process of NA take-up to be driven by local service circumstances and needs. As a senior manager noted:

> The second wave (of NAs) was bottom up: we wanted to make sure we were empowering our managers to manage and develop their own workforce (SM_1)

4.1.1 Organisational Rationale

At senior management level, the introduction of the NA role was framed by a longstanding employee development agenda, which placed particular emphasis on the organisation growing-its-own workforce. In 2015, following the Francis Report[6] on Mid Staffordshire, Livewell was concerned to develop the 'resilience' of its nursing workforce, not least in terms of labour supply. It held a number of workshop sessions for staff, from which the importance of training and development emerged. Indeed, in the wake of these sessions a scholarship fund was established by Livewell, providing financial support for around a dozen support workers a year to pursue registered nurse training.

In the succeeding years and in line with this development agenda, Livewell extended the scope of practice of Band 3 healthcare support workers. Steps were also taken to introduce the Band 4 assistant practitioner (AP) role, although take up of the role was patchy in the organisation, with around 40 APs being employed, Indeed, such a patchy take-up still left a gap in the career development pathway for many Band 2 and 3 support workers wishing to progress into a registered nurse role at Band 5. In short, the NA role at Livewell was seen to fit with a longstanding learning and development agenda, providing a new opportunity for the organisation's experienced and capable HSW workforce to progress their careers into registered nursing, while leaving the AP role as a remaining stepping stone into registered therapies:

> I think one of the key things (driving the NA role) for us was around building that career pathway. We recognised we'd a very flat structure in terms of nursing with Band 5s, and then we had Band 2s and 3s and there was quite a gap in-between…We have a wealth of people who are fantastically compassionate and caring, and what they probably haven't done is gone through that traditional

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

> education route and got that qualification to support it, so we really wanted to focus on having that career pathway for our (healthcare support workers). (SM_2)

Alongside this employee development agenda, there was also a narrative suggesting that the NA role was connected to the development of a 'new type of nursing workforce'. Here the weight was placed on the generic or holistic nature of the NA role, particularly in contrast to the AP role, perceived to lack a standard regulatory framework and viewed as often emerging as a niche or bespoke role deeply embedded in the particular service needs of specific clinical areas:

> One of the biggest challenges with the AP role was that while there was national recognition for the role, it was never formalised in terms of what the learning outcomes should be, the curriculum should be. There was guidance out there but they were roles developed in very specific situations. We recognised the holistic nature of the NA role. The breadth we felt was an opportunity to increase the holistic thinking in our nursing workforce. This was a very new style of nursing role that looked at people who use our services in a very different way. (SM_2)

Despite these broadly conceived rationales centred on career pathways and holistic care, Livewell's initial engagement with the NA programme was driven by the immediate need to find a viable first wave cohort of TNAs in a short period of time, driving out some of these more elevated and considered strategic thoughts:

> From finding out we'd been successful and being the pilot, we had 6 weeks for the programme to be set up and recruit to it. We could see that it (the NA role) was a good, but we hadn't really got the chance to sit down and consider exactly what we were trying to achieve form this. What difference would it make? Yes, we wanted to give people career pathways progression; yes, we want to off-set our vacancies, and provide more support for our level 1 registered nurses but we couldn't be sure what difference the role would make. (SM_1)

Indeed, the decision to introduce the first cohort of NA exclusively in district nursing teams might be seen as a pragmatic response to very immediate nurse recruitment and retention pressures in this service area:

> We used it (the NA role) as a specific workforce solution because we were having specific problems retaining staff in district nursing. There were a lot of vacancies and here was our chance to develop our support staff and at the same time address a pressing (labour supply) need. (SM_3)
>
> (District nursing) was where we had our biggest concern around staffing. We had 40-50% vacancy factor within our district nursing teams although we could also see that the competencies we could develop within the NA role would fit well within that team. (SM_6)

4.1.2 Rationales at the Team and Unit Level

Following relatively quickly on the heels of the first cohort, the roll-out of the second NA cohort was a much more open process, with the distribution of NAs across a wider range services, albeit with a concentration on various type of in-patient wards (acute mental health, older people, stroke and neuro rehabilitation, and recovery). A meeting of Livewell service managers and other interested parties in 2017, providing further information of the second wave on TNAs, was well attended and suggested interest in and enthusiasm for the development opportunity presented. It then remained for individuals with an interest in training for the role to apply subject to the following conditions:

- Applicants were currently employed by the organisations; in other words, all TNAs were internally recruited.
- They had the support of their line managers to apply.
- Line managers assured team support for TNA supervision and mentorship, and for TNA placement cover.
- Line managers guaranteed that they could fund a new NA post when the TNA qualified.

This bottom-up emphasis for the second wave is reflected in the following senior manager's comments:

> We were happy to do a central recruitment of nursing associates but we wanted them (service managers) to do the decision making around take-up of the role. So, we put out an expression of interest. We had a 100 turned up to a meeting. We weren't

> deliberate on which areas we picked; we just made sure each area understood what was involved; understood the mentoring requirements, the placements; and was financially capable of ensuring the person in question had a Band 4 post on successful completion of the training. (SM_1)

Similar descriptions were provided by other senior managers:

> The second wave was opened out across the whole organisation and we run it as an internal process… We knew from experience that these roles work well where there's good mentoring, where managers understand the need for release time, they understand the commitment in terms of competencies and we always ask our managers and their management accountants for the commitment on the money to be there at the end because we don't want any of our guys to be put through hard work and then not be able to realise the qualification. (SM_2)

> Managers came along and the potential nursing associates, the Band threes as well, to hear about the role, and then it would be up to the decision of the individual team: could they support a TNA in practice, could they support them going out to their base areas for 4 to 5 weeks at time on placement, was there a Band 4 position at the end of those two years? It wasn't a matter of getting more streamlined workforce where we needed it. We wanted take-up in those areas that actually felt that it would improve their patient care. (SM_4)

This open, bottom-up process raises questions about how various workplace factors combined to produce the perceived need for a NA(s) in a given team or unit. Clearly Livewell's senior management was not forensically evaluating where NAs might be required or 'best suited', encouraging rather a process of self-selection whereby the most appropriate candidates would emerge as required or desired by a clinical area. Our discussions with line managers and NAs suggested a range of workplace factors leading to the emergence of TNA, particularly in this second wave:

- ***Individual career development***: the principal driver for the emergence of a NA in a given team or unit was often the career aspiration of the prospective TNA, typically a Band 2 or 3 healthcare support worker (HSW). It was this individual support worker who typically took the

initiative, presenting this development opportunity to their line manager and seeking support to take it forward. Sometimes this was complemented by the team manager, encouraging a 'high functioning' HSWs to go for such an opportunity. Thus, it was striking that most of the wave 1 and 2 qualified NAs came from and returned to their original teams or units: in the case of the first wave district nursing TNAs, only one came from another service area. The significance of individual career aspiration is reflected in the case one service area, where despite some reservations about fit between the NA role and service provided, which did not have a strong nursing component, one qualified NA was still in place alongside a new TNA.

- ***Workforce Profile***: Many of the clinical areas with qualified NAs in post had previous experience with the assistant practitioner (AP) role with a twofold consequence: the unregistered AP role provided teams with some insight into and experience of the contribution a Band 4 senior support role might make to service delivery, but it also encouraged an appreciation of the limits of such a role. For a number of the line managers the registered status of the NA, and the scope this provided to delegate with greater confidence, influenced their enthusiasm for the role:

  > We started with an assistant practitioner and we saw the role, the TNA, as a development opportunity for the HCAs as well, so encouraging them to stay within the service, but also develop themselves.

  > There is a gap in that my AP doesn't have a registration and it's a bit of a strange role: they're a little more than an unregistered HCAs but it's difficult for them not being registered.

- ***Opportunism***: The initial adoption of the NA role was sometimes simply a case of line management seizing on an available opportunity. In one team for example the decision to run with an NA role sprang from a registered nurse being on 6 months maternity leave, with money therefore freed-up to develop an individual in the new NA role. It was this fortuitous source of

funding at the right moment which then prompted a broader and more considered a discussion within the team about skills mix in the team, and how a new role might fit:

> I was aware of it (the NA role) because we have somebody who wanted to go through it and therefore you kind of know what's going on. We were back-filling a maternity, Band 6 maternity post and obviously you get a percentage of the money; what can we best use the money on? Do we need any more Band 3s? Maybe, but what do we really need? Somebody with a little bit more, which is why we looked (at the NA role). (M_1)
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> .

- ***A punt***: It follows that for many teams and units the adoption of early wave NAs was simply and frankly a bit of 'punt' (using the term in a non-pejorative way). The decision rested on a high degree of uncertainty about whether and how the role would fit into and develop within the clinical setting and team. This was perhaps inevitable given that it was a new role, and that these teams were early adopters, acting as pilots and pioneers. Rather than any clear conception of the NA role, line managers more typically appeared to be investing in the experience and capability of particular, known individuals, hoping and expecting that the role's contribution to service delivery would emerge with time:

> One of the key things that we looked at (in recruiting TNAs) was around 'let's get the right person' and we can fill-in the rest. (M_2)

It is a managerial approach which suggests the organic development of the NA role as stakeholders worked through the shape and contribution of the role within their team and units over an extended period:

> We needed to think about how we were going to provide a skill mix within the team. We're a developing the team and I think we recognised that there were very competent people out there, that it would be great to have the opportunity to work with something a little bit different, you know. But, if I'm honest, I don't know that we knew

> quite how it was going to work, if I'm honest, and I think, between us, we've made it work. (M_2)

Often it was a combination of these factors that led a team to take on an NA. For example, two stories from team managers outlining the decision to run with the NA role, juxtapose:

- A positive experience from formerly employing an AP role;
- A keenness to use the new NA role to develop a capable member of the team; and
- The enthusiasm of the prospective NA themselves in grasping and pushing for the development opportunity:

> **Story 1**: We had an assistant practitioner a few years ago that left to do her nursing degree, and that left a bit of a gap because she (this AP) had able to do some of the things that nurses could and that health care assistant couldn't. When (the AP) left this opened the door for (name of the nursing associate} who wasn't sure if she wanted to go to university or to do her nursing or become an assistant practitioner. I think she's (the NA) just quite on the ball with knowing things, and so she brought it to us and said, this is something she's heard of and she's interested in, and then we supported her through. (M_1)

> **Story 2:** I can go back quite a few years: I was very much involved with the first run of the assistant practitioners and there was a struggle then to get them registration. I've got an assistant practitioner in post as a Band four in my team. And then I've got (name), who is my NA, she was a very high-functioning HCA and hadn't been able to get on to do her university degree, and then because I go to different meetings, different forums, I was very aware that the nursing associate was coming up, so talked to (name) about it - very keen, very keen - and she was lucky enough to get on it. (M_2)

4.2 Process

The process of developing and implementing the NA role at Livewell comprises several dimensions:

- Establishing a supportive infrastructure;
- Identifying and developing nursing associates; and
- Providing ongoing support for qualified NAs.

Each is considered in turn.

4.2.1 Infrastructure

The infrastructure for the NA role can be found at both the system and the organisational level. At system level, the Devon ***Sustainability and Transformation Partnership*** (STP) has been an important vehicle for Livewell, and other health and social care employers in the area, to take forward the NA agenda. The Devon STP has a NA programme board, but more noteworthy has been the development of a ***Community of Practice*** (CoP), a network of healthcare and social care providers in Devon centred on the NA role. In the wake of the initial TNA cohort, there was a 'little CoP', involving healthcare providers in close proximity to one another – Torbay, Derriford and Livewell - and a 'big' CoP Devon-wide meeting less frequently convened. More recently the Devon-wide CoP has begun to meet on a more regular six-weekly basis, attracting an increasing range of health and social care providers including from the independent (private) and voluntary sector, general practice as well as the higher education providers.

The CoP emerged to provide mutual and a sharing of practice and experience in the context of considerable uncertainty about the new NA role:

> I guess some of the challenges were around having to do things very quickly and we were learning as we went along; so, it was a good experience for us as a group. (SM_1)

There was also a collective desire to ensure that an established NA role became a system, rather than a single employer, resource. This required, in turn, a consistent, quality assured approach to developing the role across the Devon health and social care system:

> It's really about acknowledging that this (the new NA role) is going to be business as usual, that this is a core part of our workforce. So, actually it's about that portability, about that mutual understanding across the wider system. We will in time have

> nursing associates moving between organisations, and that's really positive, getting that cross-pollination. So, from the ground up we needed to sell the fact that we were all united in the way that we were going to support the nursing associates, and that has given us consistency and quality assurance. (SM_2)

Individual health and social providers in the Devon partnership continued to exercise discretion on various operational issues, for example the choice of training provider and the pattern and organisation of their placements as well as the numbers of TNAs being developed. However, the pursuit of 'consistency and quality assurance' was given effect through a range of shared practices:

- A common job description of the TNA and NA roles[7].
- A Devon-wide NA Handbook
- A shared TNA and NA uniform
- A sharing of placement opportunities

At the ***organisational level,*** the Livewell Board was very supportive of the NA role. Access to a new role by support workers as a development opportunity was seen to align with the organisation's 'good employer' culture. Such an employee-centred culture was reflected in: recent Care Quality Commission (CQC) comments on the organisation's strength in this respect; a separate, ring-fenced education budget; and the scholarship programme mentioned above:

> We're very fortunate in that the Board absolutely buy into the development of our staff. We just had our CQC rating and that was, we're good to a patch, but I think outstanding in lots of areas, but I think the key thing is what they said is around how our staff feel invested and develop, so we've got a separate education budget for our staff. So, when I took it (the TNA programme) to the Board, they were very, very receptive. (SM_1)

Indeed, with the rolling-out of the NA programme by Livewall across to third (2018) and fourth cohorts (2019), the qualified NAs have become an important organisational resource, used to reinforce and communicate the value of the new role. Thus, qualified NAs have returned to the Board to present on their experiences of the role and on their own personal

[7] Although generic job descriptions were further refined to reflect organisational and team circumstances and needs.

development. These NAs have also been used to support the recruitment of subsequent TNAs:

> We use them (qualified NAs) a lot for our recruitment: we take them out, we use them for the interviewing for the next group. (SM_3)

Further indicative of Board level support was Livewell's appointment of a ***Placement and Development Facilitator,*** with a dedicated responsibility for the management of the (T)NAs programmes. The role has evolved and is evolving, largely tracking Livewell's policy on Band 4 clinical support roles. Initially emerging as the district nursing clinical facilitator in June 2017, the role combined support for the first wave TNAs with a wider remit to support and develop competencies and clinical evidence-based practice in Livewell's district nursing teams. As the second TNA wave unfolded at Livewell this role extended to take-on an organisation-wide responsibility for the (T)NAs, assuming its current job title and being performed by the previous district nursing postholder. Moving forward the role might well further develop to take on responsibility for the organisation's APs as well as its (T)NAs.

The Placement and Development Facilitator plays an outward and inward facing role. Outwardly the postholder engages with the training provider (currently Plymouth University, formerly South Devon College), ensuring the efficient and effective delivery of the TNA (apprenticeship) programme. Where external placements are used these also have to be organised and managed. Inwardly, the role deals not only with the supervisory and mentorship arrangements for the NAs, but more directly with the TNAs themselves in providing pastoral care and more technical support as required. As one senior manager noted:

> There needed to be a personal element of support, which was (the Placement and Development Facilitator), from a clinical perspective, but also around emotional intelligence. It was a journey and a lot of them (TNAs) hadn't studied for a while; they also had families and they were juggling all of those aspects as well and developing in their role, moving around as well. (SM_2)

The value of the Placement and Development Facilitator was highlighted by another manager who attributed the low attrition rate on the various TNA waves to the presence and efforts of the postholder:

> In terms of that investment, that facilitation, absolutely, for me, I think the key thing that's helped with our attrition because it's the little things that bother people that (post holder's name) will get in there, be very responsive, deal with it. (SM_1)

4.2.2 Developing the (T) NAs

In exploring the development of the qualified NAs, we:

- Briefly return to their emergence and distribution;

- Touch on their recruitment; and

- Explore in greater detail their training experience.

-Emergence and distribution. As noted, the initial concentration of NAs was in district nursing teams, followed by the diffusion of a second wave across a diverse range of services and teams. In terms of numbers of qualified NAs within any given team of unit, there is some variation in practice: senior management were keen to avoid arbitrarily requiring teams to adopt a given number of NAs, viewing take up rather as dependent on a team's skill mix needs (see below for a fuller discussion of skill mix):

> So we skill mix into these (NA) roles… we look at the team, discuss with the manager, look at the work that's there and look at the other roles, the (band) threes as well and the fours and what that means, complexity of the types we're looking after as well. So, it's not about evenly spreading, it's about the right person in the right team, to be able to support them within that transition as well, but support the team as well. (SM_3)

This sensitivity to context possibly accounts for the variation in the number of qualified NAs by service and team: for example, no more than one in each of the half dozen district nursing teams and 2 respectively in the male and female acute mental health in-patient wards.

-Recruitment. As noted, the recruitment of TNAs at Livewell had often been driven by the prospective trainees themselves, albeit with the explicit support of their line managers. In selecting individuals for the TNA programme management placed weight less on formal knowledge or capability and more on whether the applicant's values aligned with the organisation's principles:

> We were very clear that the recruitment wasn't going to be a about knowledge because they weren't at that stage; it was around our values. Our recruitment event was very much around putting them in leadership scenarios to actually see how they behaved and we as a group observed them…. So, we did a lot of recruitment around values based, around getting the right person. (SM_2)

-Training: Given our principal interest in deployment, we will not dwell at length on the two-year training experience of Livewell's qualified NA. It is, however, worth briefly touching on this experience. It sheds light on how well the NAs were prepared for their role, with implications for how they were viewed and used within their teams, on qualification. This training experience can be considered in three main parts:

- The formal educational component involving off-the-job learning and engagement with the training provider;
- The 4 placements a year, of 3 to 4 weeks each, in different care settings; and
- The base or home placement where the TNAs spent most and the remainder of their working time.

In general, our NA interviewees found the ***formal educational*** part of the training programme intense and often stressful, with one interviewee characterising the programme as 'highly fractured', as constant changes and 'tweaks' were made. In large part this was a (perhaps inevitable) consequence of being in the initial TNA waves and engaging with the training before the Nursing and Midwifery Council (NMC) had published the NAs' standards of proficiency to be met in training or begun to approve training providers. With such uncertainty, Livewell was concerned to ensure that the training covered all of the elements likely to be required by the NMC, so avoiding the need for any future top-ups, but at the cost of a heavily loaded curriculum. Such uncertainty also led to a delay of around 6 months in formal registration of qualified NAs following completion of the programme. For second wave ***apprentice*** NAs and in contrast to the first wave NAs, completion of the programme was further complicated by the need to undertake an end point assessment: which was not part of the first wave qualification process.

> Because we were the first two cohorts, we did make a lot of changes, but I think, of course that's going to happen with a brand new qualification, a brand new course, no-one really knows what is to be expected and the NMC hadn't given out their guidelines when we were doing the course... The educators were going in blindly and just making sure that we'd done everything that the NMC could possibly throw at us. (SM_2)

> All the way through we weren't really sure what was happening a lot of the time, and that was through no fault of this organisation at all, but…. the goalposts were moved a lot, and I didn't feel we had any kind of stability at all. It was a difficult two years. (NDA_1)

More substantively, there was also a feeling that the college programme lacked a strong mental healthcare element, an important perceived limitation given that many of the Livewell TNAs were working in and drawn from this branch of healthcare service:

> Although it was very broad, we felt like the mental health content in the training was pretty minimal. (NA_1)

By contrast, views on the ***external placements*** were generally very positive. In the case of the former, supernumerary status provided learning opportunities in a range of care settings, with the length of these placements being extended over the course of the programme from three to four weeks to deepen this experience:

> The placements were amazing…. We did four weeks in our second year, which actually it still gave us the opportunity to go to different, lots of different places.
>
> There wasn't a single placement where I wasn't accepted. A lot of people didn't fully understand the role, but they weren't negative towards it. (NA_2)
>
> Overall, I had a good placement experience. Like anything, some were better than others, some were more inclusive, getting us to be involved and do things, so I had a good placement experience; it was nice to see other areas. (NA_3)

These positive views extended to the ***base placement***, where TNAs were typically performing support worker role at Band 3, albeit with learning opportunities and the ongoing development and assessment of competencies. In general, the NAs felt that they were provided with considerable support by teams during their training, likely reflecting the fact they were already established team members, known and appreciated by colleagues before they embarked on the programme:

> I can't fault my experience throughout my whole training of being supported by the ward, getting me actively involved in things; I really couldn't fault how I've been supported and encouraged to develop and given opportunities on the ward. (NDA_2)
>
> The unit fully embraced it (the TNA training) and at every opportunity there was a chance for us to step up; support was given to us without question really. (NA_2)

4.2.3 Ongoing support

The final dimension of process relates to the ongoing support provided to NAs in the immediate wake of qualification. This support mainly rested on a year-long Livewell preceptorship programme, which included 5 core learning days - spread across the year- and centred on a workbook of context-specific competencies to be worked through and

signed-off. Given the wide range of clinical competencies and experiences acquired by NAs during their training, this preceptorship concentrated less on ‘hard’ clinical skills and more of ‘soft’ person-centred ones:

> Our preceptorship programme is not so much focused on clinical skills. It's very much focused on those things like accountability and time management, those sorts of ‘everybody needs to know’ sessions that are relevant to all. And then the clinical skills bit tagged onto the end, specific to where you're working. (SM_3)

There was sense amongst the NA interviewees that given thorough and broadly based nature of the training programme they were well prepared for their new role, perhaps more so even than the recently qualified band 5 nurse:

> Compared to new preceptors, we have been in our role, then we've gone off to placements here and there; we've got that experience of two years' training; when the preceptors are coming in they've got all their book knowledge and may have dabbled in this and that, but we've been working the job.(NA_4)

> I sat in on the preceptorship meeting when we all get together and one thing I did say at the end of it was I was surprised at the difference, because it was mostly the Band 5s and I was really shocked at the difference of my outlook compared to theirs in the way that we've all settled in and the transitions have all been made. And it is purely, and I did actually say, it's because I've done this, I've been in the role, I've gone away, I've come back. (NA_5)

Asked whether entering their role on qualification was a ‘smooth transition’ or more like a ‘cliff edge’ most NA respondents opted for the former, although this was a more typical responses from the wave 1 than the wave 2 apprentice NAs whose completion of the programme was somewhat complicated and extended by the end point assessment requirement of the apprenticeship.

4.3 Impact

In our last findings section, we explore the impact of the NA role at Livewell on:

- The nursing associates themselves
- The distribution of nursing tasks
- Skill Mix
- Co-workers and other outcomes

4.3.1 Nursing Associates

There is value in exploring the career trajectories of those who participated in the first two waves of the NA programme at Livewell. The weight placed on the programme as providing existing staff with a development opportunity, encourages an interest in whether these workers have aspirations consistent with senior management assumptions. More generally, a grow-your-own strategy still begs questions about what kind of workforce is being grown: Were the NAs keen to grow into the NA role as an end-point in their career progression? Did they view the NA programme as a stepping stone into registered nursing? Or did their career aspirations lack such precision and evolve with time and experience?

Three aspects of NA career trajectories are considered:

- The career pathways taken to the point where the individual entered the TNA programme in 2017: the TNAs' career history;
- The reasons why they joined the programme; and
- Closely related, their career ambitions going forward, which may or may not have developed since.

In terms of ***career histories***, Table 4 below sets out the pathways taken by our NA interviewees. It indicates that:

- All but one of the NA were female (F)
- With the exception of one NA (7), the interviewees had been employed by at least one other organisation before joining Livewell.
- There was a wide range of work experience, although many of the interviewees had held at least one care role prior to coming to Livewell.
- There were clearly what might be called 'epiphany' workers, as they had been working in very different industry settings - retail (NA3), engineering

(NA6), building (NA5), factories (NA12), hairdressing (NA8) – and had sought a dramatic career shift into care work.

- Most striking was the degree of career movement amongst interviewees once they had joined Livewell. In part, this movement was along an apprenticeship route (NAs 6, 7, 8). In other instances, it was across different work roles and services (NAs 3, 4, 9,11,12,13). Typically, the movement was between clinical roles, for example, from phlebotomist to HCA (NA 3,11,12); but there were cases of a shift from non-clinical roles- in administration (NA9) and cleaning (NA12) - to a clinical role.
- Given career movement within Livewell, it is unsurprising that our interviewees had considerable organisational experience. The average length of interviewee service was 7 years, although the spectrum of experience was broad, ranging from a couple years (NAs 4, 5) to 14 years (NA 12).

Table 4: NA Career Trajectories

NA	Since leaving school →							Years at Livewell
1	College (care related) (F)	University (not care related)	Livewell Current service					8
2	Domestic responsibilities: Children (F)	Nursing access (incomplete)	Pubs	Volunteering (care)	Care Home	Acute Trust HCA	Livewell HCA	
3	Sales/marketing (F)	Livewell Phlebotomy	Livewell mental health team	Livewell DN team				
4	Learning disability care (F)	Livewell end of life care	Livewell DN					2
5	Building worker (M)	Care home						2
6	Engineer (F)	Livewell Apprentice in administration	Livwell B4 role mental health					6
7	Livewell apprentice HCA (F)	Livewell HCA mental ward						

8	Hairdressing apprentice (F)	Carer community	Livewell HCA apprentice	Livewell				6
9	University (care related) (F)	Domestics: Children	Retail management	Livewell Ward based HCA	Livewell Admin role			9
10	Apprentice in Nursing home (F)	Livewell HCA stroke						5
11	Admin (F)	Livewell Phlebotomy	DN	10 years				10
12	Factory (F)	Domestics: Children	Livewell cleaning	Livewell Phlebotomy	Livewell HCA			14
13	University (non care) (F)	HCA Acute hospital	Livewell mental health ward HCA	Livewell Children and Adolescent Mental Health HCA				
								Average= 7 years

In general, the ***reasons for joining*** the TNA programme in 2017 were associated with a broadly conceived future career aspiration post-qualification as an NA. However, there were some important differences of nuance as to why individuals joined the programme, and considerable variation in the degree of planning informing their decision to become an NA. Table 5 below sets out the stated attraction of the NA role to interviewees, alongside their broader ambitions and perceived futures.

Table 5: NA Motivations and Career Aspirations

	Attraction to the TNA programme	**Ambition/Future**	**Illustrative Quote**
NA1	Job requirement Financial consideration Enjoyed learning on the job	Nurse (planned)	Prior to applying to do the nursing associate role, because things were taking a little bit of time, I'd applied to Plymouth Uni to do mental health nursing and just the standard three-year progression route through, but when this came up it was a much better option because there was no student debt attached to it and we were being paid whilst we were learning, so it seemed like a no-brainer, really. The decision I'd already made was to become a nurse, but this just seems to be the more logical

			option for me at the time. So I saw it and applied for it just because I really liked... I knew, having done an apprenticeship already, I liked being able to learn on the job
NA2	Good opportunity Not premeditated	Nurse (emerging)	Prior to starting as an apprentice health care assistant, I had no idea that this was where I was going to end up. I was just taking my time and as it came up I thought it was just a really good opportunity to go for.
NA3	Deepening Understanding/knowledge	Nurse (emerging/deferred)	I just wanted to be able to understand more of what nurses do and what type of assessments they had to carry out and how we could support our patients more really. When you're on the floor we're doing more stuff like personal care and we don't actually know what's going on in mental health terms of the chemical reactions, why they're on certain medications, so I just wanted a better understanding really of what we can do to help patients more. And I think progression for myself as well, that sense of achievement; I never thought I would go to uni, never thought I would be able to even get a degree,
NA4	Shift from admin to clinical Progression Finances	Nurse (planned)	I did want to register, but I just didn't know how to go about it, how I could fund myself; because I've got four children at home there was just no way that I would be able to afford to just go off to uni for three years and be put in placements all over the place, so it was just an amazing opportunity to be able to develop into a more clinical... a registered clinical staff member
NA5	Progression Finance	Nurse (planned/deferred)	Just progression. I knew I was better than just an HCA. I thought I had more skills than that and it was just a good way to go up while still being paid, which is a good motivation, and it was just a good opportunity.
NA6	Progression		I wanted to progress more than anything, expand on my skills. I still loved being a HCA but, because the opportunity was there I felt I should at least apply. I thought I'd done as much as I could as a HCA and I wanted to develop, so this is the next... I've always want to go into some sort of nursing, so this was the way forward.
NA6		Nurse – emerging	I wanted to progress more than anything, expand on my skills. I still loved being a HCA but, because the opportunity was there I felt I should at least apply. I'd say I thought I'd done as much as I could as a HCA and I wanted to develop, so this is the next... I've always wanted to go into some sort of nursing, so this was the way forward. I didn't want to come out of learning and then attempt to go back in, because I think... it was tough, wasn't it, the nursing associate, and you're in that mindset at that time, and I just thought if I stopped now, I'm probably going to enjoy it too much and not want to go back.
NA7	(Pay) Progression		I wouldn't have been able to get paid band four wage unless I had the nursing associate role,

			qualification. So I was stuck at a band three unless I left and did my nursing, but this was a way forward to learn on the job and progress
NA8	Confidence Work and Learn		It was confidence thing; I didn't want to drop out, stop working and go to university full time. One, I couldn't afford to do that but, two, I don't think I could mentally cope with doing it. So to be able to work and learn at the same time and have that support and that wage, it's a natural progression, isn't it, it's just a win-win situation.
NA9	Deepen understanding and knowledge Work and Learn		It was going onto the band four, there was no progress, but also being able to learn new skill and learn more behind it, what we were doing, why we're doing all these things and being able to help more people in the broader reach of people we can now help.
NA10	Become a nurse	Nurse planned	So within my team, I work with CPNs (community psychiatric nurses) and when I originally started, going out with them and seeing what they do, I thought, wow, this is what I want to do, so the nursing associate programme came up and I thought it would be a massive stepping-stone for me to progress onto my career to become a Band 5 hopefully at the end of it, but that's what made me want to pursue the nursing associate.
NA11	Become a nurse	Nurse planned	So initially, before any of my jobs, I was at university, so I had my children young, so I got into care work and from there I saw my job at ( ) I worked alongside nurses and ever since then I thought, that's what I want to do, I want to be doing more, so then each job has been like a progressing... I've progressed to where I am now and so my main aim is to be a registered nurse eventually, so it's just to do it.

The material presented in Table 4 should not obscure a degree of uncertainty underlying the decision to become an NA. Such uncertainty was perhaps inevitable. As a new role, its likely substantive form was unclear, particularly within a community and mental healthcare setting. As various NAs noted:

> We went to a meeting originally, where they discussed what it (the NA role) was; why it was brought in; the aim was to bridge the gap between health care assistants and nurses. But we were quite unsure of how that would look in our workplace.
>
> There was a lot of guidance about transitioning the role into general health care to adult health care, but there wasn't that much in the way of how that was going to work in the mental health setting, so that was a little bit strange.
>
> At the time, when it first happened, nobody really knew much about the nursing associate role. We had the basics, but it wasn't until we went on our training that the role was more defined.

Possibly as a consequence of this uncertainty, the initial response of many NAs as to why they were ***attracted to the programme*** was articulated in broad terms typically as a simple 'chance to progress'. However, drilling down, it is clear from Table 5 that this progression was conceived in different ways, often by the same individual combining various motivations. Thus, progression was seen by NA interviewees as…

- **Opportunity**: for some the programme was an unexpected chance, not actively sought but enthusiastically embraced on becoming available (NA2).
- **Material advancement**: in one instance, an interviewee presented progression very much in terms of improved pay and the ability to earn a Band 4 wage (NA7).
- **Capacity to deliver 'better care'**: driven less by extrinsic and more by intrinsic reward, some interviewees were keen to advance in terms capability and competence, mainly as a means of providing better quality care for their patients (NA9 & 3).
- **Practicality**: there were cases where the TNA programme represented a cost-efficient and effective means of developing their career. For those with domestic responsibilities and associated financial pressures, an 'earn as you learn' approach to training provided an apparently viable and, for those previously completing apprenticeships, a proven route to advancement (NA1,4 & 5).
- **Planned**: This view of progression was reflected in the comment of an interviewee that 'it was always the plan (after completing the NA programme) to move into registered nursing'. In such instances, becoming a registered NA was just one step on a clearly conceived and premeditated onward career path (NA10 &11).

  This latter form of progression as a planned career strategy connects involvement in the NA programme to the individual's broader career intentions. It was striking that almost all of our NA interviewees wished at some point in the future to progress into registered nursing. Three of the interviewees from the first TNA cohort had already done so. Three of the qualified NA interviewed, still in post, had applied to move through to registered nurse training, but unsuccessfully at this stage. More broadly, it has already noted above that around a third of Livewell's NAs had immediately advanced to nurse training (10 out of 30).

  This near universal ambition to progress into a clearly defined registered nurse role perhaps accounts for the propensity of the NAs to gloss over any uncertainties about the nature of NA role when embarking on the NA training. With the intention of

moving into registered nursing, it was not a role they would likely be performing for long, so why be too pre-occupied with what it might look like? At the same time, the NA interviewees appeared to be relatively young. We did not collect age data, but impressionistically most of the interviewees were in their early to late-thirties. This suggested that they could become registered nurses in just three and half years with the majority of their working lives ahead of them. With their futures before them, it was perhaps unlikely to be a final stopping point: indeed, if they were ambitious enough to go for the NA role, they were likely to have the drive to go further. However, from an organisational perspective this rapid throughput of NAs into registered nurse training risked individuals not consolidating their skills and the NA role not embedding itself in the service areas:

> It's a bit of a double-edged sword, in that we are producing people that we want to stay within the (NA) role, which is brilliant, but actually we're training them to leave us, certainly in my speciality, and so we are constantly struggling to keep up with that, and that's the downside of it, although I appreciate that it's, in terms of developing people into their full potential, it's a good thing, but we do struggle with it. (M_2)

Indicative of these organisational concerns was Livewell's recent decision to require future qualified NAs to spend at least a year in the role before considering moving onto further training.

Despite the general NA desire for progression into registered nursing, such aspirations had developed in different ways. As stressed, there were NAs who from the outset had envisaged this form of career movement. For other NAs the nurse aspiration had not been a priority at the outset of their training. Rather it had emerged more iteratively as their learning and experience progressed. These individuals had found themselves on a training 'merry-go-round', and were often worried that if they got off, they would never get back on. There was also a group of NAs who had retained a nurse aspiration, but chosen to follow this path in slower, more incremental way. In part this approach was perceived to provide a rest from the pressure of training on the completion of the intense TNA programme. These NAs also saw the pause as a chance to consolidate their skills. Amongst those unsuccessful in immediately moving onto nurse training, such a pause was often seen in retrospective as being of value in letting them take stock:

> I applied (to the scholarship), but didn't get it because there wasn't enough funding. However, I'm very glad to have consolidated because I've now been able to fully put into practice the things that I learnt in the classroom; I can understand things more and my practice is different and it's probably a lot more professional than what it was before. (NA_2)

4.3.2 The Distribution of Nursing Tasks and Responsibilities

Given our interest in the deployment of qualified NAs, the (re-) distribution of nursing tasks and responsibilities following the introduction of the role is crucial to our evaluation. A focus on the distribution and responsibilities allows us to assess the nature of the NA role and how it is being used in the delivery of frontline care:

- What are the boundaries of the role or its scope of practice?
- What can the NA do which lies beyond the remit of the HCA?
- Are there residual nursing tasks which remain the preserve of the registered nurses?

Table 6 below provides an overview of the tasks and responsibilities performed by NAs in the services covered by our fieldwork[8]. (A fuller version of this table which includes supportive quotes, is included as an Annex). In short, Table 6 indicates that the NA is developing a distinctive scope of practice which distinguishes it from the HCA and the registered nurse. More specifically it suggests: first, that NAs have taken-on a clear set of tasks and responsibilities, which in the main were formerly undertaken by the registered nurse; and second that in doing so, the NA role has extended well beyond the remit of the HCA.

The Table suggests that many of the tasks and responsibilities taken on by NAs were generic patient centred tasks and responsibilities such as undertaking forms of assessment, care planning and the administration of medicines. Indeed various activities are worth highlighting as indicative of heightened levels of responsibility: NAs in district nursing undertaking first visits to patients' homes and therefore completing the initial assessment and care planning; NAs in acute in-patient wards

[8] These are the tasks and responsibilities raised by our interviewees. They are unlikely to comprehensively reflect the character of the NA role, but might still be seen as indicative of its content and shape.

acting as the 'named nurse' and assessing patients for Section 17 leave[9]; and NAs in both these care settings administering a broad range of non-controlled medicines.

Table 6: Indicative Activities and the Boundaries of the Nursing Associate Role

	NA but not HCA	Registered Nurse but not NA
District Nursing	• First/visit/ Initial Assessment • Patient review/monitoring • Complete a wound care assessment • Case load at care homes • Out of hours skin/wound care • Administration of most types of medication • Intramuscular injections	• Syringe Drivers • Complex visits/cases (involving for example end of life/safeguarding issues)
Health Visiting	• Development checks on children	• New births and more complex visits
Complex Needs Team	• Pre-referral assessment	
In-patient mental health wards	• Drafting care plans • Clinical discharge summaries • Most medication • Ongoing risk assessment 'on the floor' • Second checker: controlled drugs • ECT team member • Section 17 leave assessment • Patients' named nurse • Sub-cut, inhaler, rectal & IM injections • Increase the frequency of patient observations • Participating in MDTs	• Administer controlled drugs • IVs • Acceptance of section papers • Signing transfer papers • Full clinical assessment • Reducing frequency of patient observations
Liaison Psychiatry	• Second assessor (including complex cases) • Sole basic assessor (non-complex cases) • Writing up assessment	• Leads assessor • Sole assessor (all cases)
Neuro Rehab	• Managing HCA	

[9] Section 17 of the Mental Health Act 1987 which allows periodic, unplanned patient requests to leave the ward for a short period, subject to an assessment of the patients' condition by a member of the registered nursing staff.

At the same time, Table 5 draws attention to the service-specific nature of certain NA activities: for instance, the pre-referral assessment undertaken by the NA in the complex needs team and the development checks on children performed by the NA the health visiting team. Clearly the NA role is shaped differently not only across but also within services, reflecting, for instance, line management style; the character of the services; the catchment area served and whether there is previous experience of the NA role:

> Each team, because of their different care needs, and their patient groups, actually support the TNA differently. In terms of the TNAs, band fours in district nursing won't have a case load, but in mental health teams they will…Everybody compares with each other, but it's very team-specific on what sort of role you would do. (SM_3)

While Table 6 presents a snapshot of the NAs' activities, it remains important to drill-down to the dynamic micro-processes which have facilitated and encouraged the NA to take on these tasks and responsibilities. Throughout this report we have stressed not only the newness of the role and associated uncertainties about its form, but raised questions about how it might be accommodated within established service delivery routines and by multiple stakeholders. The following points emerged about how the NA role was accommodated within the different Livewell services and composite teams:

- **Evolution.** The NA role developed organically and in a situated or context specific way within different teams and units. The NA was an emergent rather than a 'ready-made' role, with its boundaries incrementally formalised over an extended period pre- and post-NA qualification and registration:

> I was in the first cohort and it was a case of we'll figure it out as we go along, we'll find how you fit, where you fit in; we'll all learn as we go along. (NDA_3)

> It's things like finding what we can and can't do. Because we were the first there wasn't enough knowledge on what we could and couldn't do to begin with. You can't do that, we can do this, so... you can't do a PICC (peripherally inserted central catheter) line, but you can do a drain; I can't do this, but I can do that. To begin with it was like, '(NA name), can you do this?' and I'd say, 'I don't know because you're my line manager'. (NDA_2)

This gradual shaping of the role as it interfaced with established systems and other stakeholders was illustrated in Liaison Psychiatry team where the scope for the NA to write up the notes of a patient assessment was challenged by a senior registered nurse. As the NA noted:

> So, when we do assessments, one person will talk and one person will write or type and if the Band 6 leads, then I'll write the assessment up, and there was a conversation the other day about whether that needed to then be checked by the Band 6. (NA_6)

In such circumstances, a decision on the boundaries of the NA role is needed and made in this case by the team leader:

> One of my band seven colleagues had said 'no, I think somebody needs to check it' (the NA's assessment write-up), and the NA came to me and I was like, 'no, you're an accountable practitioner now'. (M_3)

- **A 'soft landing'.** The adoption and accommodation of the NA role within teams were facilitated by several processes. First, and already noted, in NAs in the initial Livewell waves were recruited from the current Livewell workforce and largely returned to their original teams on completion of their training. The NAs were therefore known, and trusted by other team members when it came to the allocation of tasks and responsibilities:

> She (the NA) fits brilliantly now, but that's I think about the individual; not just the qualification, it's about her and her confidence, so... but it's a work in progress. (M_5)

Indeed, trust in the NA was key to the sensitive and flexible management of the NA's role boundaries. As known team members, NA postholders were trusted to perform within the limits of their scope of practice as well as being trusted to check, confirm and refer back to a more with a senior professional if and when they were confronted with uncertainty about an activity or their remit:

> When it's a team that know you and have known you for years and years... it would be very different if it was just somebody that had come in and didn't have lots of previous experience. That's why the role's worked so well in Livewell because they've taken the people that have worked for the teams

and it does make a massive difference. (RN_1)

You're able to give her a job and know that it'll get done really well. (M_1)

If there's anything she's not sure about she'll bring it back to an MDT every day to discuss anything, or she'll just bring it back to the practice lead; I think, actually, we could discharge this patient, what's your opinion? (M_2)

Second, the two-year TNA training period, much of it undertaken within the base placements, allowed the NA role to be gradually crafted and the relevant competencies incrementally acquired, allowing smooth progression post-qualification:

I felt that it (the NA role) transitioned okay, to be honest. When you've been working somewhere in a student or trainee role for two years, gradually that level of responsibility is increasing over those two years; when we actually got our registration I didn't feel like I was just chucked in at the deep end at all, I felt I was well prepared. NA_2)

Because we'd been in the team and I'd done my competencies throughout, when I got to it, I already had it. (NA_3)

- **Registration.** For NAs registration represented a significant change in status, generating a legitimate sense of self-worth:

It's a bit more of a personal achievement having the registration. Like qualifying, you've not just done a foundation degree, but you have got a registration. (NDA_1)

In terms of job performance, such status also impressed upon NAs their new level of responsibility with implications for how they delivered care:

Having the registration has definitely improved my practice, I thought I was doing everything I possibly should and could, but actually it's 100 per cent improved it because I have to be more accountable, more aware of the decisions I'm making, I have to actually know the whole rationale for why I'm doing it or why I'm not doing it, even something as simple as a prescription chart that is missing one thing; I'm going to get that sorted before I carry on

> because I'm registered now, so I can't pass the buck; so my practice is so much better now. (NA_4)

As another NA noted:

> I'm a lot more cautious in my decision-making now. Like, massively, because of the accountability of it, and I don't think that's necessarily a bad thing at all. Yeah, I think that your decision-making changes and I think you're having to perhaps take leadership on decisions where perhaps before you probably wouldn't have done. (NA_5)

These views were echoed by an NA from a mental health ward:

> At the first shift when I went in (as a qualified NA), someone was coming to me and saying, can you assess this patient to go out on leave? They're sectioned, there's risk involved, and I was like, oh, suddenly I'm making this decision to let someone out and do that risk assessment; so yeah, it just makes you more cautious and aware and I just take the responsibility that I have, that comes with having a PIN (registration number), very seriously. (NA_2)

Moreover, in the workplace context, registered status increased the confidence and willingness of more senior staff to delegate tasks to the NA. In Liaison Psychiatry, for example, specific mention was made of registered status as underpinning the decision to send the NA as a second assessor in dealing with non-routine, more complex patients. As the team manager noted:

> I think for me (NA's name) skills would come in because they're accountable; if there was a complexity, I think people would feel very happy going with (NA's name). (M_5)

In an example from district nursing, registered status provided an underpinning assurance allowing the NA to undertake out-of-hours skin care activities in care homes;

> Skin care … it's not deemed urgent, so they're (registered nurses) able to send their nursing associate in who's registered, is able to do the task, is competent in the task and then a nurse in the day team will be able to follow that up the next day or the day after. (SM_3)

- **Complexity.** The final aspect of NA accommodation in established routine and by various stakeholders concentrates on the underlying dynamic by which tasks and responsibilities are allocated to NAs. The NA role is often characterised as marking a move away from a task-centred approach to care. A training programme nurturing a strong knowledge base and encouraging a deeper understanding of the nature and consequences of the care provided has been presented as allowing NAs to adopt more broadly conceived responsibilities, to be undertaken with a degree of discretion and autonomy. In providing the context for the development of the NA role, a senior manager at Livewell noted:

> Previously, it (care delivery) was very task-focused: people going in and doing a role and coming out because that's all they could do. I think now we're able to workforce plan and grow a workforce with people able to use the wealth of their knowledge to signpost and manage a situation. So, we're not just going in for somebody to re-dress their legs, we're looking at the social isolation, we're looking at the other factors, what matters to them, really, and addressing that. (SM_3)

As an NA succinctly put it, her role is characterised by a shift away from a narrow focus on tasks to 'seeing the bigger picture':

> As an HCA you do go out and you do the wound care or you do the catheter but you don't think about the bigger picture; whereas actually now we're going out and doing the catheter and they say, I've got a bit of pain today, and you elaborate on that pain, or I haven't been hungry the last few days, so you're constantly thinking of the bigger picture. Now it is why have you got pain, why are you not hungry? Whereas as an HCA I never did that; it was just 'oh, have you?' (NA_6)

As another NA from a district nursing team noted:

> Whereas as a band three I could follow a care plan, I could make suggestions and we can bring things back, now in my role (as an NA), I can go in and I can assess the whole wound and everything else that goes with the patient, and then I can make those decisions, provided I'm competent to do that, then I can go ahead and make the decisions that need to be made and then bring them back to the team, rather than have to wait and just see. (NA_7)

However, as the NA role moves beyond a mechanistic task-centred performance to

the discretionary exercise of more broadly conceived set of responsibilities, there is, by implication, a decision-making process which allows the NA to practice in this way. In many of the Livewell settings, this process rested on the allocation of tasks and responsibilities, typically by a team manager or senior registered professional and often taking into account the complexity of the case.

As a NA in district nursing noted:

> In community nursing the band three is very task-orientated and they will get their list of patients, go and do the task, whereas for you (as a TNA), throughout your learning, it's about a case, so if that wound is changed you can complete the wound care assessment, and you can take that and feed that back to the registered nurse and just have an agreement that that is all correct. As a nursing associate you are able to go and do first visits, depending on the delegation, the needs of the patient and the complexity of that. (NA_6)

This is not the place to examine in detail definitions and interpretations of 'complexity' used by managers in allocating tasks and responsibility. Suffice to say that complexity played itself out in different ways at Livewell. We have seen that in certain care contexts complexity allowed the NA to safely take-on more responsibility than say the HCA: for example, the NA in Liaison Psychiatry accompanying the Band 6 nurse to undertake assessment of patients with quite complex needs. As the NA from this team noted:

> Someone taking a massive overdose or something like that, which is a bit more complex as a situation, they wouldn't want to just take a Band 6 and a Band 3 because you'd want to be able to have the discussion and each be on the same page in order to go forward and know what you want to do, so I think most people would feel comfortable going with me (rather than the Band 3). (NA_6)

More typically, the greater the complexity of the case the more likely the registered nurse was to take responsibility. This is well illustrated in district nursing, as described by a line manager:

> Much depends on the complexity of the patient. So if you have a patient that's discharged from an acute hospital, who maybe has a complex wound or some surgery, maybe is end of life care or last stage of life care, then for me that's quite a complex assessment that needs a really strong care plan that

> may need referral to all different members of the MDT, multi-disciplinary team, and so as a Band 5 or a Band 6 I would say actually that complex care would be for a Band 5 to go and assess. But if a patient was discharged from hospital and they've knocked their leg and they've got a wound on their leg that needs looking at, and again first visit, then I would be very happy for a Band 4 nursing associate to go and see them as a first visit because it is about one element of care in one way, and they can do a wound care assessment, they can plan that care. (SM_6)

Indeed, this manager continues by noting that the number of cases allocated in district is likely to be a reflection on their complexity:

> During allocation for the day in a district nurse team, you would expect to see that the Band 3 would have the most visits because their visits are very much you go to see the patient to provide care and you document and you come out again. So they would likely have between eight and ten visits a day. You then see a Band 4 perhaps have 6 to 8. It would be less because they would have more assessments to do, which would take longer; they would look at, for example, a wound, is the wound's care plan up to date, if not they would complete it. You'd expect a Band 5 to have between 5 and 6 visits because they're more complex. (SM_6)

4.3.3 Skill Mix

Skills mix is the balance between registered and unregistered staff and, in a more refined sense, between staff from different pay bands, on any given shift or in any particular team. The emergence of a new registered role sitting between the HCA and the registered nurse was always going to raise questions about this balance and how the NA would be accommodated within it. Indeed, exploring the accommodation of the NA in these terms raises not only the narrow technical issue of skills mix ratios, but broader matters related to whether and how such ratios might influence the scope and nature of the activities performed by the NA.

The skill mix implications of the NA were still playing themselves out at Livewell as the role's contribution to care delivery settled down and became clearer. Against this backdrop the following three themes related to skill mix emerged at Livewell:

- ***Influences***. The first theme relates to the contingent nature of the skill mix consequences flowing from the NA role. In part, these consequences were sensitive

to service context. In the Liaison Psychiatry, for example, broader work re-organisation was well underway, as the team moved towards meeting national guidance on skill mix for the Core 24 service it was commissioned to provide. This had seen the introduction of the Band 3 mental health support worker, although the national guidance was somewhat unclear how the NA role fitted in[10]:

In district nursing teams, the introduction of the NA had if anything led enrichment of skill mix:

> We looked at the community nursing teams and reprofiled. We didn't remove any band 5s from the skill mix but we did remove some band 2s and 3s. (SM_3)

However, serving very different catchment areas, the skills mix implications of the NA for different district nursing team were sensitive to the demographics of local service need:

> When we looked at the whole community nursing team there was an increase in cost in some areas (associated with the introduction of the NA) but we did it based on our geography as well. So slight reduction (of cost) in some of our rural areas and an increase in investment in the very deprived borough in Plymouth, where would we see more complex people, acuity, higher end of life of care: we tried to look at where higher demand was not just numbers. So overall the budget hasn't increased: in some rural areas we have less (bands) 6s, more 4s. (SM_3)

In certain service areas the use of the NA role was also related ***to vacancy levels*** particularly for band 5 registered nurses in certain service areas. As a manager stressed:

> For me initially it (the introduction of the NA) was about skill mix. It was understanding that there were people out there who might want to come and work with us .We had to think creatively about how we recruited into our service because recruitment throughout the country was a challenge and we

[10] https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

> needed to think about how we do that: who else is out there that can provide the same level of support to the team that we need? (M_1)

As another manager noted:

> We've had so many difficulties in recruiting into our band 5 posts, so we have to look in a wider way and consider how many band 5s do we need to function correctly and how many Band 4s would we be are able to take-on…It's on the cards to review our skill mix and I would certainly be having that conversation with my seniors in terms of how the NA role is progressing. (M_3)

Indeed, in the context band 5 nurse shortages, the NA role was becoming seen as the main bridging role between the HCA and the senior registered nurse. As a senior manager noted, team leaders were increasingly 'calling for more Band 4s and band 6s', although such calls were not without dangers:

> If you talk to managers, they are thrilled to bits with the NA role and they want Band 4s and 6s: that will solve their problems, happy days. However, as time goes on and we have made adjustments to skill mix, we need to not lose sight of the band 5 in this because no one is going to pop out ready minted from a level 1 qualification be able to carry out band 6 work. (SM_1)

- **Cause and Effect.** The second skill mix theme centred on the relationship between skill mix and the substantive character of the NA role. Thus, the nature of the NA role was a cause but also an effect of skill mix patterns. Most obviously the presence of an NA had ***caused*** changes to skills mix as the emergence of the role prompted a re-distribution of tasks and responsibilities within a team, unit or services. Interestingly, at Livewell two examples worth highlighting saw an enrichment rather than a dilution of skill mix with the introduction of the NA, Thus, in an acute mental health ward, one of the qualified Livewell NAs was spending eight hours of their week working in an ECT clinic. With a traditional skill mix of two Band 6 and one Band 5 nurse, plus two Band 2 HCAs, at the time of our field work the NA working in the clinic was taking the place of a registered nurse who was on maternity leave. However:

> The plan is for the Band 2 member of staff to be replaced with a nursing associate. By having three nurses and one nursing associate the team's going to be a lot more flexible in terms of what we can accommodate in the

clinic. (M_2)

In another instance, the traditional 2:2 registered/non registered mix in an in-patient ward had been adjusted by the NA take-up one of the unregistered slots:

> Our 'safer staffing' (ratio) is two registered nurses and two health care assistants, but a lot of the time now we've got two nurses and (NA's name) and a healthcare assistant….I don't want to use the word, plug a gap, but it (the NA role) does, they're good, it's a good role to have within your skill mix. So that's what we're hoping for and I've got a few hours that are floating around within my budget that I can't really do anything with, but I can now because, once (NA's name) is done and qualified, she'll be my registered Band 4 and we'll be able to enhance our workforce. (M_3)

Indicative of the NA being an ***effect*** of existing patterns skills mix were instances of the new role having to mould itself around an already established distribution of tasks and responsibilities in a given team or unit. It is, for instance, noteworthy that Livewell had extended role of the HCA in district nursing quite considerably, developing policies which, subject to a risk assessment, allowed Band 3s to administer insulin in patients' homes and to undertake compression bandaging. In effect such an extension had negated the need for NA to perform such tasks, encouraging their use in the delivery of care in alternative, even more extended ways. Teams also varied in the make-up of the registered nurse workforce, with implications for the NAs' scope of practice. For example, an NA was in a health visiting team comprising band 6 but no band 5 registered nurses, generating a significant space between the HCA and the registered nurse professional for the NA to positioned herself in tasks and responsibilities.

- **The Dynamics of Skill Mix.** The final skill mix theme focuses on ongoing tweaks to skills mix at the workplace level also with implications for the nature of the NA role. Skill mix is often viewed in stable and static terms: the stated ratio between registered and unregistered staff. In practice skill mix is often a more 'moveable feast' subject to ongoing refinement as a response to continuous variations in say sickness levels, vacancies and the availability of bank or agency staff. At Livewell such refinements were revealed as affecting whether for any given shift qualified NAs were counted in the registered or unregistered numbers, influencing, in turn, the tasks and responsibilities undertaken by NAs. This was particularly found to be the case in

Livewell's acute mental health in-patient wards. As noted by an NA on one of these wards:

> This is something that we're still adjusting ourselves to as a Band 4 role. We're supposed to have 5 members of staff on shift, and sometimes that might be a bit top-heavy; so you might have three nurses, myself (an NA) and (name of another NA) as a Band 4 and a Band 2, and often because we're that in-between, yes, we may be registered, but we're the first to be put out on the floor.... So there are times when we are counted in the registered numbers, but there are also times when we are technically a nursing assistant in that role. (NA_1)

This mirrors a discussion with an NA in another in-patient ward:

> *Interviewer: So, are you counted as a registered member of staff?*
>
> NA: It varies, depending on the shift. It completely fluctuates. Some days there might be two nurses, an NA and then three or two nurses... so we've got to have 5 staff basically and 2 of them have to be registered.
>
> *Interviewer: And sometimes you're counted as one of the two registered staff members, is that what you're saying?*
>
> NA: Yes.
>
> *Interviewer: And sometimes you're not?*
>
> NA: Yeah. They try not to, they try and get it so that we've got... there's always two RMNs (registered mental health nurses) and one of us, but depending... the majority of the time there is two on and one of us and two nursing assistants. (NA_3)

In both wards, designation as a registered or unregistered member staff on any given shift had consequences for the NA's tasks and responsibilities undertaken:

> *Interviewer: Would your role be different, depending on whether you're counted as one of the RMNs or whether you're not in the registered nurse numbers.*
>
> Yeah, it does vary. So today, you (referring to another NA interviewee in the room) have taken more of a role on the floor (counted in the unregistered numbers) and I'm the nurse in charge, running the shift, more office based (in the registered numbers). (NA_1)

This point was articulated even more clearly by an NA for another of acute mental health in-patient ward:

> So if I come onto a shift that's very top-heavy in terms of registered members of staff, as the Band 4 member of staff you do get pushed out into the health care assistant numbers; I'm very 'boundaried' in that actually, if that's what I'm working as today then there's x, y and z that I'm not going to be doing on this shift, because it's too much; you end up doing two roles. (NA_2)

This 'see-sawing' between being counted in the unregistered or registered numbers was not an infrequent occurrence:

> I'm finding 50 per cent of my working time I'll be in the registered numbers and probably 50 per cent of the time in the unregistered numbers, in terms of safer staffing, that is. (NA_2)

The most tangible consequence of this switching of the activities undertaken emerged in relation to the NAs' responsibility as the named nurse for a given number of patients. The named nurse role by definition brought with it a continuous stream of responsibilities and tasks, retained whether or not the NA was counted in the registered or unregistered numbers. Interestingly in one of the in-patient wards, the NAs were acting as a named nurse for just one patient, and able to perform this role regardless of tweaks to skill mix and whether they were counted in the registered or unregistered numbers. In the other mental health ward, the NAs were acting as named nurse for up to four patients, a level responsibility perceived by the NAs themselves as incompatible with the time spent in the unregistered numbers. In this instance an NA had explicitly sought a reduction in the number of named patients within their remit:

> I'll have a look at my shifts that are coming up for the next month. I'll work out how much of that time's going to be spent in the registered nursing numbers, and then I'll say, I've got two (named patients) at the moment and I'd like to leave it at that. (NA_2)

4.3.4 Co-Workers and Other Outcomes

In general, our evaluation is predicated on a stakeholder approach which views the impact of the NA as mediated by the perspective of different actors affected by the role in workforce roles. Our fieldwork was able to generate rich data on the

consequences of the role for the NAs themselves, as reflected in the discussion in section 4.3.1. The responses to the role from the perspective of other actors were examined in a patchier way, and follow up research will hopefully address this gap (see below Section 5). Interviewees were, nonetheless, routinely asked how various stakeholders- co-workers and service users - viewed and engaged with the NA role. The other stakeholder reactions, therefore, remained 'second hand' but nonetheless represent worthwhile findings presented under the following headings:

- Resistance;
- Added value to the team colleagues; and
- Service quality.

- **Resistance**

Resistance to the NA role by internal stakeholders at Livewell- for example by HCAs, registered nurses and team managers- was notable by its absence. Unsurprisingly given the newness of the role, there were some initial 'irritations' and concerns amongst various stakeholders:

> We had the usual, you know, band 5's going, 'they're going to take our roles' the Band 3's going, 'I could do that'. (M_1)

However, these worries were largely passing ones. Widespread and sustained resistance to the NA role failed to emerge, the more typical response to the role being one of support and enthusiasm:

> We thought there'd be quite a lot of resistance; you can't do this or that. But they've (team members) been really keen: come with me, let's show you this, let's do that, and even sitting in learning style, we've got our medical students, we have rolling medical students and they all get together and discuss, so I think that's really good as well, the bigger picture, medical staff getting to know what everybody's doing, the TNAs and the NAs, so yeah, they're really receptive to it. (NA_2)

> My team has been amazing, you know, everyone's been really helpful, everyone's given me information about things, things to read, books, leaflets, lots of stuff like that, and my manager's like, if you need to take time out, let

> us know; if there's anywhere you want to go, let us know, placements, fine, they've been really helpful. So, I've not had any resistance from anyone within the team, yet. (NDA_3)
>
> We didn't have any challenge or resistance to (the role) or any what's this going to look like, these are going to be registered people coming in, how is this going to fit. They (team members) were really open and allowed us to also work with them of how our role would look. (NDA_2)
>
> The team consists of a number of mental health practitioners who've been around for a long, long time who potentially could have been quite resistive to a new and different role that might challenge who they are as practitioners, but I don't think have they been resistive. (NA_1)

Several factors help explain the absence of resistance, some already flagged-up. With most of the initial wave of NAs coming from the teams in which they had previously worked, the new role was wrapped up in and personified by someone the team members knew and saw as 'one of them'. It is striking that one of the few examples of 'push-back', occurred with a TNA who had come from another team and initially faced difficulty in finding support to acquire her requisite Band 4 competences:

> If I wanted to push and do my TNA competencies, because I was brand new staff, I had to start from health care assistant competencies and then work up, so I found a little bit of resistance that way. I'd come in to train as a Band 4 role and I wasn't getting that. If I was like (names of 2 other TNAs), who had already been in the team and already been a health care assistant in district nursing, it might have been a little bit different. (NA_6)

Senior management at Livewell also sought explicitly to counter the perceived threat of the NA role as the source of skill mix dilution:

> They (registered nurses) have been re-assured by us that there is no stealing of jobs going on. (SM_1)

Senior management also sought to dampen resistance by discussing the new role in workshops and placing in the new role the broader context of workforce re-

structuring and the opportunities it provided to develop the scope of practice for registered nurses:

> Initially there was some discussions with registered nurses, but I think it was also about us discussing what that meant for them. So it wasn't just around what the Band 4 role was, it was about what this means for you in a band 5 role: what it means in terms of you being be able to extend your band 5 role to cover the areas that you're qualified to do, because, rightly or wrongly, as the workforce is depleted you find yourself stepping into other roles that you don't... you're picking up some work that... so I think for registered nurses, they can see the worth and continue to see the worth of that role as well. (SM_3)

This attempt to familiarise staff with the NA is also apparent at team level. As a team manager noted:

> A lot of people don't like new things and change, so we've spent a lot of time bringing (NA's name) into the band 5 staff meetings and the band 2, 3 meeting to discuss what she's (the NA) actually going to be doing. Some people were still getting quite confused with the AP role and things like...but as she's been doing it for longer, people are getting more used to it now. (M_2)

In this instance, it is noteworthy that the presence of the AP had added some confusion to the situation. In other teams, familiarity with an established AP role had actually diffused resistance:

> The transition (to take-on an NA) was really easy because people were just sort of like, it's very similar to the AP role, but they can hold the meds (medication) keys and do meds and that's kind of... so that transition was pretty straightforward from our point of view because that Band 4 role was quite established on our ward. (M_3)

- **Added value to team colleagues**

Any challenge to the new role was further dampened by signs that NAs were adding value to the team. For example, in certain teams NAs were supporting and providing clinical supervision to HCAs:

> The band 3 I've been given is not very computer literate, so she struggles with a few things, so it's going through certain assessments that this band three can do, that she's not got the confidence to do and helping her with

> incident forms. So she finds the pressure also, I sat down with her for two hours the other morning, we went through it all, so what she needed to write and how to do the holistic assessments to put it into context and just supporting her in that way, that then frees the band 5s and 6s where previously they would have had to do it. (NDA_1_

Indeed, such HCA support from the NA had positive knock-on consequences for registered nurses in taking away responsibilities from them and allowing them to concentrate on other activities:

> She (the NA) also takes on non-clinical roles, like she can take the roster now for HCAs, so that's taken off an additional task from the RGNs, it's relieved us of from having to do that. (M_2)

One of the widely perceived benefits of the NA role has always been seen to be this capacity to free-up registered nurses, and at Livewell it was manifest not only in the NAs taking-on managerial and supervisory responsibilities for the HCAs but also in their handling of more routine cases and other clinical responsibilities. Most obviously NAs were freeing-up nurse to take on more complex cases:

> They're (NAs) able to free up then that band 5 time, so maybe go and spend half a morning with a complex end of life patient and the Band 4 can obviously go and visit a patient who maybe has a new wound, but complete the whole assessment, and deliver that quality care to free up than Band 5. (M_2)

Less commonly cited was the freeing-up of registered nurses to engage once again in some of the fundamental of frontline nursing care in terms of more direct, one-to-one contact patients. As an NA from an inpatient ward noted:

> They (registered nurses) get to spend a lot more time with patients now because we're balancing out tasks and stuff. So I've been in the office doing the work, paperwork today, and the other two nurses that are on have gone out and they've done the meds, they've spend the time with the patients, they've gone into meetings with patients. (NA_1)

This was echoed by another NA:

> So like today, I've done lunchtime meds, and the band 6 nurse was able to sit down and spend one-to-one time with the patients, listening to music, and it's like when would you normally get the time to do that, as a band 6 nurse. It's strange, isn't it? (NA_2)

- **Service Quality**

There were examples of the NA role contributing to an improvement in service quality, although at this stage these instances remained somewhat impressionistic and anecdotal. In part this improvement in care quality can be seen to derive from the broadly based nature of the TNA training, which allowed trainees and qualified NAs to bring back to their teams, experience of and knowledge from different care settings:

> They're coming back to their workplace, to their base and saying, actually, this is how it works on the ward…They're mentoring up when they come back to base and they're providing that systems approach; they're breaking down boundaries in a way, I think, probably beyond what we expected, and some of them have even seen patients go one placement and then they've picked it up in the dementia unit over here, and they've seen someone go round, and they go back to the community again and that's golden, that experience. (SM_3)

Indeed, in covering physical health in their training, NAs had often provided an added dimension to care assessment and planning in a mental health care context. As an NA noted:

> We've been able to teach the nursing staff, the registered nurses about physical health things. We're starting our 'well-man' clinics where we can assess male physical health as well and give some advice to (them). (NA_3)

As manager in Liaison Psychiatry indicated:

> I saw a nursing associate in the Emergency Department reel-off all the signs of sepsis much better than any general nurse could do in the room. She (the NA) was equally talking about sepsis and she was as talking about someone having an acute episode in mental health…. (M_5)

> …You have an established RMN workforce, confident in the field mental health so by bringing NAs who have that breadth knowledge and confidence in working with physical health problems as well. We're finding the NAs are educating their level 1 registered colleagues.in terms of physical health, and their confidence is helping building confidence in others too. (M_4)

5. Summary and Conclusion

Livewell is the first of a series of case studies in this evaluation of the introduction of the nursing associate (NA) role in NHS England. As the first, it represented a pilot, an opportunity not only to generate intrinsically worthwhile and interesting material about the organisation in question, but also to reflect more generally on the analytical and methodological approach being taken. In this summary and conclusion, the key points from the case are drawn out along the lines of our main themes - rationale, process and impact - followed by some next steps actions.

Rationale. As a social enterprise providing community and social care services to the population of Plymouth and its surrounding areas, Livewell took on the NA role with alacrity. As part of the Devon Partnership, it participated in the first two waves of TNAs launched in 2017, employing 30 TNAs, almost all of whom qualified and registered as NAs two years later. Livewell's enthusiasm for the NA role was striking given a history of developing its unregistered workforce. It had extended the role of band 3 HCAs and introduced the assistant practitioner role, albeit in a patchy way, but still saw a place for a new Band 4 registered nursing role sitting between the healthcare assistant and registered nurse.

Livewell's attraction to the NA mainly lay in the role's perceived value in developing a new career pathway, able to meet not only the personal career aspirations of its experienced and capable unregistered employees, but also to help the organisation grow-its-own registered workforce. Yet despite this elevated rationale, Livewell's first cohort of NAs, rapidly assembled in the short timeframe for the initial call, was narrowly focused on district nursing and seen as a workplace solution to the specific problem of shortages of band 5 community nurses. The second Livewell cohort was developed in a more open, bottom-up way, existing employees being able to put themselves forward for the TNA programme if sponsored by their line manager and with assurances of team support and a substantive NA role on completion of the training. This approach saw the diffusion of the role to a range of teams and service areas beyond district nursing, in particular in-patient wards, as well as by various miscellaneous teams such as in complex needs, health visiting and liaison psychiatry.

Nonetheless, underpinning the adoption of the role, particularly at the service and team level, was a degree of uncertainty and opportunism, perhaps inevitable given the novelty of the role and a lack of clarity, even at the national policy making level, as to the nature of the NA role. Rather than 'buying-in' to a precisely conceived job role, more typically line managers at Livewell were investing in the enthusiasm of known, often experienced and capable, members of their team with the perceived potential to add value to the service delivery. This close relationship between the NA role and the personalities of those performing it was to become crucial in how the role developed and came to be used and viewed by team members and others stakeholders.

Support. With strong support for the new role from Livewell Board, the TNA programme was taken forward on a partnership basis with other health and social care providers in Devon. Mirroring and connected to the Devon STP, this Partnership assumed a distinctive identity as a Community of Practice, designed to ensure that the NA became a system resource, and requiring, in turn, that the partners align key practices, for example, their job descriptions and uniforms. This alignment did not detract from organisational discretion in taking forward and supporting the new role. Thus Livewell, for example, appointed a Placement and Development Facilitator with a dedicated responsibility for the outward - and inward-facing management of the organisation's TNA cohorts.

Internally recruited on the basis of personal values and their alignment with the principles underpinning service delivery at Livewell, the 2017 TNA cohorts completed an intense two-year period of training. Reflecting an ongoing uncertainty about the training required by the NMC to secure NA registration, this intensity was particularly felt by TNAs in undertaking the formal College-based component of their programme. In contrast, the base and other placements were viewed very positively by the NAs, generally providing them with a rich learning experience in different health and social care settings.

Impact. With an extensive work history, many of the early wave TNAs also had considerable work experience within Livewell, often in different roles, before joining the programme. Typically, uncertain about the precise nature of the new role, attraction to the development opportunity was generally framed by the NAs

themselves in broad terms as ‘the chance to progress’. This progression was characterised in a variety of ways, a chance to: earn and learn; deepen knowledge and skill; and to advance materially. However, by the end of the training, most of the TNAs were keen to progress onto registered nurse training and indeed many had done so. Such a rapid progression risked weakening the establishment of a registered bridging role in the organisation and the capacity of qualified NAs to consolidate their skills, prompting Livewell to require future cohorts to stay in the role for at least a year after qualification.

As the early wave TNAs qualified they moved relatively seamlessly into their new role, although uncertainties remained about the precise nature of this role. The NAs’ status as established and trusted staff members facilitated team acceptance of the new role, but the specific contour of the role developed iteratively as postholders began to engage as registered employees in different aspects of care delivery and with workplace stakeholders.

At the same time, NAs were clearly developing a distinctive scope of practice, distinguishing them from HCAs and registered nurses. This scope of practice included a number of specific responsibilities, embraced by postholders on the basis of deeper and significant levels of knowledge and skills, for example: in district nursing undertaking first visits in less complex cases; in mental health wards acting as a ’named nurse’ and undertaking section 17 assessments (considering permissions to leave); in health visiting undertaking development checks on children; and in liaison psychiatry acting as a second assessor on complex cases.

The impact of this redistribution of tasks and responsibilities on skill mix was still working its way through at Livewell. However, if anything, NAs appeared to be enriching rather than diluting skill mix in replacing Band 2 and 3 HCAs rather than Band 5 nurses, although skill mix outcomes varied by service and even by team. Perhaps most striking were the more dynamic shifts in skill mix, which depending on the availability of registered and unregistered staff on any given shift could shape the role played by the NA. Thus, a ‘top heavy’ shift, especially in wards, could push the NA into the unregistered numbers and the performance of more traditional HCA rather than newly acquired tasks and responsibilities.

The NA role appeared to have met with very little resistance from other stakeholders at Livewell, an outcome again reflecting the fact that many postholders were well known and respected by the team. Indeed, in a number of contexts, the new role was positively viewed and welcomed by stakeholders. For HCAs in some teams, the NA role had developed a mentoring and supervisory capacity which provided them with additional support. For registered nurses, there were indications that the NA role was 'freeing them up' to spend more time on complex cases and advance their specialist clinical skills. Indeed, in communicating with nurses, senior management at Livewell had placed the NA role in the context of a broader re-structuring of the nursing workforce which provided opportunities for registered nurses to re-position and further develop as a profession.

By implication, the nature of the role NA at Livewell suggested positive care outcomes, for patients or other service users: receiving more timely medication and wound care; having their section 17 leave request assessed more speedily; being allocated a 'named nurse' with more time to devote to them than the overstretched nurse; having their home-based care monitored and reviewed more thoroughly and regularly. Yet, the impact of the NAs on measured care outcomes remained elusive and difficult to assess in standard way given the NAs' presence in a diverse range of care settings. At a more impressionistic level, there were, however, signs that the broadly based nature of the TNA training was bearing fruit as qualified NAs brought back to their teams their experience from different care settings and prompted the development of a more holistic form of care delivery.

Future Opportunities. There is scope to undertake further fieldwork at Livewell, building on the initial visit and findings. In methodological terms:

- Our engagement with certain stakeholders was limited, in particular ***patient and other service users***. Clearly the type of user is likely to vary quite considerably by service area, being more accessible in some cases than others. But exploring how service users and patients view the NA role remains central to our evaluation.

- We have mainly relied on focus groups and interviews as data sources, but remain keen to undertake ***observations*** as a means of deepening our

understanding of the NA role. Cleary such observation requires an analytical rationale, and comparing the NA role with the registered nurse role would allow us to more precisely gauge and contrast their respective scopes of practice. Given the presence of the NA in various Livewell care settings, there may be some value in selecting a number of specific settings - perhaps district nursing and in-patient mental health wards - as the basis for this observation.

- Given their elusiveness, we might explore with Livewell whether there are ***viable metrics*** by which we might assess the impact of the NA role on clinical or care outcomes. Again, the diversity of care setting suggests the need to focus on metrics in particular services or teams. For example, changes across time and or space in the number and complexity of patient cases dealt with by district nurses following the introduction might yield interesting results (assuming we can control other factors influencing case management).

- Given the evaluation remit, we have focused mainly on the first two cohorts of NAs at Livewell. However, with the organisation's recruitment of two further cohorts, and plans to continue recruiting to NAs, there might be value in exploring how the role is being taken up and consolidated across the organisation and with its partners in the STP or Integrated Care System.

In more substantive terms, there are several themes which we might follow-up and explore in greater depth:

- While the impact of the NA role on the ***skill mix*** balance between registered and unregistered staff has figured prominently in this report, there is scope to examine this issue in a more systematic way across and within services and, closely related, to explore the ***financial implicatio***ns of introducing the NA role into teams.

- Equally worthy focus for further research is the impact of ***ongoing tweaks in skill mix*** on the activities performed by NAs. Being counted in the registered or unregistered is clearly important in this respect, encouraging

an interest in the malleability of the NA role and the shifting experiences of those performing it.

- Another striking finding from our Livewell fieldwork was the near universal desire for NAs to ***move into nurse training***, in many cases straight after completion of the TNA programme. It is a pattern which raises questions about: the expectations of those coming forward to take up the NA role; how these expectations are being shaped (or not) by Livewell; and how the organisation selects individuals for the programme. With a new organisational requirement for NAs to stay at least one year in post following qualification, it will be interesting to examine whether this affects NA career aspirations and contributes to the role becoming even more fully embedded in the organisation.

- After ***internally recruiting*** to the TNA programme, Livewell is at the cusp of seeking external applicants. One of the main themes to emerge from the fieldwork was the close relationship between the development of the NA role and the known and trusted personalities performing it. Certainly, there were instances of an individual joining a team as an NA from another part of Livewell and quickly becoming valued and accommodated. However, the introduction, possibly at scale, of external recruits from beyond the team and the organisation raises new questions on the readiness of staff and their working systems to accept and assimilate the NA role going forward.

- Finally, our fieldwork took place just before the Coronavirus pandemic was establishing itself across the UK. The pandemic has been affecting every part of the NHS and social care, its impact on the work of NAs and their deployment during the pandemic period and any legacy will be of interest to employers and professionals. We hope to address questions arising from this period in further phases of this evaluation.

Annex: Distinctive NA Tasks and Responsibilities		
District Nursing	• Initial Assessment • Patient review/monitoring • Complete a wound care assessment • Case load a residential home • Out of hours skin/wound care	There's a lot more initial assessing now. So whereas as a Band 3 from our side, we could follow a care plan, we could make suggestions and we can bring things back, but now my role, I can go in and I can assess the whole wound and everything else that goes with the patient, and then I can make those decisions, provided I'm competent to do that, then I can go ahead and make the decisions that need to be made and then bring them back to the team, rather than have to wait. First visits, when you go in and first meet the patient…There's a lot more paperwork involved now, with gathering all the information that you can about a patient; we're not just looking at a wound any more, we're looking at the patient as a whole, so absolutely everything, yeah. There's a lot more involvement with their family sometimes as well We know the nurses are stretched, and sometimes in the community it was found that a patient had too many HCA visits, so by introducing the NA role you're not replacing the nurse, but someone with a bit more knowledge glancing over the patient that can take that back to the nurse. I think definitely helps, and then the nurse can then go out and do it next time. We would always expect a Band 5 to review that patient, or above, every two or three visits, but then obviously the nursing associate role can now come in and that and they can review the patient and monitor care. You can complete the wound care assessment, and you can take that and feed that back to the RN and just have an agreement that that is all correct. They (NAs) would be very capable of actually going to a residential home for the morning, taking the case load there, assessing all the patients there and taking them back, so that would be freeing up time, I guess, for Band 5, so then the Band can look at those very complex cases who it's not just about health, it's about social needs and things like that, On the out of hours because the nursing associates are able to go in and do the wound care themselves, rather than having a nurse. There's a duty team, they go out, normally a nurse and driver, nurse and HCA, but the HCAs are only Band 2s. So what they've done with the nursing associate coming in, they just send the nursing associate, if they went to a care home, for instance and had skin care overnight, they'd be able to go in for that patient, get that patient ready for the nurse to come in the next morning, rather than having if you've only got 2 or 3 nurses on at night.
Health visiting	• Developmental checks on children	We do developmental checks on children with the healthy child programme. We do a developmental check 9 to 12 months and then 2 to 2 and a half years.

		Health visitors do those as well, but we do them also.
Complex Needs Team	• Pre-referral assessment	Once I am an NA, I'll be able to do the pre-referrals myself instead of the CPN doing the pre-referrals, they'll be able to go out and complete the work they're meant to with other clients.
Acute mental health in-patient wards	• Drafting care plans • Clinical discharge summaries • Most medication • Second checker: controlled drugs • ECT team member • Section 17 leave assessment • Patients' named nurse • Sub-cut, inhaler, rectal & IM injections • Putting patients on obs • Participating in MDTs	We had MDT yesterday and she's (the NA) involved in discharges, working clinical discharge summaries, she's been doing medications, injections; at first she was doing all the care plans, risk assessments and stuff, there's a lot my support and she's been doing them more autonomously now .., and then feeding back to me, but as a health care assistant she wouldn't have been doing any of that, so she's doing a lot more. They can be the second checker… there's a competency to fulfil anyway in the CD policy, but then they are, as a nursing associate, can give all the medication, IMs, subcut, rectal and inhalers. So if you're worried that they (patients) needed a higher level of observation, say they've been seen one an hour, we can say I think we need to keep an eye on them every 15 minutes. So we can put them on, but say if we felt that they need to be reduced we'd go to the registered nurse and if the registered nurse goes okay, let's go down we'll jointly asses them, see if the patient is well enough to come off the observation.
Liaison Psychiatry	• Second assessor (including complexity) • Sole assessor (non-complex case) • Writing up assessment	If the risks are not monumental or don't appear to be monumental, they (the NA) will go along quite happily and be the second person (assessor). Sometimes we might only have 2 Band 6s, one could be covering the hospital, one could be covering ED now, which is brilliant; it's really, really good use. Out in the hospital because obviously the patients are not imminently leaving, they are in-patients, she (the NA) will go off and do basic assessments on her own; it's still a full assessment process. I have to be honest, it's quite often the elderly patients, perhaps the dementia type things that can be a longer piece of work, so we will just be advising the ward, but she's very autonomous. She'll go off and do that piece of work. If there's anything she's not sure about she'll bring it back to an MDT every day to discuss anything, or she'll just bring it back to the practice lead. I (as an NA) don't do full assessments on my own. I will do it as a second practitioner and we'll discuss at the end and then I might write up the assessment and they don't really check it or anything, unless they want to, or unless it's something particularly complex, yeah, or that I don't feel comfortable with just sending off. One of the things that the Band 3 mental health support worker, if there are less complex assessments, they may go and support the Band 6, perhaps take some notes or participate in an assessment, whereas I think for me the NAs' skills would come in because the NA is

		accountable, if there was a complexity, and I think people would feel very happy going with the NA.
Neuro Rehab	Managing HCAs	Her (the NA's) role is support for the HCA, but she does take on physical tasks as well, like bowel care for our spinal patients, which is quite specific, and they do the catheter as well, they can insert them, but she also takes on non-clinical roles, like she can take the roster now for HCAs, so that's taken off an additional task from the RGNs, it's relieved us of having to do that as well. And I think the HCAs appreciate that because they've got somebody, a sort of peer.

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