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Evaluating the introduction of the Nursing Associate role in social care

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Deborah Sturdy OBE, Chief Nurse for Adult Social Care in England

I am so pleased to introduce this useful report which lays bare the huge challenges for the sector in getting the new role of Nursing Associate off the ground in adult social care. I am sure the Coronavirus pandemic has had a significant impact on the ability to make this happen. The researchers have set out the other challenges on multiple fronts including funding, access to higher education institutions (HEIs) and supervision.



The report exposes the multiplicity and diversity of employers and the huge efforts needed, both to set up and support new roles such as Nursing Associates in this context. It makes clear the financial disincentives that are particular to adult social care compared to the NHS, for example, the need to meet backfill costs which affects the appetite to invest.

For me it was so encouraging to read that where Nursing Associates have been successfully supported, it has had a positive impact on care and quality, though the numbers are small.

Reading the report raises many questions for me about future uptake of this role and the need to make the process so much easier for employers. They need to engage with HEIs, demonstrate cost benefit and make skill mix changes, all of which need to run alongside excellent support and proper delegation and impact.

Learning from the sites where this has worked well will be crucial to developing this role. It may be possible for some sort of consortium approach under the Integrated Care System (ICS) umbrella to support this role in adult social care as well as the NHS, so that we maximise its contribution to the multiplicity of career opportunities social care has to offer. And at local ICS level, there would seem room to consider a commissioning element in supporting both training and the additional pay requirements.

I commend this insightful report to readers with an interest in adult social care workforce developments, which are so vital to social wellbeing and to those committed to making the most of nurses' competence, care and compassion.

A handwritten signature in black ink that reads "D Sturdy". The signature is stylized and written in a cursive-like font.

Deborah Sturdy

April 2022

Abbreviations

ADASS	Association of Directors of Adult Social Services
ARRS	Additional Role Reimbursement Scheme
AfC	Agenda for Change
AP	Assistant Practitioner
CHAP	Care Home Assistant Practitioner
CCG	Clinical Commissioning Group
CPEP	Clinical Placements Expansion Programme
CPD	Continuing Professional Development
CQC	Care Quality Commission
DCC	Devon County Council
HCPC	Health and Care Professionals Council
HEE	Health Education England
HEI	Higher Education Institute
ICS	Integrated Care System
KCC	Kent County Council
NELFT	North-East London Foundation Trust
NMC	Nursing and Midwifery Council
NA	Nursing Associate
PCN	Primary Care Network
RN	Registered Nurse
RNDA	Registered Nurse Degree Apprenticeship
SfC	Skills for Care
STP	Sustainability and Transformation Partnership
TNA	Trainee Nursing Associate
WCK	West Kent Consortium

1. INTRODUCTION

Since early 2019 researchers at the NIHR Health and Social Care Workforce Research Unit (HSCWRU) at King's College London have been evaluating the development of the Nursing Associate (NA) role. The NA is a registered role, graded at Pay Band 4 in the National Health Service (NHS)¹ and positioned between the healthcare assistant and the Registered Nurse. It is a new role, adopted by health and social care employers since 2017 when the first 2,000 Trainee Nursing Associates (TNA) were taken on, completing their Level 5 qualification two years later. TNA cohorts have been recruited by employers in each of the subsequent years with, at the time of writing (Feb. 2022), around 4,000 registered NAs in post and 6,000 TNAs in training. Our evaluation to date has included consideration of the NA role in social care, and sought to involve stakeholders from the sector, such as Skills for Care² and Care England,³ in its programmes of interviews. However, the take-up of the role in social care has been patchy. In examining the first three waves of 7,000 Trainee Nursing Associates (TNAs) (2017-2019), the research-based consultancy Traverse⁴ found 140 trainees, that is 2% of the total, from the social care sector, employed by just 50 social care providers.⁵

With the limited take-up of NA role in social care our general evaluation of NA deployment has mainly focused on developments in the NHS. This has left important questions unanswered:

- Why has the adoption of the role remained relatively limited in social care?
- Why have some social care providers been able to run with the role but not others?
- Are there lessons to be drawn, in terms of policy and practice, on whether and how the role might be encouraged and supported in the sector?

In Summer 2021, the Department of Health and Social Care commissioned us to undertake a scoping study of the NA role in social care, designed to address these questions. We set out the methodology adopted in conducting the evaluation and then present the findings in the following parts:

- Take-up
- Rationale
- Positioning
- Challenges

¹ Social Care providers are not covered by the NHS pay agreement (Agenda for Change) and have discretion on staff pay rates.

² [Home - Skills for Care](#)

³ The representative organisation for small, medium large care providers in England see:

[Care England | A representative body for independent care services](#)

⁴ [Home - Traverse](#)

⁵ [Business Options Testing \(hee.nhs.uk\)](#)

2. APPROACH

This evaluation took the form of an exploratory study seeking to draw out key themes and issues related to the NA role in social care, with a view to then assessing the value of a more in-depth piece of work. The fieldwork was conducted between September and December 2021, and principally comprised interviews with stakeholders from across and at different levels of the social care sector. The study interfaced and in part overlapped with a series of Health Education England (HEE) pilot projects on the development of the NA role in social care. Commencing at the beginning of 2020 there were 9 HEE pilots centred on 4 regions (the Midlands, North-East/Yorkshire, East of England, and North-West). Their aim was to recruit a total of 300 new social care TNA starts. The individual pilots took different forms centring on a single Integrated Care System (ICS) catchment area in the North-West and East of England, covering two ICS areas in the North-East and spread across five localities in the Midlands.

The HEE pilot projects were winding-up as we undertook this scoping study. Seeking to connect to the pilots and their activities, we attended two of the HEE project's online monthly review meetings, including the last one held on 9 December 2021. Subsequently and as part of the interview programme for our study, we spoke to the respective HEE T/NA leads in the pilot regions, drilling down into the developments and experiences of taking forward the social care pilots. However, our study was broader than the pilots. We were interested in how the role had progressed in social care prior to the start of these pilots and sought to cover all parts of the country including the three regions outside the pilots: London, the South-East and South-West.

Table 1 below sets out the full programme of 34 interviews completed for our scoping study, broken down by region (columns 1-2) and then by type of stakeholder interviewed (columns 3-4). It can be seen that interviews were conducted with actors across all seven HEE regions, with a concentration in the South-West and London, where we had already developed connections with social care practitioners in the context of our broader NA project. The stakeholder profile of interviewees highlights a preponderance of HEE respondents, reflecting an interest in the pilots, but also the value of talking to T/NA HEE regional leads in providing an overview of developments in social care across the respective areas. The 18 HEE interviewees included regional as well as local HEE funded posts: for example, we interviewed three HEE funded Out of Hospital T/NA leads embedded in three different London Integrated Care Systems (ICS).

Table 1: Interviewees by Region and Stakeholder			
Region		Stakeholder	
EoE	4	HEE	16
Midlands	5	Support Organisation	10
NE/Yorkshire	2	T/NAs	4 (3 TNAs/1 NA)
NW	2	Care Homes	4
London	9		
SW	9		
SE	3		
Total	34		34

Other, non-HEE actors were included in the interview programme. The interviewees classified under ‘support organisations’ in Table 1 came from a range of bodies variously engaged in facilitating the introduction of T/NAs and supporting the broader development of the social care workforce: thus, four Skills for Care locality managers were interviewed, three managers from care associations - networks of social care providers in different parts of the country - and two officials from local authority adult social care departments, as well as a representative from a Higher Educational Institute (HEI) delivering TNA programmes. Three of the four T/NA interviewees were still in training and came from a programme in the South-West. The fourth was a qualified NA from a care home in the Midlands. The four care home interviewees were responsible for care homes with nursing: two drawn from large private sector organisations with chains of homes across the country – the Maria Mallaband Care Group and Exemplar Health Care - and the other two working in smaller, private, care homes. Managers from care homes without nursing and home care providers were not covered. This represents a gap in the interview programme, although indicative of the low take-up of the role in these parts of the sector. A full list of the interviewees by job title is provided in an annex.

Most interviews were recorded and transcribed. Reflecting the exploratory nature of the study, the interviews were open discussions, based on a small number of broadly framed questions centred on our main themes: take-up of the NA role, reasons for engagement with it, approaches adopted to introducing the role, and challenges faced. In the following sections we present the findings structured around these themes. Where quotes are included in the text, they are referenced according to the stakeholder categories used in Table 1 above - HEE, Support Organisation (SO), T/NAs and Care Home (CH). For example, interviewee 1 from the HEE is referenced HEE_1, interviewee 2 is HEE_2; Support Organisation interviewees are coded SO_1, SO_2 and so on.

Finally, it is worth noting that a draft of this report was sent for comment to a member of the Unit's Patient and Public Involvement and Engagement (PPIE) Advisory Group. In doing so we were keen to acquire a service user perspective on the findings and ensure that the report was readable and accessible to a lay audience. Various useful comments were received, and changes made, with these aims in mind. However, in general the PPIE member noted:

As a lay person it seems to me that this scoping study has very much served its important purpose and highlighted the many and varied opportunities and challenges in developing the NA role.

3. TAKE-UP

3.1 Overview

In general, we found considerable interest in the NA role amongst both social care employees and providers. An interviewee from a care association noted that prior to Covid taking hold, she was advising around 100 social care workers in her region keen on joining the TNA programme (SO_7). Amongst social care employers, interest was reflected in the significant numbers joining typically online /webinar events on the role, organised at national and regional levels by Skills for Care, HEE and other partner organisations, such as care associations. The prospect of such a role seemed to have an intuitive appeal to social care providers:

The (social care) service seems to see how it (the NA role) would add value. It is different to health. In health you have to explain how it would help. With social care there seems to be an understanding that it is important to the career development of their staff. It is important to have more qualified staff to support the people you care for (HEE_2)

Such enthusiasm had, however, so far failed to translate into significant numbers of T/NAs in the sector. Certainly, tying down the precise number of **qualified** NAs in social care is difficult. In correspondence with Skills for Care,⁶ it was suggested that there were currently only around 450 'NA jobs' in social care. The basis for this calculation remains unclear, but, if referring to qualified NAs in the sector, it may be an overstatement.⁷ As noted, Traverse provided a figure of 140 for the initial three TNAs waves (2017-18). On a two-year training programme, these early wave TNAs are the ones likely to have now qualified. TNAs starting in 2019 would also have completed the programme. However, on the assumption that all 140 early wave TNAs completed the programme and are now still in an NA role, the suggested 450 NA figure implies a spike to over 300 TNA starts in 2019. Even with such a spike, the figure of 450 'NA jobs' remains low, and can be placed in context by noting that there are around 17,700 care organisations in adult social care across 39,000 care-providing locations, with a workforce of around 1.67 million.⁸

Data on the number of **Trainee** NAs (2020 and 2021 starts) currently on programme is more readily available. HEE regularly collects returns from its regions on TNA starts. Moreover, in providing a per

⁶ Email correspondence 9.12.21

⁷ It may be that the notion of 'NA jobs' is a combined figure of qualified NA **and** TNAs presently in post.

⁸ The State of the Adult Social Care Sector and Workforce 2021 (skillsforcare.org.uk)

capita £8,000 financial subsidy to employers for each TNA (£4,000 a year for two years⁹), HEE should be able to track payments and therefore numbers of TNAs in social care (and beyond). We did not have full access to these HEE data but were able to construct a picture of TNA starts over the last couple of years, particularly in the HEE pilot sites. This suggests a continued low and uneven take-up of the role amongst social care providers.

As Table 2 below indicates the four HEE regions with their 9 pilots generated 132 TNA starts. Facing major challenges over this period, not least those associated with the Covid pandemic, this figure is, unsurprisingly, well below the target of 300 starts. Indeed, with some of the pilots, the number of starts achieved covers two calendar years: 2020 and 2021. With the HEE pilots mapping on to ICSs, the average number of TNA pilot starts comes in at just 15 per ICS. Assuming this average is achieved in all 42 ICSs in England, this produces a total of 630 TNAs currently on programme in social care. Given the uneven pattern of starts in the pilots a median figure might be more appropriate in projecting total starts. With the median number of TNA starts in the pilots standing at 8, this suggests a total of 336 TNAs starts in social care across the 42 ICSs.

Region	Pilot Site	TNA Recruits
North-West	Greater Manchester	23
North-East & Yorkshire	Humber Coast and Vale	7
	North-East & North Cumbria	50
East of England	Norfolk & Waveney	8
Midlands	Herefordshire & Worcestershire	0
	East Midlands Lincolnshire Care Association	21
	Northamptonshire	10
	West Midlands Care Association	5
	Staffordshire Sustainability & Transformation Partnership (STP) ¹⁰	8
		132/300

⁹ Given the need to boost nursing capacity, a HEE higher subsidy of £7,900 for each on the two years of training (total £15,800) is available to employers for TNAs who spend 50% of their time working within learning disability services

¹⁰ STPs bring together health and social care providers along with commissioners and local authorities with a view to developing more integrated forms of service provision. Most recently they have developed or are developing into Integrated Care Systems

In the interviews, we were able to generate further information on TNA starts in social care, especially in the regions not covered by the HEE pilots (London, the South-East and South-East). Covering a further 18 ICSs, this information (presented in red in Figure 3 below) suggests an additional 79 TNA starts in 2020-21. In combination with the HEE pilot data this produces a total figure of 211 TNA starts for 2020-21 in 27 ICSs (with an average figure of 8 TNAs per ICS).

Table 3: Additional Data on TNA Starts		
Region	Site	TNA Recruits
North West (3 ICS)	Greater Manchester	23
North East & Yorkshire (4 ICS)	Humber Coast and Vale	7
	North East & North Cumbria	50
	West Yorkshire (2021)	11
	South Yorkshire (2021)	2
East of England (6 ICS)	Norfolk & Waveney	8
Midlands (11 ICS)	Herefordshire & Worcestershire	0
	East Midlands/Lincolnshire Care Association	21
	Northamptonshire	10
	West Midlands Care Association	5
	Staffordshire STP	8
London (5 ICS)	South-East: 2021 (Greenwich)	4
	South-West: 2021	6
	North-East: 2020-21	6
South West (7 ICS)	2021	14
South East (6 ICS)	2020: 17	17
	2021: 19	19
		211

3.2 Patterns

These headline figures on 'NA jobs' and starts, provide little insight into more refined patterns of T/NA distribution across the social care sector. The HEE pilots did reveal some noteworthy variation in TNA starts by ICS, with relatively high numbers in North-East and North Cumbria and in Greater Manchester and East Midland/Lincolnshire but much smaller numbers elsewhere. It suggests differences in approach by the pilots, considered in more detailed in Section 4 below. Questions remain, however, as to whether take-up is sensitive to a range of other contextual factors including:

- **Care setting:** for example, care homes with nursing, care homes without nursing, and home care.
- **Organisational form:** ranging from large national care home chains or services to the small, private, locality-based provider.
- **Service user group:** including, for instance, older people, those with learning disabilities, mental health problems and experience of substance abuse.

Interest in the T/NA role was apparent amongst providers in different *care settings*. An interviewee noted enthusiasm for the role in care homes with nursing:

Nursing homes see it as a cost-effective way of getting some of the nursing services done. They don't need to have a nurse they can use somebody regulated but at a lower level. That is what the NA is about doing the basic functions that frees the nurse up to do complicated work. (HEE_11)

While proceeding to note:

Non-nursing homes are also interested. Hearts and minds stuff, no shortage of hearts and minds they would love to grow staff with potential. (HEE_11)

The appeal of the NA role in different settings is echoed by other interviewees:

You don't have the Registered Nurses, but the skills attached to the NA role are so relevant to what is happening in residential care homes. I have talked to Skills for Care and the workforce lead in the ICS to see if it could work in residential homes, to find a way forward. (SO_3)

If I could train people (TNAs) in domiciliary and residential care, it would be wonderful. Every single domiciliary and every residential home would absolutely adore to have an NA, but it is really hard to train them. (SO_7)

The interest from domiciliary care and non-nursing provision is higher than from nursing homes. For care at home, it could be a real role development to help with hospital discharge. (SO_2)

Yet despite this broadly based enthusiasm, our study pointed to the adoption of the T/NA role as being confined mainly to care homes with nursing. This is essentially a function of the NMC regulatory provisions underpinning the development and use of the role which require the presence of a Registered Nurse to supervise and, during training, to assess the T/NA. This concentration of the role in nursing homes should not detract from innovative steps (discussed below) being taken to establish supervisory and assessment arrangements in residential care home and domiciliary care/home care services, but these providers face distinctive challenges to the introduction of the role.

The influence of the **organisational form** on engagement with the role was less easy to tie down, with suggestions that provider size and structure can both facilitate and hinder adoption of the T/NA role. Larger social care providers, with a chain of homes and a regional or national footprint, are more likely to have the training infrastructure to develop the T/NA role, and we uncovered high-profile examples of such employers taking-up the role:

- With around 10,000 employees providing 154 services nationwide, Cygnet Health Care,¹¹ for example, went early and at considerable scale with the T/NA role. In April and November 2018 cohorts of respectively 21 and 23 employees started on the TNA programme.¹² Cygnet was not part of this study, and consequently details of the programme (linked to the University of Wolverhampton) and the distribution of the TNAs by location and setting are not available.
- At a similar scale to Cygnet, Maria Mallaband Care Group¹³ has maintained a steady pipeline of TNA cohorts over the years across its 80 homes: 2019: 11; 2020: 12; and 2021:21.
- On a slightly smaller but still noteworthy scale, Exemplar Health Care,¹⁴ providing specialist nursing care and rehabilitation, had 7 NAs qualify in October 2021. A further 22 are currently in training (12 qualifying this year), with an additional 3 starting their training in April 2022. These T/NAs are distributed across 19 of Exemplar's 35 homes, located mainly in the north of England.

Larger providers with both nursing and residential homes are well positioned to address certain regulatory requirement associated with the role. Thus, an example was presented of a Registered Nurse in a nursing home acting as a supervisor/assessor for T/NAs in a residential home run by the same company. There were also instances of staff being transferred from a residential to a nursing home within the same provider, to allow access to the necessary supervisory support from a registered professional:

So, where we have staff in a residential only service, we are now liaising with those to move them into the nursing home service if they want to do this course because they have to be facilitated by a nurse. (CH_1)

However, the alacrity with which large providers have embraced the role should not be overstated, with suggestions of patchy take-up amongst them. As noted by the HEE lead in one region:

¹¹ [About Cygnet Health Care - Cygnet Health Care](#)

¹² [2nd Cohort of staff begin Cygnet's Nursing Associate Apprenticeship - Cygnet Health Care](#)

¹³ [Residential, Nursing & Dementia Care Homes UK | Maria Mallaband \(mmcgcarehomes.co.uk\)](#)

¹⁴ [Welcome to Exemplar Health Care | Exemplar Health Care \(exemplarhc.com\)](#)

That has been the bit that is a little surprising: those large national employers that have got regional presence; we thought they would come forward much more strongly (to adopt the role). You can kind of understand it with 'one-man band' guys who say we just don't have the resources to support this or we can support one student every two years, but those large players who have got the resources and a national set-up to support them, an education department and apprenticeship manager, we're not being knocked over by them banging on our door and saying we want to be involved in this. (HEE_8)

There are various possible reasons for the uneven adoption of the role by larger social care providers. It was suggested that such providers might be waiting for the role to be developed in the NHS, so avoiding the high training costs and then recruiting qualified NAs:

There is a strategy (in social care) that says let the NHS train them and when they qualify, we can pay over odds and have these people. A bit of sitting back and see how it pans out. (HEE_8)

It was also argued that these larger social care providers are often principally driven by transactional considerations, with the short-term business case for running with the NA role difficult to establish (discussed further below). Indeed, as the business case argument for the role is considered at senior managerial levels, it is all too easy for the issue to get lost or bogged down in opaque procedures and readily vetoed by a key manager:

In the bigger care home organisations, like the national ones, the managers in the local areas may be up for supporting it (the NA role). However, when it goes up to the chief nurse or directors, it becomes 'another role we have to consider'; 'we already do this training programme'. (HEE_6)

If the nurse director is a bit resistant to it, we have found buy-in is difficult, so you need that initial interest in the role, for people to say this sounds interesting rather than this is just another thing to do. (HEE_10)

Certainly 'champions' for the NA role were needed to both initiate and then drive through the NA programme in larger organisations with their often diffuse decision-making processes. As an interviewee noted:

You need key players in organisation to be on board with it; once they are on board with it your flying. (HEE_11)

An interviewee from a care home chain was even more specific:

The (NA) role was taken forward by Learning and Organisational Development Manager. When she was working in the NHS, she started off the project herself in 2017 and rolled it out with us in 2019. (CH_1)

The capacity of smaller social care providers to engage with the T/NA role can in many respects be seen as the opposite of what is apparent amongst the larger ones. Most obviously smaller providers are less likely to have the supportive training infrastructure:

You introduce something into the NHS and there is a raft of managers who are going to pick that up and run with it. In social care 75% of providers are small businesses, they have a registered manager and that's it. So doing care, payroll, recruitment and marketing and they look at this and say 'wow, this is really confusing and, you know what, I don't have the time to think about it'. (SO_2).

When you're having registered managers with so many hats on already, a new role is really difficult. (HEE_2)

At the same time, small more compact and independent care providers are often able to act more immediately and directly to initiate a TNA programme. The scale of engagement of such smaller providers is inevitably modest. One of the homes covered in our study, a medium sized nursing home in London supporting 64 people of various ages with a range of mental health conditions, had two qualified NAs, and a further TNA working through the programme. A smaller nursing home in the South-West with 25 older residents had two TNAs half-way through their programme. In homes of this size, constraints on training capacity come through in limited numbers of TNAs taken on at any one time. As a manager in this smaller home noted:

For us and the size of our home and the set up with our nurses, we wouldn't want more than a few TNAs at any one time. Because we are only small to medium, I am quite relieved not starting any more this year (CH_4).

Despite the limited scale of their involvement, smaller providers can not only be more agile than larger organisations, able to make quicker decisions on the NA role, but can also be closer and more sensitive to the career needs of their staff and keen to provide them with development opportunities.

There is no obvious relationship between take-up of the NA role and *service user or client group*: as implied, the role was being adopted by social care providers delivering services for a variety of such groups. This is well illustrated in Table 4 below, setting out the range of different providers - nine across the 2020 and 2021 cohorts - currently involved in the Greater Manchester TNA programme. These providers are only taking on a couple of TNAs, but the role is working with diverse user groups, varying by age, condition and need: including younger and older individuals, those with complex needs, dementia and learning disabilities and being provided with care in supported living accommodation.

Table 4: Provider Engagement with the TNA Role in Greater Manchester

Sept 2020: First cohort of 13 (with 1 deferred until April 2021)

- **Turning Point** (2 TNA/1 on break)- drug and alcohol rehab- short and long stay
- **EAM Care Group** (3/ 1 on break) -young adults with learning disabilities and complex needs
- **Equilibrium Healthcare** - (3 TNAs/1 left) – residential mental health
- **Exemplar Healthcare**- (2 TNA/1 on break) different sites / mental health specialise in brain injury/residential young adults up to elderly
- **Future Directions** (1)- LD residential/supporting people with independent living
- **Belong Care Villages** (1)- residential dementia/Independent living.

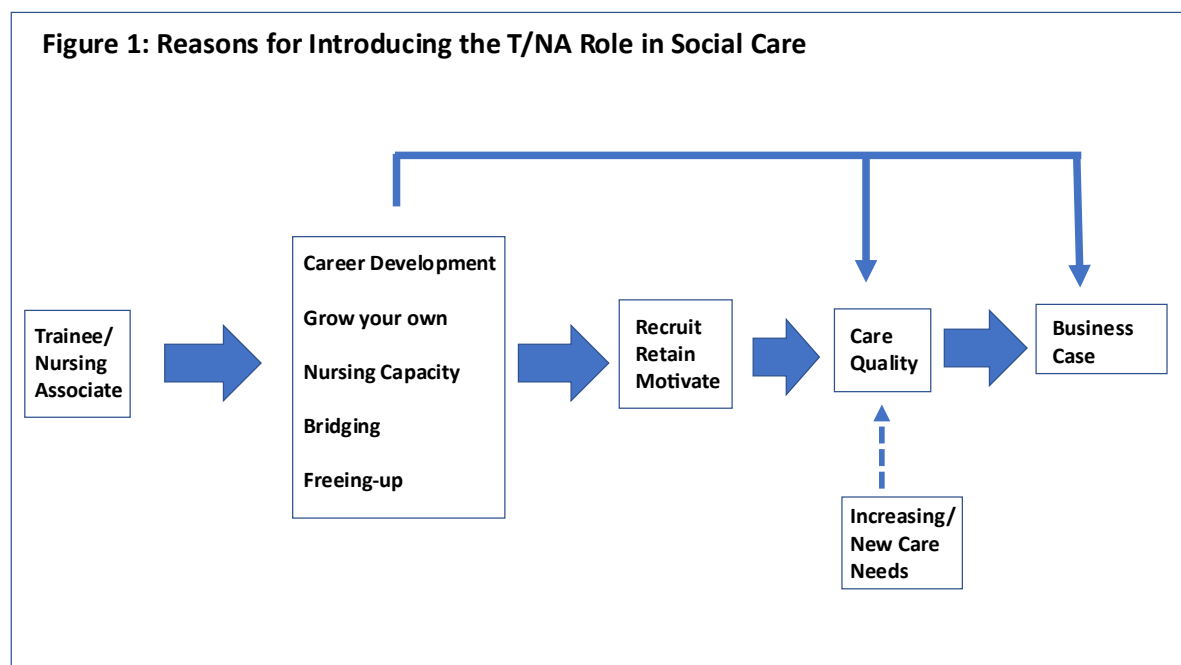
Sept 2021: 9

- **EAM Care Group** (2)
- **Exemplar Healthcare**(2)
- **The Fed Heathlands Village** (1)- residential /nursing/non nursing/ discharge to assess contract with NHS
- **Chataway Nursing Home** (1)- mental health residential
- **Bloomcare** (2) dementia residential/different sites.

4. RATIONALE

Widespread interest in the NA role amongst social care providers, despite its limited and uneven take-up, encourages consideration of the substantive reasons for this interest and an exploration of how these reasons are presented to and assimilated by different actors. The NA role often needs to be 'sold' to providers, raising question about who does this and how. Such questions in part relate to how providers and indeed employees initially become aware and engage with the T/NA role, considered in greater detail in later sections. This section focuses on the substantive reasons presented by interviewees for social care providers' take-up of the role.

In general terms, these reasons, set out below in Figure 1, resonate with those identified in our broader project work on the NA role in the NHS and consistently articulated by national and regional policy makers. However, the specific context and workforce management issues facing the social care sector inform and frame these reasons in a distinctive way. Figure 1 seeks to convey the overlapping and interconnected nature of the different reasons given for the introduction of the T/NA role in social care. Three main narratives emerged, related to: the labour market, care quality and the business case. Each is considered in turn.



4.1 The Labour Market Narrative

In providing development opportunities to prospective and existing staff, the NA role is viewed as a means of addressing the relatively high turnover of staff in the social care sector, and the

immense difficulties faced in recruiting registered and unregistered care staff. The NA role helps deal with these labour market pressures in various ways:

- First, the role represents a **career development opportunity**, especially for long serving and often highly capable care assistants. Whilst not detracting from the variety of career opportunities available in the social care sector, the current unregistered workforce structure remains relatively flat, in the care home context principally revolving around two broadly drawn roles: the care assistant and the team leader or senior care assistant, with the latter simply having greater managerial and supervisory responsibility. As a registered role sitting between the care assistant and the Registered Nurse, the NA is a new profession with an extended scope of practice. By offering a new career rung, such a role is viewed as encouraging existing employees to stay with their current employer, while enticing new employees into entry level posts, with the promise of career progression. This sub-narrative was reflected in a range of interviewee comments:

We see it as an opportunity for you to promote your senior staff, and how many of your senior staff have you lost in the last two years who wanted to develop further. We sell it on 'develop your staff, don't lose your staff'. (CH_3)

People's eyes light up when we talk about careers, the potential to recognise people by giving them a step up in some way; we can offer this as part of our career development. (SO_2)

It is partly about keeping people, really good carers who are looking to move on and do more things. (SO_7)

We want to keep people in their home. If this is their home, we need the right skilled people to keep them at home, and having a diverse workforce of carers, NAs and RNs, is a model to look at, particularly if you might have vacancies but also because you might have staff continually leaving to go to health because there is no career development option. (HEE_2)

We say to employers the NA is a development opportunity so this might enable you to keep your good workers, who are competent and want to be stretched a bit more. (HEE_12)

There is an opportunity to develop and keep your workers, because you're stretching them, giving them additional responsibilities, and giving them opportunities to continue their career by becoming fully qualified SO_4)

Career progression has not necessarily been high on the agenda (of social care employers). They have viewed the workforce in a quite passive way: employees come and go and if they go, they go somewhere else for more pay, and that's just the way it is. But with the social care NA pilots, needing to retain staff and develop

staff and have some career progression opportunities have become a bit of a revelation to them. (HEE_8)

- Second, the NA role is seen as a stepping-stone into pre-registration nurse training: a means by which social care providers can **grow their own nurses**. In short, the NA role is an essential part of a new and meaningful career pathway into the Registered Nurse role:

(Social care providers) have a more transient workforce than the NHS. So there is 'what is the progression in social care providers?' and having the NA role does provide that, so you can have somebody who comes in as HCA then NA and then RN (HEE_13).

The wonderful thing about the NA is you are training the nurses of the future. (HEE_12)

We had been struggling for a long time trying to find ways for care assistants to go onto a nursing route. We find what comes up time and time again is people telling us I really want to be a nurse, but they are struggling to find a route into it, and they will have worked in care for a long time but can't find a way of getting in. (CH_1)

This use of the NA role 'to grow your own nurse' suggests tentative steps by social care providers to workforce plan. Clearly such an approach is designed to address pressing nurse shortages, but an example was also found of a care homeowner adopting such an approach to deal with future staff retirements:

One home recognised their elderly workforce was retiring so there was a need for some individuals to be nurtured and trained. Their NA cohort is about supporting workforce plans for retirement. It is a children's hospice. So, part of the longer-term plan is to refresh the nurse workforce. (HEE_3)

Social care employers use of the NA role as a stepping-stone into pre-Registered Nurse training is reciprocated, indeed has partly been prompted, by an enthusiasm amongst existing staff for such an opportunity. As a T/NA interviewee noted:

I have always wanted to be a nurse, but life got in the way. (T/NA_1)

- Third, the introduction of a new registered **bridging role** allows Registered Nurses to delegate with greater confidence **freeing them** from routine responsibilities and allowing them to work at the top of their scope of practice. This rationale becomes part of the labour market narrative as the role is seen to improve the quality of nurses' work lives in social care, encouraging them to stay with their employer:

We all know it is getting harder to get nurses, to keep nurses; and with the NA programme we can help them (nurses), stabilise their position and give them the

confidence to know there is someone else there to assist them with their clinical duties so they can prioritise with others. (CH_3)

They (NAs) are registered with NMC and have a deeper understanding of the different tasks and things you carry out- can do some things independently HCA wouldn't have knowledge to do. NA have more independence to do things and unlike the care assistant wouldn't have to go to the nurse and say what should I do. (HEE_11)

There is an opportunity to keep your existing nurses because it takes some of the pressures off by having NAs. (SO_4)

- Finally, with a shortage of Registered Nurses both generally and in adult social care, the NA role helps providers to maintain, perhaps even **increase their nursing capacity**. It is a rationale which touches on the sensitive topic of substitution, framing the NA role as an alternative to and replacement for the Registered Nurse. However, where nurses remain difficult to recruit, providers often argue it is better to have a registered NA in place, than nobody in place at all:

For areas struggling to recruit Registered Nurses, the NA can work at a high level taking on tasks that Registered Nurses traditionally performed. (HEE_1)

There are the shortages of RNs in social care so there is that gap and the NA plays a key part in helping fill that the gap by supporting and providing care. (HEE_13)

Some (providers) are coming to me saying we need to look at the workforce differently because we can't employ nurses so we need to see if we can support existing staff into those nursing roles. (HEE_11)

You don't have the registered nurses, but the skills attached to the NA role are so relevant to what is happening in care homes. (SO_3)

4.2 The Care Quality Narrative

As Figure 1 above indicates, the labour market narrative has important implications for care quality. Where the NA role contributes to a more stable and motivated workforce, there are also grounds for arguing the service user's care experience is likely to be improved. In a more direct sense the introduction of the NA role opens a narrative about the re-organisation of work, allowing for improvements in care delivery and service design. These opportunities rest on the value of the NA **as a bridging role**: a registered role with the capacity to take on tasks beyond the scope of the care assistant and to engage in activities formerly within the remit of the Registered Nurse. This capacity feeds into care quality in

various, closely related ways. As noted above, it allows the Registered Nurse to delegate to the NA with confidence, freeing up their time to deal with more complex cases but also ensuring that those service users looked after by the NA, receive care from a dedicated and highly skilled professional. This win-win situation where service users receive the appropriate level of care for their condition - whether from the NA or the nurse- was reflected in a range of comments:

These (NA) roles were seen as a real benefit to delivering hands on care in those settings where possibly the RN or specialist palliative nurse didn't have the time to deliver that one-on-one with the patient group. (HEE_3)

(In one nursing home) they wanted to build their workforce and improve nursing delivery. Nursing Associates working alongside Registered Nurses do that; they have residents with complex needs. The nurse gets tied up with the needs side and is not available to do anything else. To have someone qualified to take on some of those duties, like wound care management, is a big one. Rather than the nurse spending all day on that, an NA can take on half of that for them. It does help to share the workload, but they also realised the NAs were picking-up more things, noticing deterioration faster, knowing what to do instead of running to a nurse who had to come from what they were doing. Little things they picked up during an ordinary day that would have fallen to the Registered Nurse, the NA can pick them up and that reduces stress on the RN as well as reducing workload. (SO_4)

Care assistants haven't got a pin or the right qualifications to do certain clinical stuff. This was an opportunity to work with those staff who are interested, and upskill them. (CH_3)

What you have is a member of your team who is interested and wants to develop herself, working to a higher standard and for your nursing staff they have someone to train up and what you have is an invigorated team who want to deliver higher quality. It can be a win for you and your residents. (HEE_12)

The value of this recalibration in the distribution of tasks between the Nursing Associate and the Registered Nurse to care quality is deepened by the medium and longer demographic trends in the scale, complexity and acuity of those requiring social care, but also by the more immediate pressures created by the Covid pandemic:

These enhanced (NA) skills are important because of the increasing acuity of needs within the sector. We need a skilled workforce. This (TNA programme) provides both an ability to offer a career but also the right skills mix in the organisation to help them support the needs of the people who are resident in care homes. (SO_3)

We know over the pandemic community services have had a job to get District Nurses into people's homes, things like wound care and pressure sores. You can imagine an NA being able to undertake that role. If you had them peripatetic, some of the franchises would like an NA to deploy in that way. (SO_2)

In care homes there is a vital role for NAs in preventing hospital admissions. Residential homes are being asked to do more and more delegated tasks, and Covid has expanded this: more third-party delegation from District Nurses, so the carers are taking on more nursing roles but without that underpinning knowledge and supervision. They can be signed off as competent in the tasks for the nurse to delegate but if that patient starts to deteriorate it is around having someone who is in that NA role, educated to that level who will then think actually we need to do a, b, c or this person needs to see a GP now, something other than ring 999. (HEE_14)

What we are doing is trying to keep people in their home. If it is a residential home at end of life, it would be nice if we could keep them in that (care) home, which they consider to be their home. With an NA, they could keep those people from going into a hospital at the last point. (SO_7)

4.3 The Business Case Narrative

As third sector or private sector organisations, many social care providers must meet financial prerequisites to ensure ongoing viability. Indeed, there is an element of competitiveness not in evidence to the same degree in the NHS:

Our NHS providers have been keen to learn from one another (on the NA role), especially those who've gone early, but in social care they are private employers, they don't want to share secrets. (HEE_8)

In such circumstances, the introduction of the NA role can rest on a 'hard-headed' business case, with a 'bottom-line' return for the investment made in the training and development of TNAs. The improved care quality argument feeds into the business case to some degree:

It is about reputation: clients will come to you because of well trained staff that are supported. (HEE_14)

But typically, a business case rests on a more systematic cost-benefit analysis of the role. As one interviewee noted, this kind of analysis, rather than a 'softer' appeal to the career development needs of existing staff, is more likely to drive the interest in the role amongst larger, business driven social care providers:

We need to work with commissioners to build a proposition which is a quick answer that stacks up in transactional terms. It doesn't rely on you having that senior member of staff with you 10 years, already doing 14 things that prop up your care home. You don't want her to leave, this is a strategy that retains and develops her. That argument doesn't travel as well as, 'It costs £14k you'll get £10k from the Clinical Commissioning Group, when they'll commission enhance services from you in years 3.' That is where we need to get to it. (SO_8)

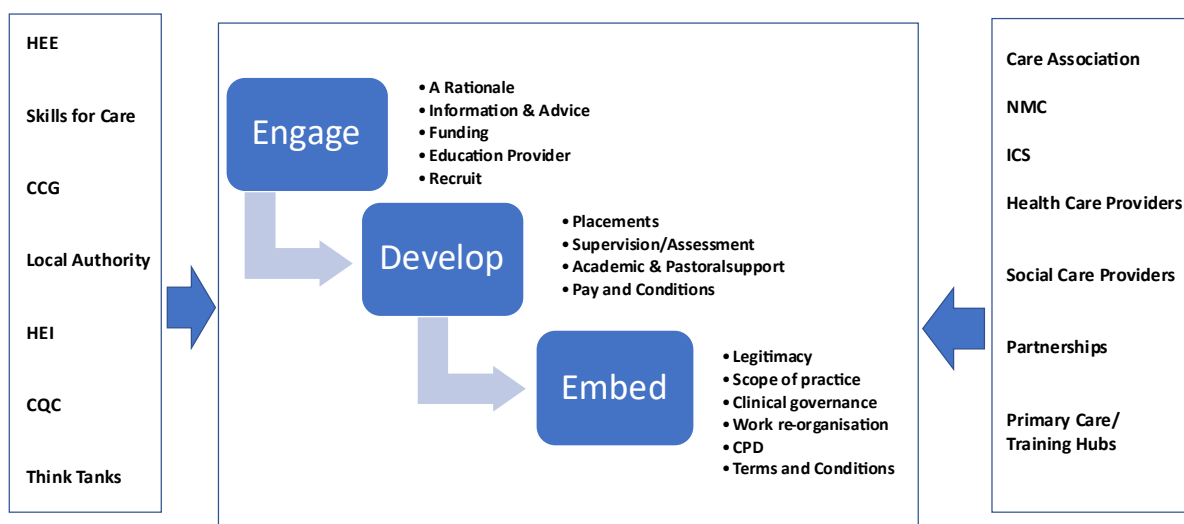
There is no simple template for the development of a business case, with much depending, for example, on the assumptions made about the nature of costs and benefits and the timescale for returns on investment in the role (see below). A focus on the business contribution of the NA does, however, encourage an interest in the practical process issues with the introduction and development of the role. These issues are considered in the next two sections.

5. POSITIONING

With the preceding sections suggesting a disconnect between a variety of plausible and clearly articulated rationales for the NA role in social care and the relatively low take-up of the role in the social care sector, there is clearly value in exploring the process of implementation. Figure 2 below provides a framework for considering these process issues. At its core are three main stages underpinning the introduction of the NA role - engaging, developing, and embedding it - and the associated micro processes falling within the respective stages. On either side of the core stages presented in Figure 2 are the range of organisations with a stake in the implementation of the NA role in social care. In Section 6 below, this framework is used to consider the implementation challenges faced by social care providers. In this section it is drawn upon to discuss two themes:

- The contribution made by different stakeholders to NA role development and
- The configuration of these contributions into different system and organisational approaches to the introduction of the role in social care.

Figure 2: Mapping the Introduction of the NA Role Social Care- Stages and Actors



5.1 Stakeholder Contributions: Complementarities and Functional Equivalence

Figure 2 above suggests that the adoption of the NA role in social care is a complex process with its multiple stages and myriad micro processes raising basic questions about:

- Who is involved in the process?
- Who is driving and accountable for it?
- How is it being organised and managed?

There are no single or straightforward answers to these questions. Indeed, from a policy and practice perspective, they have not always been satisfactorily addressed or resolved. One regional HEE Lead noted:

I think it (the introduction of the NA role in social care) has been uncoordinated. One of the things I am calling for in my role is a regional social care workforce board. (HEE_14)

In terms of stakeholder involvement in the development of the NA role, different actors can contribute to different stages of the implementation process in one of two ways:

- ***As complements to one another*** - making their own distinctive contribution albeit with scope to work in partnership; or
- ***As functional equivalents*** - constituting mutually exclusive alternatives to the delivery of a given element of the process.

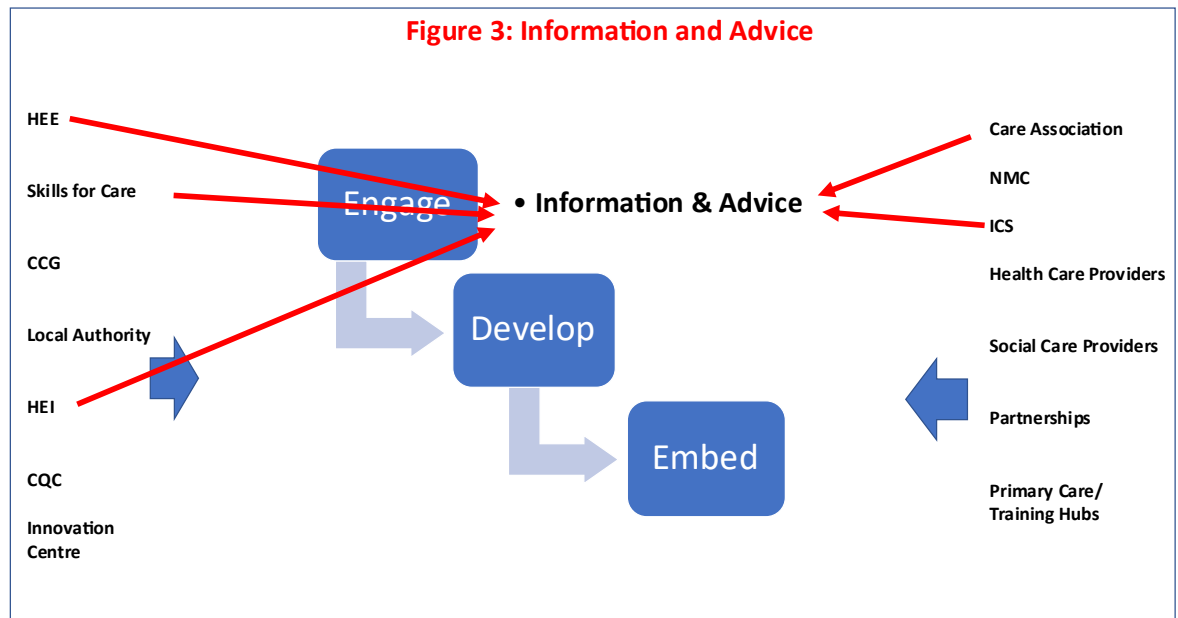
From the perspective of policy makers, these different patterns of involvement might be viewed positively or negatively depending on how they are enacted. Complementarity implies actors working in mutually supportive ways but runs the risks of confusion over respective contributions and a duplication of effort. Functional equivalence suggests different actors with the capacity to take the lead but with no guarantee that the 'best' placed comes forward to do so.

The following micro-processes underpinning the introduction of the NA role in social care can be used to illustrate complementarity and functional equivalence:

- **Information and Advice** (see Figure 3 below) - The provision of information and advice is an example of stakeholders acting in a complementary way. In part this complementarity derives from the fact that different actors have specialist knowledge and expertise on different aspects of the role: for example, an HEI will typically provide social care providers and TNAs with information and advice on the TNA college programme; while Skills for Care can offer information on the broader mechanics of implementation. Complementarity is also linked to the capacity of actors to bring different resources to the process of informing and advising. Thus, regional HEE leads often draw upon and work with the networks and contacts of Skills for Care and care associations to communicate with social care employers about the T/NA role. This is typically a positive partnership relationship, with occasional

tensions. In one locality for example SfC felt that HEE used them in a somewhat opportunistic way to achieve target numbers of TNA starts:

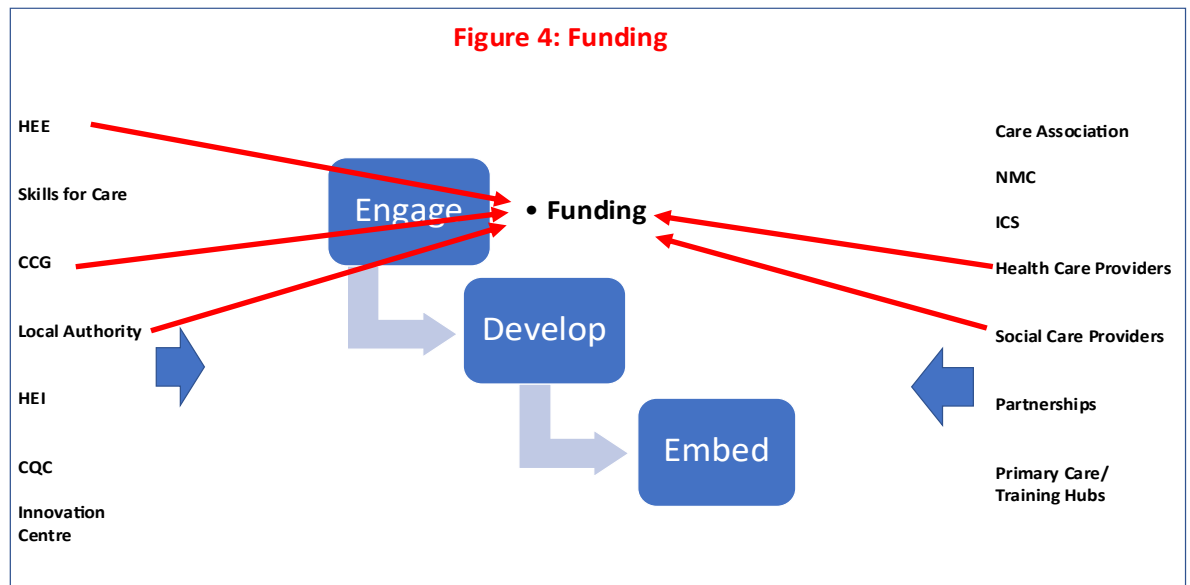
We have an on-off relationship with HEE in (locality name). They tend to get in touch with us when they are having to meet targets or are pushing on NA numbers, so it is not particularly planned. (SO_2)



- **Funding** (Figure 4 below): The provision of funding for the T/NA role is a further example of complementarity, reflecting the various types of finance available to social care providers for different elements of the programme. As noted, HEE offers a £4k per year for each TNA in health and social care to cover associated training infrastructure costs. However, with most recent waves of TNAs being trained through the apprenticeship model, other actors have been involved in sourcing and providing funding for direct TNA training costs. With social care providers often too small to pay the apprenticeship levy, they have been able to draw down around 95% of the training costs (£15K) from a central fund held by the Department of Education.¹⁵ Some have sought additional funding for training through levy transfer from other organisations, with HEE often helping to arrange this transfer. At the same time, there have been elements of functional equivalence in the funding arrangements. For instance, while levy transfer to social care providers often comes from NHS Trusts, it can also be given by local authorities and private sector employers. There are also various sources of funding for dedicated roles to support TNA programmes. In Devon it was the county council which

¹⁵ [Employing an apprentice: Get funding - GOV.UK \(www.gov.uk\)](https://www.gov.uk/get-funding-for-an-apprentice)

provided such funding. In London it was the respective ICSs financed 'out of hospital' TNA leads covering primary and social care.



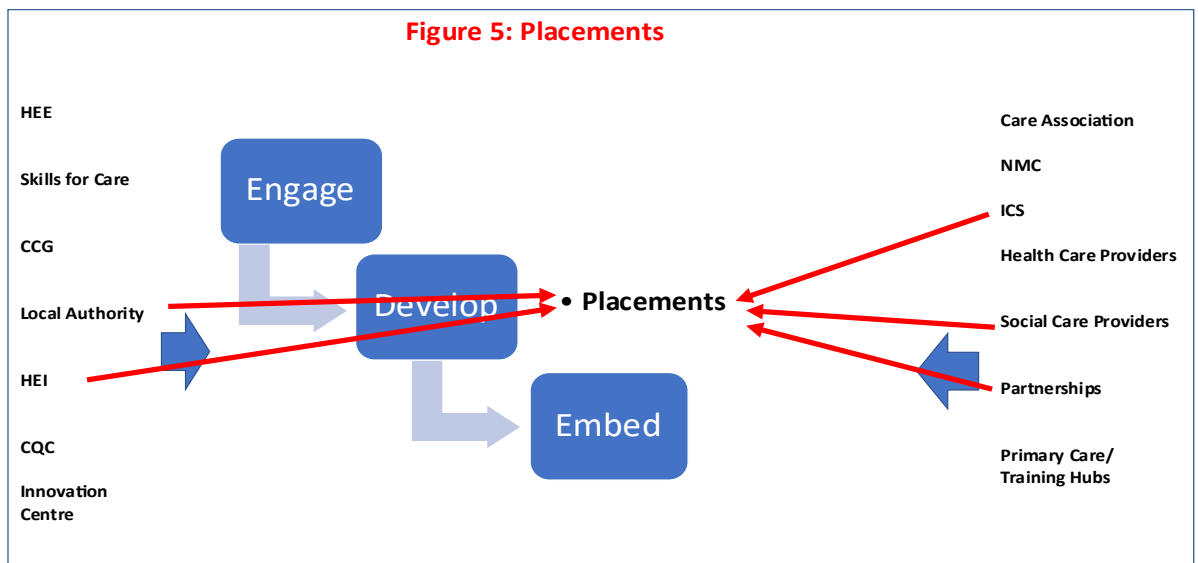
- **Placements (see Figure 5 below):** The organisation of the three or four placements required during the TNA training programme provides an example of functional equivalence. Thus, responsibility for sorting out placements was found to rest with any one of the following organisations:
 - The HEI
 - The ICS
 - NHS Trusts
 - The partnership or consortium and social care providers
 - The social care employers themselves.

The unevenness of approaches to the organisation of placements is reflected in interviewee comments:

Some of universities are great and arrange the placement; with other universities we have to arrange the placements ourselves. (CH_1)

There are a variety of different approaches (to placements) across (the region). One ICS works with a single university which handles all the placements for the NA programme. At the other extreme, we have 5 trusts and I represent primary and social care and there is a commitment that everyone will support all TNAs to rotate (placements) around the organisations. The Trusts tend to manage that because they look on it as part of their overall student nurse mapping exercise. (HEE_1)

We explore the management of placements in greater detail below. However, questions are worth raising on how and why different organisations have emerged to lead on this process, and with what consequences for social care providers and the TNAs themselves.



5.2 Organising Models

Stepping back from stakeholder involvement in particular micro processes, our study suggests that the NA role in social care is being introduced through various organising models. Presented in Table 5 below, these models are mainly differentiated by:

- The actor(s) leading or driving the T/NA initiative.
- The different relationships between actors.
- The principal purpose of the initiative.
- The interface between the initiative and local health and care system.

Table 5: Approaches		
	Area	Model
HEE Pilot Regions:		
North West	Greater Manchester	HEI ICS/Hub centred
North East & Yorkshire	Humber Coast and Vale	HEI Centred
	North East & North Cumbria	
East of England	Norfolk & Waveney	Partnership Centred
Midlands	East Midlands Lincolnshire Care Association	Preparation Centred
	Northamptonshire	
	West Midlands Care Association	
	Staffordshire STP	
Non-Pilot Regions:		
London	South East London	ICS Centred
	South West London	ICS Centred
	North East & Central London	Hybrid (NHS Trust/Local Authority/Innovation Centre)
South West	Devon	Local Authority Driven
South East	(West) Kent	Hybrid (Partnership/local authority)

Figure 5 above captures the approaches adopted by the pilots in the four HEE regions and the localities in the three non-pilot regions, with the following models emerging:

- **Preparation model.** In the HEE Midland pilots, the emphasis was on preparing individuals with an interest in taking the TNA programme. This preparation was centred on securing the formal entry requirements for a Level 5 qualification (Level 2 Functional Skills) as well as on the acquisition of general study skills. The HEE funding was distributed to the various actors - local care associations and Sustainability and Transformation Partnerships - best able to support and deliver this preparation:

We commissioned different external providers, whether it be a care association, a CCG or university. There were different approaches. It wasn't something we (regional HEE) could work on directly with individual (social care) providers. We needed a conduit so for example there were care associations that worked across that footprint who have experience of working in that social care sector. (HEE_8)

- **HEI model.** In the HEE North-East and Yorkshire pilots, the organising model was centred on the HEI. This was particularly the case in North-East and Cumbria where Teesside University played a pivotal role, with relative success, in recruiting participants to its TNA programme (see Table 3 above). For Teesside the delivery of a TNA programme which included trainees from social care, was viewed as a business opportunity, with the university willing to invest in a supportive infrastructure:

Teesside keep the numbers afloat because they're keen to invest in social care. They have seen social care as part of their market, and they want to bring in business for themselves..... Teesside do really well in supporting the (social care) employer from Day 1. They help them with the (apprenticeship) levy. They hand hold them and provide assessors or supervisors to make sure they have that support Teesside took it upon themselves to use the (pilot) money internally; they set aside some time for their apprenticeship lead and one of their lecturers who focused on the social care (HEE_4).

- **ICS model.** At the outset the HEE North-West pilot similarly adopted a HEI centred model, with Salford University given HEE funding to develop the infrastructure to support this development of NAs in primary and social care. Indicative of the university's interest in encouraging participants from these service domains, the money was transferred to Heywood, Middleton, and Rochdale primary care academy where it was used to host and employ a Practice Education Facilitator. The post has since moved again and now sits within the Greater Manchester training hub, suggesting a shift towards more of an ICS centred approach to the T/NA programme in social care. A similar approach can be found in London, where (non-pilot) HEE funding has been used to employ dedicated 'out of hospital' primary and social care T/NA leads at the ICS level: in South-West London as part the Richmond Training Hub; in North-East Central London as part of the ICS Apprenticeship Lead role; and in South-East as a project lead for TNA in out of hospital settings.
- **Partnership model.** The Norfolk and Waveney HEE pilot was rooted in a locality-based NA partnership mapping onto, but pre-dating the establishment of the ICS. In general, such NA partnerships were the main vehicle for taking forward the early waves of TNAs, especially in the NHS, and have continued in many localities. Typically, they comprise health and social care employers within a catchment area and provide the basis for a shared approach to the development of the NA role. Partnerships have varied in their inclusivity, or efforts to include social care providers, but in the case of the Norfolk and Waveney partnership, social care employers have been represented in it by Norfolk and Suffolk Care Support Limited.
- **Hybrid model (Local authority and NA Partnership).** An organising model based on an established locality-based NA partnership can also be found in the non-HEE pilot South-East region, in the form of West Kent Consortium (WKC). In this case, the social care sector has been represented in the partnership/consortium by the Kent County Council's (KCC) adult social care department. The WKC was formed around three years ago, comprising two local hospitals, two hospices, CCGs and GP practices, along with social care in this part of Kent.

Established to jointly procure training, there was an initial reluctance to involve social care, a reluctance overcome in part by social care offering much needed placements and by healthcare providers belatedly appreciating the value to them of involving the care sector:

They (WKC) were initially not that interested in having social care representatives join in, so we offered placements that was our 'in' to the consortium. Then as the consortium developed and involved us in their Memorandum of Understanding, they saw a benefit to their services of having better skills in care sector and opened it up. (SO_4)

A 2018 WKC pilot involving 2 TNAs from social care, who both failed to complete, did not deter the partnership, with subsequent social care cohorts launched: 3 TNAs in September 2019 (2 now qualified); 3 TNA in September 2020; 1 TNA in April 2021; and 7 in September 2021 (2 deferred to 2022).¹⁶

Kent County Council's (KCC) direct involvement in the WKC was driven by a dedicated innovation unit, now named the Innovation Delivery Team, staff by around 45 council officers, with its own information hub and a mailing list of around 660 social care providers in the locality. Tasked with pursuing any innovation which might 'improve the care sector', its interest in the NA role was underpinned by the labour market narrative highlighted above on the importance of addressing staff recruitment challenges, as a means of maintaining and increasing nursing capacity within care homes:

Because of the pressure on recruitment, we needed more nursing provision within the county. People are living at home longer and with more complex needs, so we knew provision was going to be in demand, but we couldn't recruit nurses. The idea of the NA was an opportunity for services to grow their own nurses. (HEE_4)

- **Local authority model.** Elements of the Kent approach were found in another non-HEE pilot region, the South-West. In Devon a local authority organisational model was identified, with the county council playing a central and directly supportive role in the development of the NA role in social care. Devon County Council was prepared to support a small cohort of TNAs in social care starting in 2020, providing two years funding for a Placement Facilitator post and covering certain training related costs for the care homes involved. The reasons for the council's interest echoed those raised in Kent: Devon County Council was concerned about

¹⁶ 2020-21 TNA figure included in Table 3 under the South-East region.

the number of homes in the county forced to de-register for nursing care in the context of nurse shortages, viewing the NAs role as again a way of boosting nursing capacity and in doing so retaining the number of nursing home beds:

What convinced Devon County Council to run with this pilot was the fact that nursing homes were deregistering, and that would be massively problematic for the council because they needed nursing beds in social care. They wanted to be able to say to nursing homes 'if you think about one of your HCA team leaders and support them to develop as an NA then they would be a really good resource and support for your Registered Nurses which means your nurses might not feel as overwhelmed and leave and you can remain as a nursing home'. (SO_9)

- **Hybrid model (Local Authority, Trust and Innovation Centre).** Local authority involvement was also evident in an East London model, although in a less direct form. The London Borough of Barking and Dagenham had providing funding to support the development of an innovation centre, Care City. Overlapping in purpose somewhat with the Kent Innovation Delivery Team, Care City operates as a not-for-profit Community Interest Company, at greater arms-length from the council. It has developed a specific interest in the introduction of the NA role in social care settings without a Registered Nurse presence: in residential and domiciliary care/home care. The partners working alongside Care City are three social care providers employing four Trainee or Apprentice NAs (3 in two residential care homes and 1 in domiciliary care), who are now halfway through their programme, and the North-East London NHS Foundation Trust (NELFT), crucial in providing the underpinning arrangement for TNA supervision and assessment. (This initiative is further discussed in the next section.)

The different organising models discussed in this sub-section point to the different ways in which actors with a stake in the T/NA role configure in driving and leading the programme. The HEI-centred model, highlighted in the case of North and North-East Cumbria with Teesside University, proved the most successful of the HEE pilots in terms of TNA starts, being well placed and willing to develop supportive infrastructure for social care employers and TNAs. As striking was the involvement of local authority adult social care departments in other models, typically found in two of the non-HEE pilot regions, the South-West and South-East. Thus, Devon County Council was crucial to launching the T/NA programme, although the sustainability of such support is in doubt:

For Devon County Council to keep providing money with no bigger picture on developments is quite difficult. They've done the project, proved it can be done, and it is beneficial to social care now it needs to go wider, so responsibilities need to go across the patch, across the ICS. (SO_5)

Devon County Council is not making a commitment at the moment to continue this NA pilot. (SO_9)

The Kent model appears more securely founded, not only with links to a local Nursing Associate consortium but resourced through a standing County Council-funded innovation unit for social care. The value of such a unit was further apparent in the East London, where the more arm's length Care City, was working through the challenges of introducing the NA role in residential and home care settings. It remains open to debate, however, as to whether local authorities in other parts of the country were playing a similarly proactive role:

I am not convinced local authorities see it (the T/NA programme) as part of their remit yet. NAs, they think it is something the ICS will do because it is a role development with nurse in it. In (region name) there is very little coming from LAs, it is all coming from HEE and HEIs. (SO_2)

I don't get the sense from them (councils) that they see workforce in social care as their issue to solve. If there are providers with workforce shortages, with skill mix issues, they don't come across as 'we need to solve these issues, we need to find a workforce solution'. They see that as the providers' problem. I don't see that broader OD (organisational development) conversation you'd have in Trusts, the workforce planning conversation that ensues. (HEE_8)

(Anonymous) City Council, all of their focus is on social workers. Care homes, nursing homes are not their priority issue; they have so much going on with deprivation and social issues, that the social worker is their king pin. (HEE_9)

The suggestion that local authorities might use their commissioning relationship with providers to encourage the NA role, was dismissed by one interviewee as unlikely:

We go round this time and again with any initiative, 'let's stick it in contracts' and it just doesn't work. At the end of the day local authorities are just trying to find providers that can provide for them, at the lowest price possible so they are not going to put barriers in the way, which means the people they are having to find care for end up with no care because nobody has met these criteria. (SO_2)

While an interviewee from another region suggested that many social care providers were simply not contracting with local authorities as they were able to rely on self-funders (private payers):

Local authorities are commissioning less than self-funders are commissioning, so you are not going to get to half the providers in quite a lot of (the region); so they are not necessarily the biggest player in that sense. (SO_2)

6. CHALLENGES

In this final, findings, section we unpack and examine the challenges associated with the various micro-processes underpinning the three main NA implementation stages - engaging, developing, and embedding - as set out in Figure 2 above. As a preamble to considering these challenges, it is worth making a few general, cross-cutting points on the possible difficulties faced by the social care sector in introducing the NA role:

- **Complexity:** A cursory glance at Figure 2 (p. 22), illustrating the multiple actors and micro-processes underpinning the introduction of the NA role, suggests the daunting nature of the task, especially for small and medium sized social care providers, and even larger ones. It is an extended process, difficult to navigate and requiring considerable time, effort, resource, and commitment, not only on the part of the providers, but the T/NAs themselves.:

It is lots of work to let somebody out of the home and support them and then to have to find placements for the people: it is quite intense. In the care industry they are so used to training being given to them and almost being persuaded to do training, whereas this is something they really have to believe in. (SO_7)

In general, it is on people's agenda, but it is a bit tricky and when things are a bit tricky, they sometimes don't get done. It is like 'we'd like an NA, but it is an apprenticeship so how do we go about getting people onto an apprenticeship, what do we need to do?' Without having someone to offer (care providers) with support at a localised level, it could easily fall away. (HEE_2)

- **Infrastructure:** In more general, structural terms, with the delivery of social care services fragmented and mainly dependent on small and medium sized, privately owned and run providers, the training infrastructure to develop the role is often simply not in place. In contrast to the NHS Trust, with its learning and development departments and leads, practice assessors, supervisor and educators, and myriad diverse workplace learning opportunities, many social care providers often have only a basic training function and limited capacity to support new role development. With the NA role being a registered role, and consequently underpinned by detailed regulatory requirements, the challenge becomes even more intense:

Many employers are a 'one-man-band'. They have one home. Maybe they want to send one student on a programme. In those early days we were looking for employers to have significant numbers in cohorts, that's what the universities wanted as well. We have been about trying to achieve that critical mass for so long. (HEE_8)

Where I see the challenge in social care is in not having the set-up of education teams, that education wrap around support that would really add value and really help get people onto programme and support them while they are on it. That is a crucial part because when you're having registered managers with so many hats already, if they then become the practice educator, or introduce a new role, that is really difficult. (SO_2)

- **Sector Context:** Partly related, interviewees did raise concerns about the sensitivity of the NA role and its development, to the social care context. While the role was widely seen to have value in the sector, there were nagging concerns about the national policy and practice assumptions underpinning it, perhaps reflecting a healthcare 'bias'. An interviewee articulated these concerns succinctly, 'How do we get social care providers to engage with something that is NHS led?' (HEE_13). Another elaborated:

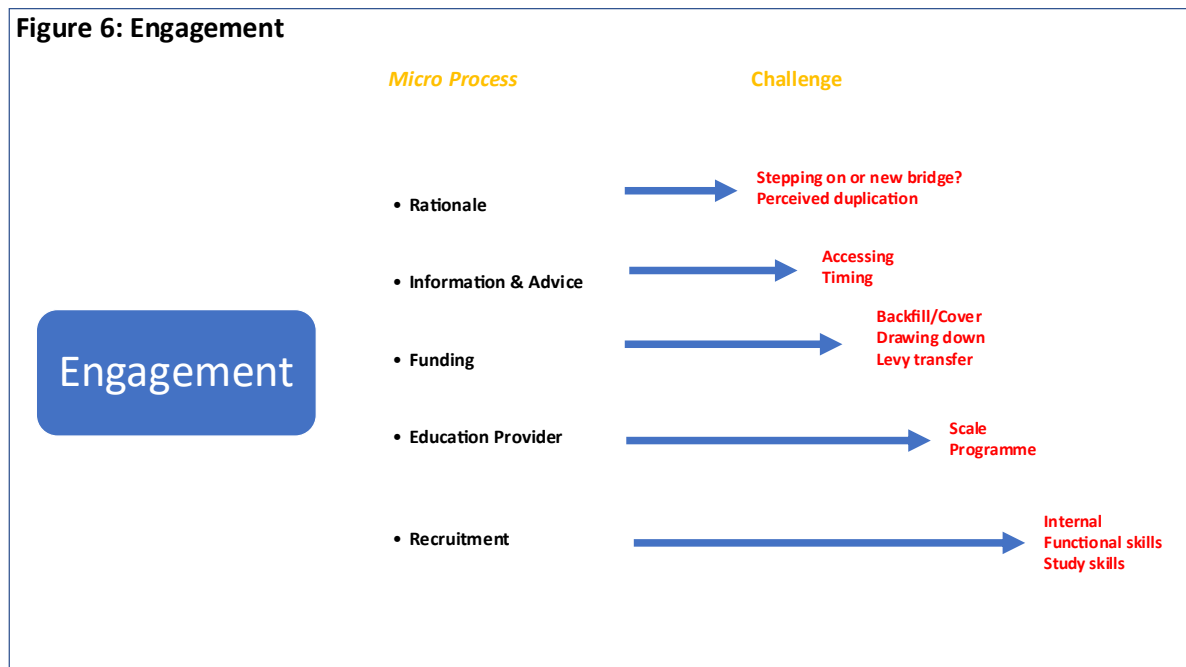
The role was developed and offered to social care, rather than being co-produced with it. At the moment we have people in nursing homes who in the not-too-distant past would have been in hospital; people in care homes who would have been in nursing homes; and people at home who would have been in care homes. With that sort of change, the complexity of care tasks has increased but this has not been recognised or built-on (in developing the NA role). Consideration was not given to what would be useful to the social care sector, for example peripatetic supervision for people performing health related care tasks in communities. If it had, things would have looked very different and it (the NA) would have been much easier to accommodate and sell to the sector. We've had the introduction of a health nursing role in the form of the TNA that, even though the skill set and activities might be very similar in social care as in health, hasn't really been developed from that perspective. (SO_2)

- **The Pandemic:** The challenges have been deepened by the Covid pandemic, with many of the interviewees noting the difficulties faced in introducing the NA role in the current context. The specific problems faced by the social care sector, especially at the outset of the pandemic, have been well documented and commented on. It is simply worth noting here that for many providers, the last couple of years have just not been a good time to embark on the uncertain and challenging process of taking on a new role.

We've had this Covid pandemic and care homes were hit the hardest; to try to kick start a new role in the workforce in social care in the middle of a pandemic has just been too much for them to contend with. (HEE_5)

6.1 Engaging

Figure 6 below sets out the micro-processes and associated challenges faced in engaging social care providers in the development of the NA role. The challenges are considered in turn.



6.1.1 Rationale

Clearly social care employers need a rationale for engaging with and developing the NA role, and we have dealt at length above with the main narratives prompting interest. Caution is needed, however, in assuming that employers necessarily connect with these narratives. Attention was drawn to social care providers who felt they simply did not need the NA role. Thus, amongst some larger providers there were claims that a similar role already existed in the form of the Care Home Assistant Practitioner (CHAPs), with the NA role a perceived duplication:

Bigger homes say 'oh we have our own internal qualifications'. They have Care Home Assistant Practitioners. (SO_3)

Some have a programme in place called CHAPs. They pay them a nice wage and they will say I have CHAPs don't need NAs. (HEE_15)

There are faint echoes of this argument in the NHS where some Trusts have built their senior nurse support workforce through the Assistant Practitioner (AP) role. However, neither healthcare nor social care AP roles are registered, while the argument for the CHAP as an alternative to the NA is

especially weak: in the NHS the AP receives a robust two-year level 5 qualification, the CHAP role is not based on a qualification but simply a 10-week programme of training.¹⁷

Where social care employers do find different rationales for the NA role, there can, as in the NHS, be tensions between how these relate to one another. For example, in seeking to use the NA role as a stepping-stone into registered nursing, social care employers not only open themselves to additional training costs going forward, but they risk weakening the establishment of a new bridging role of value in its own right. In healthcare, this risk is heightened by the fact that a significant majority of qualified NAs are keen to move into pre-registration nurse training.¹⁸ Based on an extremely small sample, the same appears to be the case in social care with three of the four TNAs interviewed for this study also wanting to move into the Registered Nurse role, the fourth being uncertain about her future.

6.1.2 Information and Advice

Social care employers are likely to find a rationale for adopting the NA role from information and advice provided by another party, rendering the presentation of this material especially important. In terms of timing, such employers will seek information and advice not only at the outset but also as the programme rolls out and as the NA role develops. Indeed, with social care providers diverted by current pressures, it becomes important for policymakers and practitioners to take the initiative and provide the necessary information and advice:

(Social care) managers are bogged down with the day to day, and unless someone comes along and spells it out. they don't know enough. (SO_4)

However, access to and the provision of information and advice is a potentially challenging process in several respects:

- As stressed, the implementation of the NA role is complex with considerable information and advice on different aspects of the role and programme needed by social care employers. One interviewee suggested that employers first needed to be 'socialised' about the role - its use, management, and regulation - then told about how apprenticeships work, before they even get to details such as the organisation of placements:

The first phase is socialising employers- how you can deploy them (NAs) in social care, how they fit with the CQC, all those challenges that social care employers face,

¹⁷ [CHAPS Training - Support Your Nurses With Highly Skilled Assistants \(caringforcare.co.uk\)](https://www.caringforcare.co.uk/chaps-training-support-your-nurses-with-highly-skilled-assistants)
[What is a Care Home Assistant Practitioner \(CHAPS\) | brighterkind](#)

¹⁸ Our survey of T/NAs in the NHS found that around three quarters were keen to become Registered Nurses.

and making sense for employers of what has to be done. But then there is the bolt on delivery through the apprenticeship offer. So there is another area you have to develop; employers understanding apprenticeships, and how they get into a levy share and negotiation with HEIs. Then we have the whole issue of placements and how you make them safe and sound. (SO_2)

- In contrast to the 'command-and-control' NHS model, information and advice are especially important in persuading social care employers, with notionally greater discretion, to take up the NA role:

In (area name) we often talk about the command-and-control bit: the NHS will say it will happen and therefore it will. In social care you have to do a lot more influencing and negotiating and making it fit, for the people to give their support, and some providers are keen business people and if they invest they ask, 'What I am getting for that?'. (SO_2)

The fragmented nature of the social care sector, with services delivered by myriad providers widely dispersed across any given catchment suggests the logistical challenge of communication on the NA role and the importance of partnerships and intermediary organisations in disseminating material. An interviewee in a local system with over 400 social care providers noted:

One of the key pieces of learning is the need for engagement with the right partners in social care. You can't just go to an ICS and say right can you tell everyone in this ICS and that need to do 'X'. It doesn't work like that: you need to find the partnerships. (HEE_8)

Representative employer organisations, such as care provider and manager associations with their network of contacts, are crucial in communications. As a regional HEE lead noted:

We work closely with a social care support organisation, and they have been instrumental in developing the TNA pathway in social care. They have all of the links into the social care settings. If they get contacted, they'll pass the details to me and vice versa. (HEE_10)

For HEE traditionally rooted in healthcare, Skills for Care with its greater sensitivity to the nature of and challenges facing the social care sector has been a particularly important partner:

HEE wanted us to employ somebody who would be in charge of promoting the NA role in (region's name) and they thought that post should sit within Skills for Care. (SO_1)

In (region's name) we have developed a good relationship with our Skills for Care colleagues. That has been a critical step. (HEE_2)

Cold calling an employer never works. For me it is getting into those networks and understanding the ICS and Skills for Care are a key partner. All social care providers are aware of Skills for Care. They are the best avenue in. They are seen as part of them. (HEE_13)

We work with Skills for Care because the employers sign up to their updates. Short of going onto the CQC website and downloading all their providers, there is no way to identify and have the contact details of everybody in the patch: they are independent organisations. So, if that could be more strategically managed perhaps, we could have more strategic conversations to ensure everyone gets the information and then you could work with people that way rather than them volunteering themselves to receive updates or be informed about something. (HEE_9)

In many cases, it is not solely a question of contacting the right providers, but connecting with the right person in that organisation:

In health you can get through to everyone because they all have Directors of Nursing. In social care, if you can't get the information to the right people, how can they know about it (the NA role) and how can we develop it within workforce. (HEE_6)

- This sensitivity to the social care sector also become a challenge in framing of the information and advice provided. As an interviewee noted:

They (social care employers) do need a bit more support, repeated conversations, sign posting, cases to represent the sector and material that represents the sector. You can't assume all the materials for health are relevant to or needed for care. (HEE_2)

6.1.3 Funding

The process of funding the T/NA role has been presented above as technically challenging, especially for small and medium sized providers unlikely to pay the apprenticeship levy and therefore required to draw down central funds and seek levy transfer to cover direct training costs. More substantively, it was suggested that providers could be deterred from engaging with the TNA role by the high indirect costs of the training. These costs include the occasional employment and use of training supervisors and assessors, but most significantly high backfill costs. The training programme requires the TNA to be away from the workplace, on college days and placement, for 40% of the week, with the employers needing arrangements to cover for their absence:

They will say we just can't afford this. Yes, we can see the benefits, but we can't afford backfill costs - the staff for placement and cover costs. (SO_3)

The significance of backfill and other associated costs is reflected in business case calculations developed by the TNA Lead for a London ICS and presented in Table 6 below.

Table 6: APPRENTICE NURSING ASSOCIATE (ANA/TNA): Employer costs

Resource	PCNs		General Practices and Nursing Homes	
	one Year	TOTAL Years (2yrs)	one Year	TOTAL Years (2yrs)
Apprentice Salary	£25,671	£51,342	£11,232	£22,464
Backfill 40%	n/a	n/a	£11,232	£22,464
Practice Supervisor (2hrs per week)	£2,342	£4,684	£2,342	£4,684
Practice Assessor (half day a month)	£1,013	£2,026	£1,013	£2,026
Management time				£0
Training Costs	£7,500	£15,000	£7,500	£15,000
TOTAL COSTS	£36,526	£73,052	£33,319	£66,638
Funding				
ARRS for PCNs	£25,671	£51,342	£0	£0
HEE for employers	£4,000	£8,000	£4,000	£8,000
Apprentice levy	£7,500	£15,000	£7,500	£15,000
TOTAL FUNDING	£37,171	£74,342	£11,500	£23,000
BALANCE	£645	£1,290	-£21,819	-£43,638

The training costs for a TNA in nursing homes are presented alongside those for a TNA introduced into a Primary Care Network (PCN). The difference is striking: the suggested net cost of a TNA in a nursing home over the two-year training period is put at over £40,000, while the PCN, with external financial support, can make a net gain of around £1,000. The difference is largely accounted for by the fact that the NA is a named role under the Additional Roles Reimbursement Scheme (ARRS) available to employers in PCNs, covering the full salary costs of the TNA, including backfill. Some caution is needed in interpreting and using the costings in Table 6. They are drawn from a single part of London. Moreover, the notional nursing home used in the calculation is likely to already be employing and paying the salary of the care assistant, with only the new backfill cost to be met, and producing a total net cost figure closer to £20,000 over the two years. The costing also fails to build in any medium-longer benefits from the NA role, for instance arising from downstream change in skill mix and improvements care quality. As an interviewee noted, this longer-term horizon is important in establishing benefits:

Most of the time people are looking at the short-term consequences of it (the TNA programme). 'If I release this member of staff, we'll be thin on the ground; we are already'. But it is about investing in your staff and saying these apprenticeship opportunities are becoming more available to people and if you don't invest in your staff, they could go somewhere else to further their career. And when the NA qualifies, they can come back with this rich, robust experience, not field specific. You're getting experience across the four nursing disciplines from the TNA; they are coming back with that wealth of knowledge, that they can implement in the team, and share through clinical practice. (HEE_5)

As another interviewee noted about the TNA programme:

Business-wise it is one of the few courses you can say it is worth the money as long as it is somebody who has worked for you for a long while, that you believe in and will stay. It would be so useful and make such a big difference to them because a lot of homes are thinking of changing from nursing to residential because haven't got these skills - it is absolutely crucial to the industry continuing to be able to offer nursing homes. (HEE_7)

However, even with these longer-term benefits, the upfront investment in TNA training remains significant, with certain, especially smaller providers bound by a financial model requiring more immediate returns:

The (TNA) infrastructure costs money. Many homes are run on very limited numbers so asking them to provide additional protected learning time for the TNAs: who will pay for that? The funding is crucial to enable them to support people to do additional shifts or to get agency staff or recruit

more people. (SO_5)

You are going to have that (NA) staff member in place for at least 20 months to recoup the costs and social care providers want instant results. (SO_3)

As the former comment implies, the challenge is not solely to cover the costs of backfill but to cope with the absence of key employees more generally, in the context of tight staffing regimes with limited spare capacity:

Lots of managers are keen on the role but once they find out about it, it is about capacity to free that person up. Those being put forward are their best care workers. To lose them two days a week is quite a hit for some of them. That's why quite a few are deferring so they can sort out their in-house mechanisms to support that person. (SO_4)

Smaller providers, nursing homes with 30-40 clients have small staffing teams. They will have people off sick to cover and then you're saying in advance they will have to lose this person for two days a week for next two years; that takes some thinking about, and there is not always enough staff to cover. (SO_4)

6.1.4 Education Provider

The Higher Education Institution (HEI) is one of the key stakeholders in the introduction of the T/NA role, for the employer an essential actor. One of the larger employers covered in our study, drove its TNA programme through in partnership with an HEI, engaging few, if any other actors, 'We took to this forward with the university. Other organisations were not involved' (CH_1). However, for certain social care providers the HEI relationship could be challenging. At the engagement stage, the social care provider needs to find an HEI programme for what is often a small number of potential TNAs.

This will likely necessitate procuring a programme with other health and social care organisations to secure membership of a viable TNA cohort. The employer will also need to fully understand the scale of the future commitment of TNAs to their college studies and on how this will impact organisational staffing and management. Such understanding is not easily secured. In contrast to NHS Trusts, social care providers are unlikely to have developed longstanding relationships with HEIs (or indeed Further Education colleges):

Social care providers have struggled to engage with the university and understand the complexity of the recruitment process and to understand the curriculum requirements, off the job learning, protected learning time. For example, a number didn't appreciate the amount of time that learner would have to spend outside of their employment base doing hub and spoke.¹⁹ (HEE_3)

One of the big challenges for social care providers is in negotiating with HEIs. Whereas health have their relationships with HEIs, and they can say we want x, y and z, in social care you are dealing with one employer who needs to talk to someone about what they want or just take what is given. It is very difficult for them to negotiate well with the HEI around how it is offered, how placements go, what information they need. It is a bit smoke and mirrors when you start talking to some of the HEIs because they won't tell you what they don't want you to know. (SO_2)

6.1.5 Recruitment

Recruitment to a TNA programme is a double-edged process whereby the applicant must be accepted by and meet the entry requirements of both the social care employer and the HEI. For the social care providers, recruitment is partly an issue of scale: how many TNAs are they prepared to take on? Ongoing uncertainty about the nature of the role has prompted some caution on numbers, with examples of social care organisations launching pilots involving small TNA numbers to 'test the water'. In larger chain companies with different sites and services, careful consideration also needs to be given to the distribution of TNAs across the organisation. Selection must ensure that not too many TNAs come from any given home or facility, so risking a depletion in workforce capacity and the imposition of unreasonable supervisory burdens:

We'd make sure the home was not overwhelmed with too many (TNAs). The maximum we have is two in any one home and that depends on size. So, we have a home with 120 odd beds and others with 15 beds. We make sure we don't overwhelm them (with TNAs). (CH_1)

Additionally, there is the challenge of ensuring that the capacity and resources to support the TNA are in place:

¹⁹ i.e. placements

Any homes where we have inspected internally and feel they have challenges, we don't put the TNAs there. We want to ensure they have a good, solid foundation in learning, so we don't want them to be in any of our challenged homes. (CH_2)

For the HEI, the recruitment process centres on 'harder entry' requirements especially the need for level 2 functional skills,²⁰ which presents challenges to TNA applicants, typically experienced employees who have long since left formal education, and often without a wealth of formal qualifications:

I left the (TNA) interviews, they asked if I had my exam results and I had been in school in 1986 and still not maths - they said I had to get my maths. (T/NA_1)

Early evaluation showed that preparation prior to the (TNA) Foundation Degree was absolutely essential. Foundation Degree students in the main are not 18-year-olds coming straight from school onto a programme. They come with other commitments but because they are recruited from the existing care workforce they come with few academic qualifications. The hike up to level 4 or 5 qualifications is a steep learning curve. Some have taken it in their stride, but those with additional learning needs have really struggled. (SO_3)

The challenge of ensuring TNA applicants have secured level 2 functional skills is shared with the NHS but appears especially acute in social care. An HEE Lead noted that in their region:

Less than 20% of social care workers have got a level 2 qualification. Before you even think about NAs you need a bridging programme to get people to level 2 maths and English. (HEE_14)

Another, involved in an HEE pilot, noted:

The skill set of those in social care (keen to become TNAs) came to the fore early on: the entry requirements to get on to the programme. Straightaway the problem was laid bare: not having the Maths and English. A lot of the social care pilots for us in the early days were about that preparation: Who is the right candidate? Is this the right opportunity for you? What pre work can you do so you are ready to get onto the Foundation Degree? It was definitely a more complex environment with a lot more investment required for a lot less return because you're only getting 1 trainee per home and we have limited resources to do lots of things. (HEE_8)

Moreover, this lack of recent experience of formal education raises challenges around the study skills of prospective TNAs and their capacity to meet the college components of the programme. One of our social care employers was keen to address this point by ensuring that their TNA applicants were aware of the commitment they were making in taking part in the programme:

²⁰ Level 2 equates a GCSE grades 9, 8, 7, 6, 5, 4 or grades A*, A, B, C

We have internal interviews before they go to university interview. So we know we have imparted exactly what this course is going to do, exactly the involvement they need to do outside of working hours. We need 100% commitment from these guys. (CH_1)

There is, of course, a shared interest amongst not only the HEI and the employers, but also the TNAs themselves in being able to successfully engage in and complete the college element of the programme, with the Midlands HEE pilots, as noted, placing particular emphasis on addressing this issue and preparing TNAs with study skills:

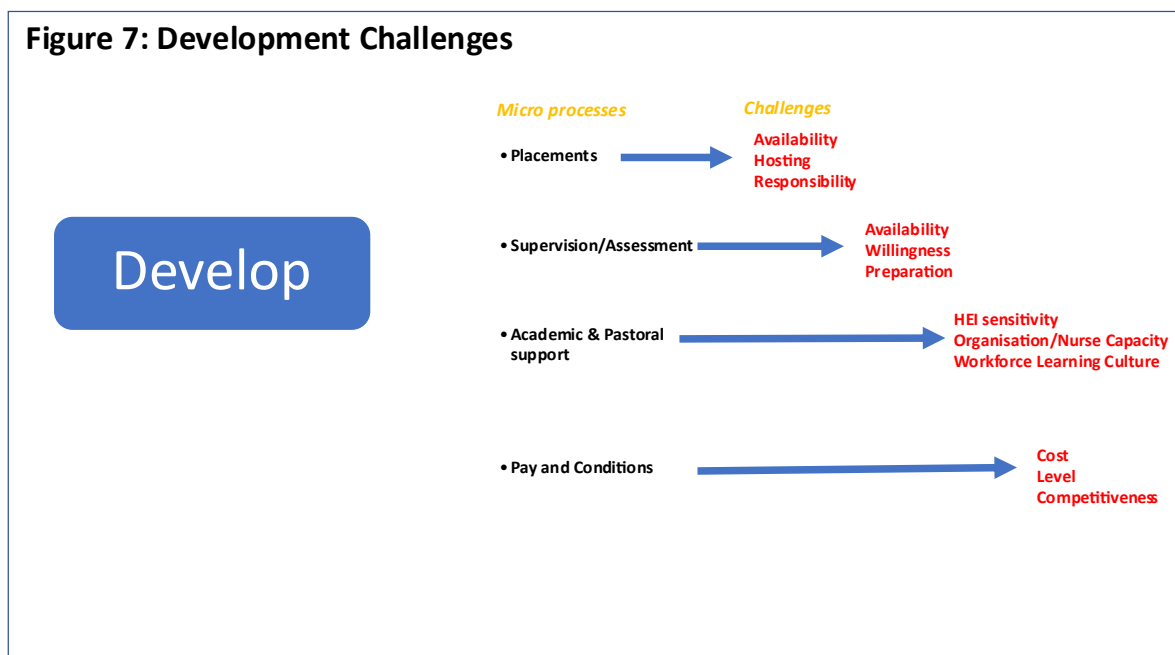
Brokering the relationship between the student, the university and the employer, that is what they (the Midlands pilots) have all done whether it be through putting on face to face 12-week modules in college for Maths and English or whatever; that was the problem early on, the missing bridge between those three parties. (HEE_9)

This view was echoed by interviewees from other regions:

In social care there was additional need for a lead time to prepare the TNAs commencing the programme. Quite a number of care home applicants didn't have functional skills. Sometime the on-boarding process of getting them ready was challenging. (HEE_3)

6.2 Developing

The development stage covers the two-year training period for the NA role, comprising a range of micro-processes and associated challenges. These are set out in Figure 7 below, with each challenge considered in turn.



6.2.1 Placements

Under NMC requirements, TNAs must complete a minimum of 460 hours of external placements, experiencing care across the life span and in all four fields of nursing (adult, paediatrics, learning disabilities and mental health). We touched on different approaches to the arrangement of placements in Section 5.1. Indeed, we might well have covered placements in the previous section examining initial engagement with the NA programme. Thus, several interviewees drew attention to regional and locality attempts to encourage social care providers to act as a TNA placement host, with a view to giving them a feel for the NA role and allowing them to assess whether they would then like to employ any themselves:

When a provider approaches us or Skills for Care, we say there are different things you can do; so if you're thinking about next year why not be a placement provider so you can get used to what it looks like to support learners. We have a learning disability setting in (area name) which doesn't have any learners but is a placement provider. (Company name) is also interested in introducing the NA role but starting from scratch so we're suggesting to them they start by hosting a placement. (HEE_2)

Whether and to what extent social care providers are acting as placement hosts remains an open question. Data on the number of social care TNA host placements is not readily available, although in one region concerns were raised about an unequal 'playing field' between health and social care in this respect. It was suggested that while in health an employer could be a placement with a CQC regulated service that 'requires improvement', this was not the case in social care, where the rating had to be 'good' or 'outstanding'.²¹

For the social care employer with a TNA, the arrangement of the various placements in different workplaces over the two-year training period is a major responsibility and organisational commitment:

One of the biggest barriers for TNAs from social care backgrounds for their employers was placements. (HEE_9)

With these numbers (of TNAs), demand for placements is growing and that has been difficult especially making sure people get the three disciplines and close to home, , hospitals. (SO_4)

The difficulties faced by social care employers in providing placements feed into a broader challenge centred on the capacity of health and social care systems to offer such placement opportunities.

²¹ Whether this is indeed the case needs to be checked with HEIs and perhaps the NMC but this was certainly the perception.

TNAs in social care are not alone amongst pre-registration trainees/students in looking for such placements:

For us trying to get placements has been really difficult. I feel it with the NAs because they come low in the pecking order. (SO_5)

The HEE Clinical Placements Expansion Programme (CPEP) reflects attempts to deal with this broadly based challenge. At least one of the regions covered by our study was keen to use its CPEP funding to focus on developing placement opportunities in social care.

While many NHS Trusts provide a range of services, allowing internal placements for their TNAs in different parts of their organisation, social care providers lack the scope to offer this same internal breadth of experience. This is especially the case with smaller and medium sized social care providers, although some larger employers in the sectors might be able to offer internal placements in a range of settings. As a care home manager working for a large provider of multiple services noted:

Initially we worried about how we would meet placements, like child placement, hospital placement. The Associate Dean (at the University) said to me, 'Get creative'. So we looked at the home element, and for all of our residents that is their home- so we met that element straight away. Let's look at the adult care, we met that element, done, LD (Learning Disabilities) we have LD units and mental health; there a lot of people here with mental health problems. We have an eating disorders unit, so we're a great place to go to get experience. We can get different experiences; there are a lot of things we do. (CH_2)

More generally, the scale and nature of the placement challenge faced by social care employers clearly depend on where responsibility for organising such placements lies. We saw above in Section 5.1 that in some cases HEIs took on this task. Arguably this responsibility is included in the fees HEIs receive for the training, with one ICS covered in our study keen to take over placement arrangements from the HEI and requisition some of this funding to support it in doing so. Again, arguably the HEI is best placed to deal with placements given their responsibility for accrediting and approving placements. However, we have seen the important role played by a dedicated placement facilitator or co-ordinator respectively in Greater Manchester and Devon. Locality-based NA partnership and ICSs have also been seen as the basis for reciprocal placement arrangements. In some areas this link to a broader network of health and social care providers has been the preferred option in arranging placements, allowing employers greater control of the process:

I don't think having one person to manage placements for primary and social care is the answer. It needs to be tied into the community of practice so involves all Trusts and all others tied up in NA world. (SO_5)

There is value in social care employers being part of these reciprocal placement arrangements. However, the scope for social care employers to reciprocate can be hampered in several ways:

- First, social care employers feel they must establish the value of a social care placement to sceptical healthcare employers with placements to offer in return, even though once taken up such a social care placement is often found to provide a rich and worthwhile experience:

TNAs working in primary care had gone to one of our nursing homes where we have two TNAs, with the idea of 'I just need to get the hours in'. However once experienced they were banging on about what an amazing learning environment it was and how supportive the staff were. I am going to take that to the COP (Community of Practice) to say this what people are saying about nursing home placements, so please don't let trainees think it is just to get tick in (the) box. (SO_5)

- Second and more prosaically, there is simply an issue of balance, smaller social care providers with one or two TNAs being unable to reciprocate the placement needs of NHS Trusts with much larger TNA cohorts:

The reciprocal arrangement is amazing but look at (name of small care home), they have three TNAs, but there are healthcare employers with 6 or 7 and that's when the reciprocity doesn't work as well. That is when we have to liaise with other organisations and say help us out. (HEE_1)

- Third, one narrow but important legal-technical point, it appears that TNAs from primary or secondary healthcare in social care placements are not covered in terms of indemnity.²² Social care employers can extend their indemnity coverage but this would be at a cost.
- Fourth and arguably the most significant barrier lies in the difficulty residential care and domiciliary /home care employers, typically without Registered Nurses in employment, have in offering supervisory and assessment arrangement for trainees. This is one of the key challenges to the take-up of the NA role in large parts of social care, which we turn to now.

6.2.2 Supervision and Assessment

The NMC requirement for a registered health or social care professional to act as the practice supervisor and assessor for the TNA remains one of the most critical challenges to the introduction of the NA role in social care. This is most obviously the case in residential care home and domiciliary/

²² TNAs in a social care placement are not covered by the Clinical Negligence Scheme for General Practice or the Clinical Negligence Scheme for Trusts.

home care settings, but even in small and medium sized nursing homes, with a limited number of such professionals in the staffing establishment, this remains a key issue:

Until we really get cracking around supervision and mentoring, and the qualification people need to do that, which most care home and domiciliary managers don't or won't have, it is a barrier. They'll think who is going to do that bit then. Unless you have an organisation to swoop in and say, 'Don't worry about that we'll sort it out,' it is going to be struggle because it is that high barrier that social care managers just don't have that skill set and experience to deal with and it is just one too many things for them. (SO_2)

This is not to detract from examples of the role being taken-up in residential home and domiciliary/home care settings. A couple of examples were cited of Registered Nurses working in such settings as managers, who could act in a supervisory capacity. However, these examples were not common, with the T/NA relatively rare in these contexts.

There was some criticism of the regulatory framework on practice supervision and assessment, with suggestions that it underestimated the capacity of non-professional, but still CQC-registered, managers to provide such support:

We're sending the wrong message to social care if we're saying a very experienced senior carer cannot on a day-to-day basis supervise a student nurse or TNA or registered manager who as part of their registrant managers qualification has done a whole module in at level 5 on clinical supervision. What are we saying social care staff are that they aren't up to supervise a TNA? (HEE_14)

In more pragmatic terms, there were various initiatives underway to address this challenge:

- The first, raised in general terms by several interviewees, centred on the development of peripatetic, arms-length practice supervisors and assessors that might be shared by social care providers. This option raises issues centred on the funding, employment status and accountability of such a figure, but an example of such a role can be found in the Nursing Associate Practice Facilitator role as recently advertised by Voluntary Organisations Disability Group (VODG) in partnership with Health Education England (London). It is a role specifically focused on developing T/NAs in learning disability, with a remit including the provision of clinical supervision and coaching to apprentices in the workplace as well as the delivery of on-line and telephone pastoral support.²³

²³ [Microsoft Word - 20190501 VODG practice facilitator.docx](#)

- Another initiative sits within the Devon training hub and is very much linked to attempts, noted above, to expand placements for a range of health and social care professions in pre-registration training, including T/NAs. If placements are to be expanded, especially in residential and domiciliary/home care settings, supervisory and assessment arrangements need to be in place. Devon is seeking to develop a 'collaborative model' for such arrangements. The model is being piloted, with an interviewee describing its use in one provider organisation:

Headway - an acquired brain injury day service - is testing this collaborative supervision model. Day to day supervision and development of the student will be undertaken by the vocational workforce in the service and in addition to that and to satisfy the HCPC and NMC, we will have a long arm practice supervisor that will go in and support their student with clinical supervision. The hope is we can evaluate the model early 2022 with a view to roll-out across good and outstanding providers. (SO_9)

- The final initiative centres on the East London partnership between Care City, NELFT and a small number of residential homes. Here a district nurse employed by the local community NHS Trust is key to providing supervision for the TNAs employed by the homes. Again, this raises issues of accountability and indemnity, currently being worked through. With a year to the completion of the pilot, the aim is to recruit another larger cohort of around 20 TNAs in residential care, with a view to further testing and consolidating the supervisory model at scale. Taking forward the model in domiciliary/home care, with the dispersed and isolated nature of the working, has proved more difficult, further work being needed to find viable supervisory arrangements in this setting:

Domiciliary care is even more of a challenge because you haven't got the team around you. You're often working on your own, so the accountability and risks associated with that are so much greater than in care homes where there is a team around you can refer and relate to. (SO_3)

6.2.3 Academic and Pastoral Support

In common with healthcare, the social care TNA interviewees in our study found the College component of their training especially challenging, often a function of difficult educational experiences in the past and the paucity of recent engagement with academia. Academic difficulties were deepened by the shift to online teaching during periods of the pandemic lockdown. As an NA interviewee noted:

I sat (in lectures) with girls younger and more able, and the academic side blew my mind, I didn't know what I was doing. At 12 weeks I broke down at university, but then barriers began to fall away, and they began to help me. (T/NA_1)

The source of this help is important, with the provision of academic support notionally resting with the HEI, required to appoint academic assessors and supervisors. However, as at the engagement stage, the quality of HEI engagement with the social care sector is at best uneven. Indeed, an interviewee suggested universities were less inclined to take on social care TNAs given the (high) level of support they would need during their academic studies:

We've been struggling with the universities. They would rather you take people from health rather than from the care industry, because they are fully supported, they can let them go and they can back them more easily. (SO_7)

More generally HEI delivery of the TNA programme was presented as sometimes heavily skewed toward healthcare and perhaps not sensitive enough to the social care sector:

With online learning, you have to understand medical terminology. I asked the lecturers not to use abbreviations. Hospital people have the heads up on that. (TNA_2)

(Our TNAs) would be sat in the (classroom) audience and people might have spoken about doing ward rounds and things like that - we don't have ward round; we don't have the luxury of an x-ray department or a doctor round the corner. Initially our guys they really struggled with this, so we had to go back to the university and say this needs to be an inclusive programme; it is not an NHS based programme we have to work together as joined up care services. (SO_1)

I started (the TNA) programme in Sept for first 12 week, I cried, and I cried, and I cried, because it was very NHS based. (T/NA_1)

At the same time, TNAs in social care also require mentoring and pastoral support from their employers and colleagues during this development stage, with the workplace becoming a supportive learning environment for them. Caution is needed in generalising on the availability of such internal organisational support in the sector. There were examples of highly developed learning and development functions, especially amongst the larger social care providers, with the resource and capacity to provide such support. One interviewee from such a provider noted:

I have two practice learning facilitators who work for me who act in a pastoral role, who have a very close contact with the university. They are glue that holds the whole TNA programme together. (CH_1)

Whether that support is available amongst smaller and medium providers is open to debate, particularly relative to the healthcare sector:

Acute colleagues have been doing it (introducing NAs) since 2017. They have got the practice educators, clinical educators supporting whereas that is not evident in a social care setting. It is trying to overcome that isolation and that need for those individuals. (HEE_2)

Another interviewee pointed to the challenge of developing Registered Nurses in social care to provide that T/NA support:

With the practice supervisors and assessors, it is not just funding it is also about availability. In the NHS nurses will be much more familiar with educational scenarios, some nursing homes accept students and get it, but there are more full-time nurses in the NHS and they have a little bit more space let's say to do the educational stuff. They are more likely to have been on practice supervisor, practice assessor, mentor training, possibly as part of their CPD. In nursing homes, the nurses tend to be less confident. They are basically hands on and let's get on with it because here time is limited and focused on what they have to do on the floor. (HEE_11)

As with many of these support activities, much depends on the availability of collective, system-level resources to deliver this mentorship and pastoral help. It is noteworthy that the Devon Placement Coordinator and Greater Manchester Practice Education Facilitator roles had extended to provide social care TNAs with the necessary support. These figures often acted as broker between the university, the individual TNAs and the members to raise and deal with personal issues:

Where we had the educator role in place (at ICS level) it really helped with that synergy between the university, the employer and the apprenticeship team. That individual really coordinated the on-boarding process (to the programme) and where that happened there were less deferrals and breaks in learning. That individual (in the educator role) quickly escalated concerns and worked collaboratively with the university to head off problems. If an individual TNA is out there in practice, feels isolated, and get can't get in touch with the university, it is about someone sitting down and going through the paperwork and offering solution, bringing key individuals together. (HEE_3)

These system level figures also helped social care TNAs organise social media networks and online meetings, providing a degree of mutual support and allowing them to share their experiences, information, problems, and solutions.

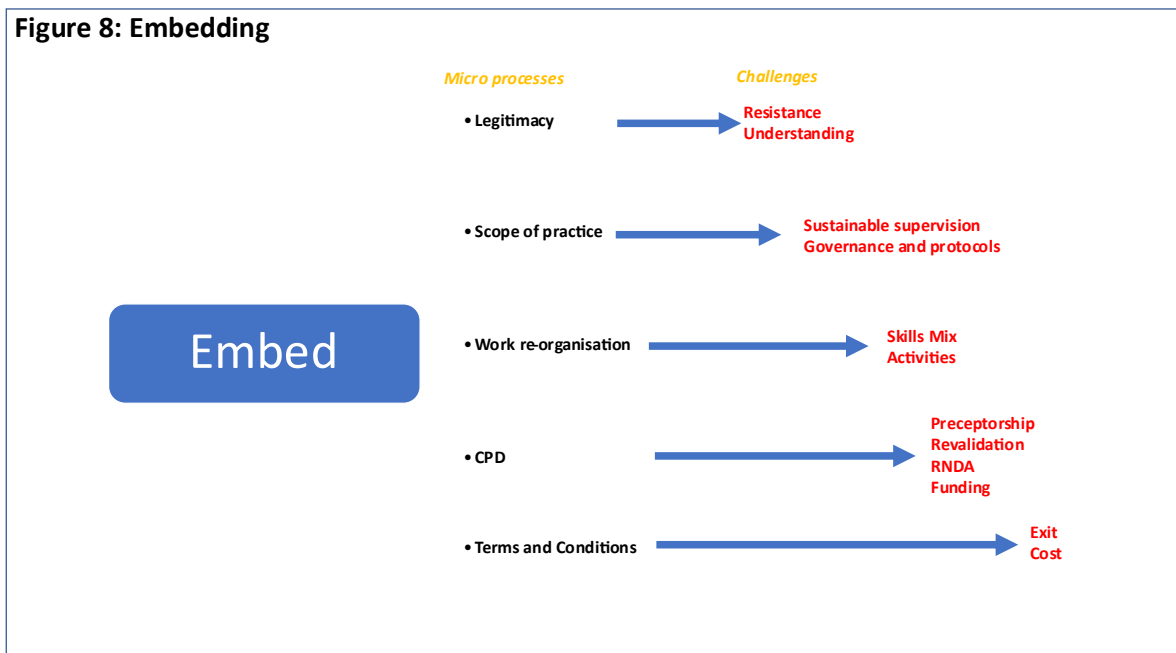
6.3 Pay and Conditions

For the social care provider questions are raised about the terms and conditions of employment of the TNAs participating in the programme. With many TNAs being existing employees, they could

continue on their current employment arrangements. This was the case for the three TNA interviewees who were paid normally even for time at college and on placements. However, with care workers often paid on hourly basis, this is an issue worth exploring in broader terms, further including travel costs and equipment expenses. Instances were highlighted of changes to terms and conditions of employment on becoming a TNA. In one case an existing employee had been asked to move down from their current to the basic apprenticeship pay rate, a move prompting their withdrawal from the programme.

6.4 Embedding

Given the significant challenges faced in engaging with and the developing the T/NA role, there is a danger of social care providers losing sight of the downstream consequences of employing a qualified NA. Certainly, qualification marks an important point of closure for the employer and employee, but it opens a different set of issues centred on how a newly registered professional role is viewed, used, and managed in social care. The embedding stage, covering this post-qualification period, comprises a range of micro-processes and associated challenges. These are set out in Figure 8 below, with each challenge considered in turn.



6.4.1 Legitimacy

The most basic of these micro processes is the newly qualified NA's pursuit of legitimacy: the degree to which the role is accepted by workplace stakeholders - co-workers, managers, and service users - and fully integrated into care delivery routines. In one of the larger, chain providers included in our study, there was initial resistance from care home managers to the TNA, with concerns raised about the dissipation of workforce capacity during TNA training period. However, this resistance fell away post qualification and with experience of the role:

There was a little bit of resistance from (care home) managers: what am I going to get back because I have this staff member going out for a full day to university? Who is going to cover shifts? A mindset change was needed. Now if you speak to our regional directors, they want NAs in all their homes. A mindset change has happened. (CH_2)

There was also some sensitivity as to how the NA role might impact on the jobs of care assistant and senior care assistant. This is reflected in comments from a qualified NA, showing concern about this issue but countering it by highlighting her distinctive contribution as a support to the Registered Nurse:

There is going to be a lot of us (NAs) in our organisation and I don't want us to take over what the senior carers and carers did before. You have people talking and saying well where does that leave me? But the NA role is going to open up things all over. If you are in a nursing home with 40 residents and one nurse on that day, if I was on, that nurse could prioritise what she was doing knowing full well I was here because I have done the NA programme. (HEE_11)

Notwithstanding these glimmers of concern, workplace resistance from co-workers to the NA role in social care appeared limited. This typically reflected hard work on the part of care home managers to ensure the role's integration into the teams, a process eased by the fact that those moving into the role were typically existing employees known and trusted by co-workers. In some organisations, acceptance of the new role also stemmed from the imaginative use of supportive £8,000 per capita funding from HEE to support the introduction of all TNAs (see p7 above). One small care home, for example, had used this money for the continuing professional development of other care staff, a means of building the home's capacity to support and mentor its T/NAs.

As in healthcare, in social care the challenge of legitimacy was manifest less in resistance and more in uncertainty amongst work colleagues about the nature of the role and its contribution to care delivery:

Initially there were teething issues where they (social care providers) didn't necessarily understand the concept of the NA and realise it was a generic role (HEE_11)

Clearly this has implications for workplace communication on and preparation for the role, but it also links to questions of scope of practice: clarity about the tasks the NA postholder can and cannot perform. There was even some uncertainty amongst the TNAs themselves about the tasks they would be performing on qualification:

We got no information about what we were doing, how it is going to end when we pass, what we would do and everything. We just got told there was training, told we'd be between carers and nurses. I thought that is ideal because that's what a leader is about now but this is more qualified so we can do a few new things but we still don't 100% know what we can do once we qualify. (T/NA_3)

6.4.2 Scope of Practice

This uncertainty over the nature of the qualified NA role connects to the broader issue of the NA's scope of practice, and the challenges faced in clarifying and developing it. As in healthcare,²⁴ this being an iterative process, but from a very limited number of T/NAs covered in our study, there were suggestions that the NAs were contributing in new and significant ways to care delivery. A qualified NA stressed their increased contribution to the administrations of medication in a nursing home context:

In social care we appear to be able to do more than an NA on a hospital ward because we are able to give nursing medication and talk to a doctor and say there is something wrong here and doctors listen to us. I am able to do much more clinically than before: your catheterisations and your planning, your antibiotics. Medication calculations is a big one: before we gave what was in a box, whereas now we understand the calculations. In the past when the nurse was calculating we just went 'yes, yes', now we understand and so we are able to back the nurse up ensuring she's got this right. (HEE_11)

A care home manager echoed these comments, while also stressing the NA's contribution to reviewing care plans:

They have a pin (registered NMC) number. They would never be left alone without another nurse direction within the home. If they were to review a care plan they can't evaluate or plan that care. But everything else they can do- administration of medication; there can be involvement in MDT meetings, they can be involved in care plan reviewing. (CH_1)

Other interviewees focused less on specific tasks the qualified NA might (and might not perform) and more on a new NA mindset rooted in a deeper knowledge-based understanding of tasks, which opened the possibility of a more extended scope of practice:

²⁴ Kessler, I., Steils, N., Harris, J., Manthorpe, J., and Moriarty, J. (2021) [NHS Trust Survey 2020 on the Nursing Associate Role: Emerging Findings](#). London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

The challenge has been moving them (NAs) away from task-oriented work to look at evidence based practice, to think about why they are doing things. One TNA said to me I do medication anyway. But do you understand how the drugs work? They are now able to understand what a resident needs whereas before the Registered Nurse had to tell them. (SO_5)

Others stressed how a broadening scope of practice was allowing NAs to take on new tasks, freeing-up the Registered Nurses to deal with more complex clients:

One home wanted to build their workforce to improve nursing delivery, and an NA working alongside RN does that. They have residents with complex needs. The nurse gets tied up with these needs and is not available to do anything else. So to have someone qualified to take on some of those duties, wound care management is a bog standard one, is great. So rather than the nurse do all of those an NA can take on half of them. Assessments take a long time, but the NA can do half of that. It does help to share the workload but also what they realise is the NA is picking up more things: so, noticing deterioration faster and they know what to do instead of running to a nurse. They can do some observations, try positioning to see if that works. Also ringing a GP and saying we have a poorly patient you need to see this patient whereas before everything fell to the Registered Nurse. (SO_5)

At the same time, the development of the NAs' scope of practice in social care within the context of broadly drawn NMC standards of proficiency will depend on the formulation of new protocols, an issue in turn linked to matters of clinical governance. Whether and how social care providers are dealing with such challenges is more of an open question:

When you talk to primary care you have NAs keen to do anything asked of them and in acute hospitals, they are doing all sorts of stuff. In social care we wouldn't know how to governance manage some of that stuff in a risk mitigation way. (HEE_9)

There is a lot of push and pull on what they (NAs) can and can't do, and that's in health settings where you can have those conversations with people who are professionally qualified. Those conversation aren't necessarily happening in social care. It calls for stronger governance. (SO_2)

6.4.3 Work Re-organisation

As the NA's scope of practice evolves and sharpens in social care, so opportunities for re-organisation of work emerge, with new skill mix options for employers, particularly as care needs in communities and homes become more complex, chronic as well as acute:

The NAs really support the RN and they work together. From the nurse point of view, they are discussing patients with the NA, they will be going around supporting them when doctors are around, doing observation but having more knowledge than the care assistant. (HEE_14)

It is about offering a skill mix possibility to the organisation; a bridge between a care worker and a nurse and those enhanced skills. Those enhanced skills are so important because of the acuity of needs within the sector. We need a skilled workforce. This provides both an ability to offer a career but also the right skills mix in the organisation to help them support the needs of the people who (are) resident in care homes. (SO_3)

More specifically, an interviewee drew attention to a care home provider keen for a qualified NA to take responsibility for managing one of three floors in the facility. This was seen as reducing the need for Registered Nurses from three to two:

There is something around them (NAs) being a semi-autonomous professional. In one case, a large provider, they have three floors and normally have two or three nurses covering; they now can have a nurse and 2 NAs. They see it almost as solving their nurse supply situation. (SO_2)

This arrangement was also raised by one of the care home interviewees:

Nursing Associates are actually running a floor and there are no issues or concerns. (CH_2).

As the NA becomes a new element in skill mix, providers will naturally be sensitive to how the CQC views developments, especially in relation to safe staffing (which is less prescriptive in social care than the NHS). The potential re-distribution of tasks between the nurse and the NA also raises questions related to the nature of care delivered by the social care provider. Where the provider can deliver enhanced care with NAs in the skill mix, the willingness of CCGs to commission such care arises (for example as Continuing Health Care²⁵):

You could really increase the sophistication of what care providers can deliver but if they are delivering a health service then the funding needs to follow that person and that is where the CCG need to be involved because it is health funding. (HEE_11)

6.4.4 Continuing Professional Development (CPD)

The personal and organisational challenge of continuing professional development arises following NA qualification. Most immediately, this is manifest in the need to complete a preceptorship programme, a short period of practice training on qualification to consolidate skills. Such a programme is not easily delivered in or by small and medium sized social care providers, with their small number of qualifying NAs. Interviewees highlighted cases of such providers working in

²⁵ [NHS continuing healthcare - NHS \(www.nhs.uk\)](http://www.nhs.uk)

partnerships with neighbouring NHS Trusts allowing newly qualified social care NAs to join their programmes. However, such an approach is not without perceived risks:

Preceptorship is an issue. We haven't worked out what the preceptorship will look like for primary or social care. Trusts have invited NAs, they can join theirs. But only some of that will be relevant, in fact we don't want them to be too Trust inducted because they will leave. (HEE_11)

Our first cohort will qualify next March. This presents new problems because they have to go into preceptorship module. That wasn't factored in to start with. We don't have the infrastructure within (locality name) to get that off the ground. We have linked in with (Trust name) looking at their preceptorship, but the preceptorship was established for them, not for social care. (SO_4)

In the longer term CPD remains important for NAs in part to retain their engagement with the role but more tangibly in the context of NMC re-validation. Social care providers also need to consider their willingness and ability to support their NAs in pursuing their Registered Nurse ambitions. Such support opens up new costs for the employers (backfill costs for the Registered Nurse Degree Apprenticeship are even higher than for the NA apprenticeship), but such support is clearly in line with the 'grow your own nurse' strategy adopted by some social care providers. Moreover, in the absence of such support, employers run the risk of losing their NAs to an employer willing to provide it. Certainly, Cygnet and the larger providers covered in our study - Maria Mallaband and Exemplar - were keen to support their NA into pre-registration nurse training:

We like to think ahead. We have invested 2, years all this money and we have got you to this point, but we want to progress you to that nurse we clearly know you want to be, so we're investing in them again to send them to university for a further two years. (CH_2)

6.4.5 Pay and Conditions

In the absence of a national agreement, analogous to Agenda for Change in the NHS, social care employers will need to consider the pay and conditions of their qualifying NAs. TNA interviewees were all assuming pay increases on qualification, although interestingly all had joined the programme without establishing what this increase would be:

I hope to get a pay increase on qualifying- it will have to be discussed. (T/NA_4)

As hinted at in this comment, from a social care employer perspective NA relative pay is likely to play an important part in the capacity to retain their NA with opportunities at an established pay band 4 level, available in the NHS. The attraction of working in the NHS should not be overstated. Interviewees noted that employees in social care often welcomed their greater opportunity to engage more directly with service users and 'move things along' in delivering care:

Some of our managers were concerned that their candidates were going in and having placements in the NHS and might see it as a more attractive place to work. But then we had people from the NHS coming into social care and saying what they like about it compared to NHS is they were with the clients longer and able (to form) long term relationships with them. (SO_4)

As a check on the qualified NAs' propensity to move to the NHS, the longstanding NA relationship with and commitment to their social care employer should not be understated. Indeed, long serving T/NAs had been able to tailor working arrangements to their personal needs:

I want to see what work will offer me first. If it is not what I want, I'll look to go to the hospital. However, when I finish the course I will be 53. I don't want to be working 12 hour shifts at that age and I want to be able to pick the hours I do. Presently, I can pick and choose the hours to do. I have been told at the hospital it is 12-hour shifts and you don't get to pick your days. I want more home life. This will put me in a better position, open a few more doors for me. (T/NA_2)

However, social care employers do need to offer a competitive employment package not only relative to the NHS but also to other sectors such as retail where wages are also rising, or risk losing the significant costs expended in developing their NAs. Indeed, in a sector with little if any regulation of pay, there is the danger that social care employers might outbid each other in seeking to attract NAs, in an upward wage spiral. The need for a standardisation of pay rates across social care to help address this issue and create a level playing field in pay terms has been periodically raised. For example, some time ago the scope for introducing standard pay rates in social care was raised albeit with no success:

Ages ago we tried to persuade London ADASS (Association of Directors of Adult Social Services) that local authorities should come together and have a common pay and reward structure for NAs, because that has been a big barrier because you can earn more as an HCA, so being able to pay for it is always an issue. So we thought maybe they might be able to set terms and conditions and pay but that didn't get very far. (SO_2)

As well as dealing with labour market issues, the future pay of the NA also assumes importance as a 'fair' reward for the new skills and capabilities acquired by the individual:

They (my employer) said out of courtesy would I stay on for a year at the home after qualifying. I said 'yes' but I want to see what they'll offer me for doing the course. I put a lot in, I deserve something out of it. (T/NA_3)

There is no lack of clarity about benefits (of the NA role) - shortages of district nurses, everyone is stretched for time, we have these people who are going to be really well qualified, they are going to be really good NAs because they are so committed, they know the residents in the home so and they can fulfil the nursing function in their scope of practice. But what we have got to do is work out a system that sustains it rather than leave the care home to pay a higher salary and do aspects of district nurses' and GPs' work and not get any money for it. (HEE_11)

7. OVERVIEW

With the Nursing Associate role launched some five years ago now, attention has principally focused on the role's adoption and implementation in the healthcare sector. This reflects the much lower take-up of NAs in social care but creates a lacuna in our knowledge about and understanding of the role amongst social care providers and employees. This scoping study was designed to 'kick-start' the development of an evidence base on the use and management of the NA role in social care, and to explore whether and how a larger scale study might be taken forward. The central question addressed in this scoping study centred on whether the social care sector faced a specific set of challenges in engaging with the NA role. Placing the findings in the context of our longer-term evaluation of the NA role, concentrating on the healthcare sector, there were many comparable and overlapping findings: similar rationales underpinning interest in the role and shared challenges faced, in terms of the costs and support required to introduce and develop it. However, a very particular picture emerged in social care, with the structural features of the sector and the distinctive application of regulatory requirements, especially those related to T/NA supervision and assessment, helping to account for low take-up and suggesting unique challenges for social care employers.

In this concluding section, the Report:

- summarises the study's findings;
- discusses their implications for policy and practice; and
- considers next steps in research terms.

7.1 Summary

As a scoping study, this evaluation was an exploratory piece of work, seeking to develop a general appreciation of the T/NA role across and at different levels of the social care sector and amongst the diverse range of actors with a stake in it. Such a perspective was reflected in the profile of over 30 individuals interviewed for the study. In part they were drawn from the four regions involved in HEE funded pilot projects, designed to increase the number of NAs in social care, but our project also sought to capture developments in the three other HEE regions. In the process, we captured the views of actors at regional, locality and organisational level, interviewing: HEE and ICS T/NA leads;

figures from support organisations such as care associations; care home managers; and T/NAs themselves.²⁶

The report findings covered: take-up of the role; rationale for its introduction; approaches to its implementation; and the organisational and individual challenges faced. The findings can be summarised as follows:

- **Take-up:**

- There is significant enthusiasm for the NA role amongst social care providers in different care settings, with a general appreciation of how the role might address issues of labour supply and care quality. However, this interest is still not reflected in the take-up of the role in the sector.
- While data on the number of qualified NAs in social care are not readily available, the somewhat tentative figure of 450 'NA jobs' suggests a low take-up in the early waves of TNA recruitment. With the HEE pilots only securing half of the targeted 300 TNAs in social care, adoption of the role in the sector clearly remains limited.
- Organisational size alone does not appear to determine adoption. T/NAs can be found in both large chains and in smaller, independent social care providers: arguably 'where there's a will, there's a way'. While larger providers have the training infrastructure and resources to support the role, decisions on take-up can be lost in diffuse and opaque decision-making procedures. Smaller providers lack the training capacity but can often cut through organisational 'red tape' to take more immediate action to introduce the role.
- More telling was the social care setting. The T/NA role was principally found in nursing homes, less often in residential or domiciliary /home care settings. A registered professional is required to supervise and assess the T/NA, with such professions much more likely to be employed in the former than the latter setting.
- The Covid context has dramatically impacted on adult social care, and this may have affected interest in and engagement with the NA role.

- **Rationales**

As in healthcare, several rationales underpinned interest in the NA, manifest in three main narratives:

²⁶ We acknowledge that we have not included social care service users in this study, but we will consult with our Unit's Patient and Public Involvement and Advisory Group, members of which have already engaged with our NA evaluation work.

- **The labour market narrative:** The NA was seen as a response to various labour market pressures faced by social care providers, including providing experienced senior/ care assistants with a new career opportunity as a means of retaining them; using the NA role as a stepping stone onto pre-Registered Nurse training so supporting a grow your own approach; and using the role to support existing nurses, so reducing stresses on them, improving the quality of their working lives and again encouraging them to stay.
- **The care quality narrative:** As a bridging role, the registered and generically trained NA was able to perform tasks and take on responsibilities beyond the remit of the care assistant and delegated with greater confidence by busy RNs. As the care needs in different social care setting become ever more complex, acute and chronic, the inclusion of NAs in the skill mix and the resultant re-calibration of tasks and responsibilities were argued to produce better quality care.
- **The business case narrative:** For private and possibly third sector social care providers, required to meet financial imperatives, the NA role became a business proposition: a means of changing skill mix, addressing nursing capacity, controlling staff costs and improve care quality to attract clients. However, given challenges faced in introducing the role, the strength of this business case was open to some debate.

- **Positioning**

The introduction of NAs was presented as comprising three main stages - engagement, development and embedding - positioned within a health and social care system comprising many actors with an interest in the role. This raised questions about the contribution made by these different stakeholders to various micro-processes underpinning the implementation of the role. There were examples - administering information and advice and dealing with T/NA funding - where the stakeholders complemented one another, contributing in different ways. There were, however, instances of functional equivalence where the different actors were alternatives to one another, illustrated in the organisation of placements, a task that might be performed by the HEI, the ICS, NA partnership or the employer itself.

Broader questions were raised about how various actors combined to drive and organise the implementation of the T/NA role. Different models centred on:

- The HEI (North and North Cumbria)
- The ICS (London)

- The NA Partnership (West Kent/ Norfolk and Waveney)
- The Local Authority (Devon County Council).

- **Challenges**

Several, cross cutting challenges to the introduction of the NA role in social care were presented:

- **Complexity:** The implementation of a new registered role, with the associated regulatory requirements, is a difficult and extended process.
- **Infrastructure:** In a sector dominated by small and medium sized care providers, the training infrastructure and capacity to support the introduction of the NA role are often lacking.
- **Sector context:** There was a feeling that the NA role had been introduced into the social care sector 'from above', with limited engagement by sector actors in its design and development. It was a role seen as rooted in healthcare and not always sensitive to ways of working and management in the social care sector.
- **The Covid pandemic:** These general challenges had been deepened by the pandemic, self-evidently placing the social care sector under severe pressure, and deterring providers from taking on the role.

A more detailed analysis unpacked the challenges faced by linking them to the micro-processes underpinning the three introductory stages: engagement, development and embedding. The challenges included:

- **Engagement**
 - **Rationale:** Some social care providers, especially the larger ones, saw no need for an NA given their use of Care Home Assistant Practitioners. This was the case even though CHAPs are unregistered workers, completing a training programme rather than achieving a degree level qualification.
 - **Information and advice:** Social care providers, and indeed T/NAs, faced a steep learning curve in fully appreciating the nature of the new role, and the requirements associated with an apprenticeship qualification. With many social care providers, often geographically dispersed, such communication could prove difficult, encouraging the use of representative bodies and their established networks.

- **Funding:** For social care providers faced with financial pressures, the costs associated with the T/NA role could be intimidating. A template costing put the net cost of introducing the role in social care at over £43,000, largely made up of the backfill costs associated with covering for the TNA when off-the-job at college and on placements.
 - **Education providers:** For social care employers unused to dealing with HEIs, finding one to deliver the TNA programme and understanding respective commitments could be difficult.
 - **Recruitment:** As in healthcare, TNA applicants, often many years out of formal education and without formal qualifications, were often not programme ready. Such individuals needed to develop study skills and more tangibly achieve the Level 2 functional skills required to take a Level 5 qualification.
- **Development**
 - **Placements:** At the core of the TNA programme, the organisation of the three or four placements in different care settings was a major challenge for social care providers. Approaches varied but participation in reciprocal arrangements with other employers could be difficult for social care providers. They had not always been fully involved in the ICSs and NA partnerships, often the site for organising such arrangements. They sometimes had to convince healthcare employers of the value of a social care placement. It was not always easy for them to offer reciprocal placements at the scale required.
 - **Supervision & Assessment:** The absence of a registered professional to practice supervise and assess T/NAs created particular challenges in residential and domiciliary/home care settings. It was a challenge being addressed in several pilot projects centred on collaborative and peripatetic supervisory and assessment arrangements, but these required close attention to detailed technical issues, including accountability, sustainability and cost.
 - **Academic/Pastoral Support:** With the two-year TNA programme a challenging experience for participants with multiple responsibilities and pressures, ongoing support for them during this period from both the HEI and employers was seen as crucial but occasionally difficult to co-ordinate.

- **Pay and Conditions:** As existing employees with the providers, TNA typically remain on their previous pay and conditions during training, but where pay is reduced during this period the TNA may find it difficult to manage.
 - **Embedding**
 - **Legitimacy:** There was a residual degree of uncertainty, especially amongst workplace stakeholders, on the nature of the NA role and its positioning within care delivery.
 - **Scope of Practice:** This is not to detract from an appreciation amongst stakeholders about the NAs' scope of practice and how it might contribute to care provision. In general, there was a clear sense of how NAs might perform tasks to support the RN, opening-up new skill mix options for the employer. However, questions remained about the development of new care protocols, linked to issues of clinical governance.
 - **Work re-organisation:** The introduction of the NA role opens-up new skill mix options for the social care provider. However, matters related to safe staffing emerge as well as sensitivity to how the CQC views such options.
 - **CPD:** In seeking to address the challenges of introducing the NA role, employers risked losing sight of the downstream training and development needs of the qualified NA. As in health²⁷, there were signs of T/NAs keen to use the role as a stepping-stone into registered training, opening the employer up to new costs and investments. But even for qualified NAs, in-role development became crucial, partly in supporting the postholder as their scope of practice evolves, but also in ensuring re-validation with the NMC.
 - **Terms and Conditions:** Social care employers faced the challenge of providing pay and conditions with the capacity to retain qualified NAs. With terms of employment largely unregulated across the social care sector through collective agreements, employers needed to prevent NAs from being drawn away by higher pay to other sectors or indeed to other parts of the health and social care sector.

²⁷ Kessler, I., Steils, N., Harris, J., Manthorpe, J., and Moriarty, J. (2021) The Development of the Nursing Associate Role: The Postholder Perspective. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

7.2 Discussion

This report has raised a diverse range of challenges to the introduction of the NA role in social care. A number of such challenges derive from the structure of the sector, as well as the ways in which social care services are delivered and funded, and, as a consequence, raise fundamental questions beyond the remit of this study. Within the context of this report, there is scope to systematically discuss the challenges raised, a process which would clearly benefit from the involvement of a variety of stakeholders. In this sub section, however, attention is given less to specific challenges than to ongoing and suggested interventions or practices raised by interviewees, which touch upon, perhaps address some of them:

- **Training infrastructure:** A fragmented model of service provision based on many thousands of small and medium sized provider organisations renders it difficult to establish the training infrastructure needed to support the introduction of the NA role. Various interviewees pointed to the importance of wrap-around support, but questions remain about what form this support might take, where in the system it might sit, and how it might be funded. Most striking was the need to support the provision of T/NA supervision and assessment, especially in residential and domiciliary/home care settings, as well as in nursing homes lacking the necessary capacity. Such support was essential to the Trainee NA, although with NAs supervised by Registered Nurses, it is also required post qualification. Pilot steps toward dealing with such an issue were highlighted, with instances of the collective provision of shared practice educators and facilitators. In more general terms, various bodies, particularly HEE, often provide such infrastructure support. However, HEE support is typically time limited and does not extend beyond NA qualification. The role of Skills for Care might be further explored given their experience of support for social workers post qualification.
- **The ICS space:** There is scope to review the role played by the ICS in the introduction and development of the NA role. Cases were highlighted where the ICS was at the fore in taking forward the NA agenda, but practice varied, with: an unevenness in the inclusivity of the ICS to social care employers; uncertainty about the relationship between longstanding NA partnerships and ICSs; and a lack of clarity of where lines of accountability for the NA programme in social care lay.
- **Financial support:** With cost being one of the more significant challenges, questions are inevitably raised about whether there is scope for supportive funding, perhaps analogous to the Additional Roles Reimbursement Scheme in the NHS. This scheme covers the whole of the T/NAs salary, but a less expensive scheme might cover the 40% backfill cost of the TNA.

The costing we drew upon in this report suggested that over the two years of training, these backfill costs came to £22,464 per TNA: to cover these costs for 100 TNAs would be £2.5 million and for 500 TNAs, £11.2 million.

- **Regulated pay and conditions:** There are also cost implications from the pay rises NAs might expect to see following qualification and registration. In gauging an NA pay rate, the most obvious point of reference is NHS Agenda for Change with NAs being graded at Pay Band 4. With the average senior care assistant earning £19,200 per year,²⁸ there is a shortfall of £3,348 with the bottom of AfC Pay Band 4 at £22, 548. To fill this gap by paying an AfC Pay Band 4 for 100 NAs would cost £334,800; for 500 NAs, £1.7 million. But here the issue is not so much about cost as finding ways to bind or attract independent employers, not party to a collective agreement, to paying such a rate.
- **Clinical Commissioning:** As the NA role contributes to the upskilling of the social care workforce and, by implication, the delivery of enhanced care in various settings, issues of financial return to the provider for this care emerge. Such returns are likely to feed into the provider business case for the role, and rest on Clinical Commissioning Groups/ICSGs becoming more involved in the conversation on NAs.
- **Local authorities and partnerships:** Local authorities have been seen to play a key role in the development of the NA role. In some cases, as in Kent, the council has represented social care providers on an NA partnership and in others, such as Devon, provided direct funding to subsidise employer training costs. However, the involvement of council adult social care departments in the development of the NA role has been patchy at best. With local authorities sometimes keen to secure care home with nursing places from providers and to encourage home care provision, they are unlikely to introduce conditions into commissioning contracts, designed, for example, to prompt employers to take up the NA role. It might, however, be argued that local authorities share an interest in retaining nursing capacity and therefore places in care homes or specialist skills in home care that can assist with reablement or end of life care, still raising questions therefore about how they might be stimulated to support the introduction of the NA role more widely.
- **Dedicated roles:** Dedicated roles to support TNA programmes have been key to the development of the role. Typically appointed at systems level, these roles have performed different functions: helping to arrange placements, acting as a broker in HEI-employer-trainee relations and providing pastoral support for the TNAs. Whether such roles are widely used is open to question. Moreover, they remain fragile in terms of their sustainability, often

²⁸ [The State of the Adult Social Care Sector and Workforce 2021 \(skillsforcare.org.uk\)](https://www.skillsforcare.org.uk) p. 95

being funded on a short-term, time limited basis running the risk that learning is lost and relationships have to be created anew.

- **Wider agendas:** Although not raised directly in many of the interviews the development of NAs in social care could contribute to wider policy commitments to developing skills and tackling inequalities. As noted by many, social care employees have not had much access to (academic) education and NA development could help address the skills gap in the sector which is largely female dominated and has substantial proportions from marginalised groups.

7.3 Next Steps

Originally this piece of work was commissioned as a study to scope a more detailed follow-up project on NAs in social care. Hopefully the present study has generated key themes and issues, and established links to be built upon in any further evaluative activity.

There are limitations to the current study, with scope to address them in a follow-up piece of work:

- The current study has principally remained at the level of the regional care systems, providing an overview of development and issues. With only four social care managers interviewed, there may well be value, perhaps through case studies, in drilling down to organisational approaches to the NA role.
- More broadly, in focusing on only a small number of social care providers, it remains open to conduct a large-scale survey to capture views and practice in relation to the role (access to providers permitting).
- We spoke to very few T/NAs and in a limited range of social care settings. Again, there is scope to seek the views of a larger number of T/NAs, in more diverse settings, and indeed seek the opinions of workers yet to engage with the T/NA role at all.
- The views of service users and carers, and their representatives, have not been heard and would be an important part of any future work.
- There are themes and issues which might usefully be pursued in greater depth in social care, for example:
 - o approaches taken by different ICS to taking forward the NA role;
 - o initiatives to develop and implement collaborative and arms-length supervisory arrangements in residential and domiciliary/home care settings;
 - o approaches to the management of placements; and
 - o the HEI-employer-TNA interface.

It is worth discussing the value of pursuing one or more of these different options. It might, however, be argued that the current scoping study has served its purpose, providing a platform for the development of future policy and practice. Arguably a degree of saturation has been reached, with further work unlikely to generate many new themes and issues. Any decision on next steps is perhaps contingent on how the current report is viewed, and whether it has served its purpose.

Annex: List of Interviewees

Pilots

1. HEE Senior Clinical Lead (Nursing and Midwifery) EoE
2. STP Clinical Educator Norfolk and Waveney Health and Care Partnership
3. Social Care Careers Ambassador Norfolk and Suffolk Care Support
4. Chief Operating Officers, Norfolk and Suffolk Care Support Ltd
5. HEE Senior Programme Lead Midlands
6. HEE Midlands Regional Clinical Lead- Nursing
7. West Midlands Care Association
8. NA Maria Mallaband Care Home Group
9. Head of Learning Maria Mallaband Care Home Group
10. Workforce Lead for Nursing and Midwifery NE/York HEE
11. Head of Nursing. Exemplar Health Care Services Ltd. South Yorks.
12. Great Manchester Project Lead TNAs Social Care
13. Workforce Lead Nursing and Midwifery, NW and NW TNA Lead

Non-Pilot

14. TNA Project Lead out of hospital setting Southeast London ICS
15. Nursing and Midwifery, Programme Manager, HEE London Region
16. Apprenticeship Lead, Northeast London ICS
17. Richmond Training Hib Southwest London ICS TNA Lead (out of hospital)
18. Care City
19. Sfc Head of Area London and SE
20. Sfc Locality Manager: Sussex link lead role for nurses in social care
21. Sfc Senior Locality Manager: London
22. Registered Care Home Manger Bridge Side Lodge
23. Care Home Manager DCC
24. TNA Devon
25. TNA DCC
26. TNA DCC
27. HEE Deputy Chief Nurse SW
28. HEE Workforce Lead, Nursing and Midwifery, SW
29. Skills for Care Head of Area SW
30. Clinical Placement Expansion Programme Lead, Sentinel SW Community Interest Company
31. Placement Development Facilitator DCC
32. Director Institute for Health and Social Care, Bucks New University
33. HEE Workforce Transformation Lead SE
34. Care Sector Workforce Manager Adult Social Care and Health Kent CC

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