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**IMPLEMENTATION OF THE  
NURSING ASSOCIATE ROLE IN  
GENERAL PRACTICE:  
FIVE QUALITATIVE CASE  
STUDIES IN ENGLISH  
PRIMARY CARE**

A H Y TOPPING

DBA

2023

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FIVE QUALITATIVE CASE  
STUDIES IN ENGLISH  
PRIMARY CARE**

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A thesis submitted in partial fulfilment  
of the requirements of the  
University of Northumbria at Newcastle  
for the degree of  
Professional Doctorate

Research undertaken in  
Newcastle Business School

March 2023

## **Abstract**

Workforce shortages in the NHS are an on-going challenge, particularly in nursing and primary care. In response, the government introduced initiatives aiming to expand the numbers of Registered Nurses in primary care. One of these is the introduction of the Nursing Associate (NA) role in England. To date, there is limited empirical evidence as to how the role has been implemented, and none that has focused on primary care.

This research study has investigated how, why and to what extent the NA role has been implemented in general practice. Through qualitative comparisons of five case studies in the North East of England, the enablers and barriers for role change and institutionalisation have been examined.

Semi-structured interviews and focus groups were conducted with stakeholders: NAs, General Practitioners; Managers (practice or nurse); and Nursing Teams. Template analysis with a priori themes was used to analyse the data.

Research findings show key themes of implementation challenge: (1) role clarity and place of new role; (2) role identity and transition; (3) tension at professional boundaries; (4) education and training gaps; and (5) future of the new role in terms of demonstrating added value and additional impact. The research concludes that NAs are not at this early stage able to fill the skills gap.

This study makes contributions to practice. It is the first of its kind to research the NA role in general practice and has also filled evidence gaps in under-researched areas, namely new work roles in healthcare and primary care. The study also has made potential contributions to institutional theory. It has tested the Elaborated Institutionalisation Model for new work role (Kessler et al., 2017), and suggested a 'modified' version for further research.

Finally, the study has made 16 recommendations for professional practice at both policy and organisation levels in four areas: education and training programme; professional identity; development for GP practices; and communication. There are

opportunities to enhance the quality assurance system for educational providers and ensure the curriculum and clinical placements are meeting the needs of primary care. Primary Care Networks (PCNs) are well placed to influence the current gap in the provider market for topic-based training specifically for NAs.

More could be done by the Integrated Care Boards and PCNs with GP practices to provide clarity to NA role and construct a professional identity. These include a generic job description, consistent scope of practice, and reduction of the overlap with the Healthcare Assistant role. Peer support network and preceptorship programme are also key to developing the new role as well as the identity of individuals. GP practices should be supported to develop their capabilities and capacity in change management and workforce planning.

Looking ahead, the possibility for NAs to administer medications under a Patient Group Directive should be explored. A national and regional media campaign is critical to raise public and professional awareness of the new NA role.

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## **List of abbreviations**

ARRS	Additional Roles Reimbursement Scheme
CAQDAS	Computer-assisted qualitative data analysis software
CCG/s	Clinical Commissioning Group/s
CCG/s	Clinical Commissioning Group/s
COVID	Coronavirus pandemic
DHSC	Department for Health and Social Care
DoN/s	Director/s of Nursing
EIM	Elaborated Institutionalisation Model
EOI/s	Expression/s of interest
FYFV	NHS Five Year Forward View
GP/s	General Practitioner/s
GPFV	General Practice Forward View
GPN	General practice nurse / nursing
HCA/s	Healthcare assistant/s
HEE	Health Education England
HEI/s	Higher Education Institution/s
HRM	Human Resource Management
HRMI/s	Human Resource Management Innovation/s
ICB/s	Integrated Care Boards
IR	International recruitment
ITR	Interview Transcript Review
JD/s	Job description/s
LTP	NHS Long Term Plan
NA/s	Nursing associate/s
NE	North East
NHS	National Health Service
NHSE	NHS England
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NM/s	Nurse Managers
OECD	Organisation for Economic Co-operation and Development
PCN/s	Primary Care Network/s
PGD/s	Patient Group Directive/s

PIS	Participant Information Sheet
PM/s	Practice Manager/s
PN/s	Practice Nurse/s
PSD/s	Patient Specific Directive/s
RN/s	Registered Nurse/s
SEN	State Enrolled Nurse
TNA/s	Trainee Nursing Associate/s
UK	United Kingdom
WTE	Whole time equivalent

## **Acknowledgment**

Undertaking the DBA has been a significant milestone of both my professional development and academic journey so far. The study was carried out during the COVID pandemic and this brought further challenges.

Firstly, I would like to say a big thankyou to the five GP practices and 29 participants for giving me their precious time and sharing their experiences with me. The inputs from participants are always gratefully received by researchers, but in particular, this was during a very busy time in the health service and GP practices were under immense operational pressure. Their strong commitment to support the discovery of evidence in this very important area should be highly commended.

Secondly, I would like to thank my colleagues for their support, advice and encouragement to me during the study. There are too many to name, but I want to mention Lesley Young at the Health Education England (North East and Yorkshire), and Dr Shona Haining and Helen Riding in the Research & Evidence Team at the North East Commissioning Support Unit. I am also grateful to NHS Northumberland Clinical Commissioning Group for giving me some study leave towards the completion of the DBA. There is also the practical advice and guidance from Dr Meaghan Grabrovaz at the University of Northumbria and Dr Lynn Craig my nursing colleague to get me started on the data analysis process.

The advice and feedback from my Principal Supervisor Professor Dr Hannah Hesselgreaves and second supervisor Dr Claire Hedley had kept me on the right track, with patience and encouragement throughout this journey.

I am extremely grateful for the Professional Bursary awarded by the Royal College Nursing Foundation towards my DBA, and also a funding contribution from the NHS England (North East and Yorkshire) to my professional development.

Finally, I would like to thank my family for their strong support. I dedicate this research to the memory of my father who would have been proud to see my achievements.

## **Declaration**

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through my submissions to Northumbria University's Ethics Online System on 28 July 2020 and NHS Health Research Authority on 14 October 2020.

**I declare that the Word Count of this Thesis is 57,941 words**

**Name: Annie Topping**

**Date: 27 June 2023**

## **Chapter 1 Introduction**

### **1.1 Introduction**

Workforce shortages and challenges in the National Health Service (NHS) are under constant spotlight for different reasons, often related to an adverse impact on service delivery and patient safety (Buchan et al., 2020; Rolewicz et al., 2022; Shembavnekar et al., 2022). The COVID pandemic has also increased demand on healthcare and put additional pressure on the NHS (Shembavnekar et al., 2022). However, the underlying chronic issue remains, and is an area of concern for politicians, policy makers, public managers, and think tanks. In particular, a number of critical workforce issues have been repeatedly identified in recent years, and the constant impact of staff shortages in nursing and general practices has been highlighted (Buchan et al., 2019; Shembavnekar et al., 2022). In addition to the quality challenge, there is also the innovation agenda. As well as new ways of working, new work roles have the potential to fill skill gaps and meet service demands. However, changing skill-mix is not without its challenges. Empirical studies and systemic literature reviews highlight a range of implementation barriers related to organisational and/ or operational factors associated with the introduction of new work roles (Nelson et al., 2018; Nelson et al., 2019; Sibbald et al., 2004; Spooner et al., 2022; Wismar et al., 2022). It follows that attention to the implementation process is necessary in order to realise the desirable outcomes of changing skill-mix in the NHS.

This study seeks to examine the implementation process of the Nursing Associate (NA) role in GP practices and understand how it is introduced and established. NA is a new role for the nursing profession, and one of the non-medical clinical roles being introduced into primary care as part of the Additional Roles Reimbursement Scheme (ARRS). By qualitatively comparing the experiences of five GP practices in the North East (NE) of England, common implementation barriers and impacts are identified. In turn, this offers transferrable learning for stakeholders, such as primary care clinicians, education commissioners, higher education institutions (HEIs), Integrated Care Boards (ICBs), Primary Care Networks (PCNs) and general practice staff who may be involved in the introduction of new work roles.



This study adopts the lens of institutional theory to understand the implementation process of the Nursing Associate role. Institutional theory enables an understanding of organisations from a sociological perspective (Beckert, 1999), and is considered to be a good fit for the NHS with its large workforce. Analysis and discussion of the findings will utilise the Elaborated Institutionalisation Model (EIM) for a new work role developed by Kessler et al. (2017) as a framework, which is also underpinned by the institutional theory. The intention is that the findings of this research will contribute to the knowledge of Human Resource Management Innovation at both policy level (macro) and clinical practice level (micro), as well as ongoing work on changes of skill-mix in primary care.

The remainder of this introductory chapter provides the context and drivers for skill-mix change in the NHS, followed by some background on the NA role.

## **1.2 Context for change**

In 2020/21 the Department for Health and Social Care (DHSC) spent £192 billion on a range of health and care services commissioned by the NHS and public health (TheKing'sFund, 2022a). The NHS is the largest employer in the United Kingdom (UK) and indeed, one of the largest employers in the world. As a result, expenditure on workforce is a significant component of NHS spending and the primary driver of healthcare cost (Addicott et al., 2015). In 2019/20, the total cost of NHS staff was £56.1 billion which amounted to 46.6 per cent of the NHS budget (TheKing'sFund, 2022a), excluding salaries for General Practitioners (GPs) or employees from the DHSC and other national bodies, such as NHS England and NHS Improvement. Therefore, there is a need to ensure this resource is used effectively, and the right people with the right skills are caring for patients/service users in the most appropriate settings. Against a backdrop of an ageing population and reducing supply (which will be discussed below), it is more important than ever that the NHS is able to make the best use of all the skills and experience of its current workforce to provide the care needed.

In addition to the financial and demographic reasons, there are also other key health policies in recent years pushing forward the healthcare reform and innovations agenda. This is because despite medical advances and technology, healthcare delivery remains highly labour intensive and dependant. Together these policy drivers shape the workforce development in the NHS in general and more specifically, in primary care.

The NHS Five Year Forward View (FYFV) (NHSE, 2014) sets out how the health service should change over the next 10 to 15 years. The focus is on public health and disease prevention, and to closing the widening gaps in the population's health, care quality, and service funding. It describes services that are to be delivered through integrated flexible models of care close to people's homes. This vision reflects the needs of an aging population where advances in treatments and technologies have kept people living longer, but with complex co-morbidities. To deliver this ambition, the NHS requires a workforce with the appropriate skills and knowledge that is centred in primary and community care (Addicott et al., 2015).

This was followed by the General Practice Forward View (GPFV) (NHSE, 2016), intended to be a blueprint for service transformation in primary care. The government promised an increase in funding as well as an expansion in workforce capacity: a net increase of 5,000 extra GPs by 2020 (compared with 2014), and a minimum of additional 5,000 non-medical workforce, including nurses, pharmacists, physician associates, mental health workers and others. There was also a general practice nurse (GPN) development strategy, with an extra minimum £15 million national investment including improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for return-to-work schemes. This document underpinned later development of other operational frameworks aiming to support the expansion of the primary care workforce. They include the Network Contract Direct Enhanced Service and ARRS which will fund 26,000 additional staff till 2023/24 (NHSE, 2020).

The NHS Long Term Plan (LTP) (NHSE, 2019b) continues the themes of service redesign and reform and specifically references a growth of nursing apprenticeships

with 7,500 new NAs starting in 2019. This plan has actioned the recommendation in the Raising the Bar: The Shape of Caring Review (HEE, 2015), and is the first time where the commitment of developing the new role of NA was included in the NHS planning guidance. Moreover, the plan also committed to provide the necessary investment in training to create meaningful career ladders for these staff to develop and progress, echoing the recommendations to allow care assistants to move easily into the nursing profession without having to give up their employment.

The Interim NHS People Plan (NHSE, 2019a) builds on the service transformation agenda in the NHS LTP and sets out the workforce requirement. In addition to the growth in numbers, there is a strong emphasis on a transformed workforce with a different and richer skill mix, new types of roles and different ways of working. Primary care nursing is stated as one of the areas with most vacancies and shortages, and development of NA is cited as one of the strategies for a domestically grown workforce. The plan sets out a multifaceted strategy to increase the supply and improve retention of nurses, with an ambition to grow the nursing workforce by over 40,000 by 2024.

### **1.3 Primary Care Nursing Workforce**

As at 31 July 2022, there are over 1.2 million full-time equivalent (FTE) staff working in the NHS Hospital & Community Health Service (HCHS) (NHSDigital, 2022). This figure equates to around 1.4 million people as headcount (Shembavnekar et al., 2022). Professional qualified staff make up over half (52.4%) of the workforce, equivalent to 642,608 FTE. It is also estimated that there are nearly 100,000 vacancies in the NHS (hospitals and in the community) as of Q2 2021/22, including more than 8,000 medical professionals and nearly 40,000 nursing staff (TheKing'sFund, 2022a). However, all the above figures do not include GPs, GP practice staff and other primary care providers such as dentists and opticians. This is because this group of the workforce is not on the NHS Electronic Staff Record which is a payroll and human resources system.

As of December 2021, there are around 149,000 FTE of staff working in the primary care or general practice (Shembavnekar et al., 2022). Table 1 shows the key general practice staff and the size and numbers of each group.

**Table 1: Key general practice staff groups (Adapted from Shembavnekar et al., 2022)**

	<b>Approximate percentage of the workforce*</b>	<b>Approximate numbers* (FTE)</b>
GPs	24%	36,300
Nurses	11%	16,500
Direct patient care staff (covers a range of registered and unregistered roles e.g. healthcare assistants)	16%	23,800
Administrative or non-clinical staff (covers a range of roles including receptionists and practice managers)	49%	72,500
<b>Total</b>	<b>100%</b>	<b>149,100</b>

\* As of December 2021

The direct patient care staff group has grown significantly between 2019 to 2021 particularly, due to the introduction of ARRS (Shembavnekar et al., 2022). This is in part a response to GP and nursing shortages in GP practices. These funded roles include clinical pharmacists, first contact physiotherapists, paramedics, physician associates, dieticians, occupational therapists, nursing associates and trainee nursing associates. It also includes those that are not funded via ARRS, and they are mainly healthcare assistants (HCAs), phlebotomists and dispensers.

The general practice workforce has been identified as an area under significant strain due to consistent staff shortages and high workload over the past decade (Shembavnekar et al., 2022; TheKing'sFund, 2022a, 2022b). The demands of COVID and post pandemic recovery has further exacerbated the long term issue (TheKing'sFund, 2022b). Despite the expansion plan to recruit many more additional GPs, there is evidence to show the numbers of GPs working in the primary care as fully qualified and permanently employed clinicians continues to fall (Buchan et al., 2019). This has a knock-on impact on other clinicians in the primary care teams including nurses. A recent report by The Health Foundation also raises further concerns of general workforce supply and projects a persistent shortage of GPs and GPNs (Shembavnekar et al., 2022).

There are more than 771,000 nurses, midwives and nursing associates on the NMC register as at September 2022 (NMC, 2022). Despite a year-on-year increase in the numbers of registrants, nursing workforce shortage in general is a growing challenge in the UK and increases pressure across the NHS. A report (HealthCommittee, 2018) published by the House of Commons on nursing workforce recognised that the nursing profession is overstretched and struggling to meet demands, and that the workforce needs to be expanded at pace and at scale. In comparison, the UK has below the Organisation for Economic Co-operation and Development (OECD) average of nurses per head of population, as well as training many less (Charlesworth, 2017). Moreover, the UK also ranks below the average of OECD countries for numbers of practising nurses and the annual number of new nurse graduates relative to its population (Buchan et al., 2020; Shembavnekar et al., 2022). Registered Nurses (RNs) accounted for around 45% of FTE vacancies of all staff groups in the NHS in June 2020 (Buchan et al., 2020). Together with an aging profile of the current NMC registrants with over 21% of them aged 56 years or above and another 12.9% between the age of 51 to 55 (NMC, 2022), they illustrate the scale of nursing shortages in England.

In response to this challenge, a commitment has been made by the government as part of its 2019 election manifesto to increase the number of RNs working in the NHS in England by 50,000 by 2024/25 (Buchan et al., 2020). This is 10,000 more than the earlier target in the Interim People Plan. Despite the projection that the government is largely on track to meet the 50,000 due to its large international recruitment (IR) programme, it is still not sufficient to address the projected demand for RNs for the rest of this decade (Shembavnekar et al., 2022). Moreover, IR programmes in the NHS tend to be utilised by hospital trusts and the additional staff recruited have made no / little impact on primary care nursing.

Alongside with other patient care staff, RNs play a vital role in service delivery in primary care. In 2018, NHS England published a five-point action plan aiming to improve recruitment and improve retention in general practice nursing. Despite that, a recent report remains pessimistic about the future supply and projects a persistent of shortage of GPNs in the coming years (Shembavnekar et al., 2022). With the numbers of GPs working in primary care as fully qualified continuing to fall

(Buchan et al., 2019), this has a knock-on impact on other clinicians in the primary care teams, including nurses.

As at December 2021, there were around 16,500 FTE of GPNs. The biggest group was practices nurses (68%), followed by advanced nurse practitioners (24%). Most of the nurses are women and over 4 in 5 work part-time. Overall they also tend to be older than those working in the HCHS, and 67% of the headcount is aged 45 or older (Shembavnekar et al., 2022). Between 2017 and 2021, the number of advanced nurse practitioners has grown by 23% from 3,200 to 3,900 (Shembavnekar et al., 2022). The continuing GP shortage is likely to have contributed to this situation, with more tasks delegated to the nursing team. On the other hand, a number of assistive roles have been introduced to complement and support the nursing team in recent years. This leads to a continuing dilution of overall skill mix of the nursing team, and a widening gap of growth between FTE nursing support staff and RNs (Buchan et al., 2020). This situation of changing skill mix is discussed further in Chapter Two.

#### **1.4 What is a Nursing Associate?**

*‘A Nursing Associate is a member of the nursing team in England that helps bridge the gap between health and care assistants and registered nurses.*

*Nursing Associates work with people of all ages, in a variety of settings in health and social care. The role contributes to the core work of nursing, freeing up registered nurses to focus on more complex clinical care.*

*It's a stand-alone role that also provides a progression route into graduate level nursing.’*

(NMC, 2020)

The NA role currently only exists in England and is regulated by the Nursing Midwifery Council (NMC). The 2-year training programme is at foundation degree level and it includes both academic and work-based learning. During the training, the learner (referred to as the TNA) is working to a supervising nurse. The first cohort of TNAs began training in 2017 and qualified in January 2019.

There is no standard job description (JD) for NAs as the scope of the role is dependent on areas of practice. However, NMC provides the 'standards for nursing and nursing associate programmes' which sets out what a NA should know and be able to do. In addition, guidance is also available from Royal College of Nursing (RCN, 2020) and NHS Employers (NHSEmployers, 2020) to support employers (including GP practices) to prepare a JD for their area of delivery.

The NA training programme prepares trainees to work with people of all ages and in a variety of settings. Training can be either direct entry or through an apprenticeship, with apprenticeship still the most popular route. Due to the work-based nature of the apprenticeship training, the programme attracts a diverse group of adult learners from a range of settings across health, social care and voluntary sector. For the cohorts up to now, most of them are healthcare support workers / HCAs.

There are currently two providers offering the NA programme in the NE: Teesside University and The Open University (OU). Teesside University has been running this programme since 2017 and was part of one of the 24 second wave test sites / partnerships selected to implement the NA role. The OU first commenced a programme for NA in 2018 in the South and East of England, and then rolled this out to the rest of the country including the north of England in 2019.

If the programme is delivered via the apprenticeship route, it is funded by the employer. For the larger organisations such as hospital foundation trusts (FTs), the apprenticeship levy can be used to pay for the training fees. For small and medium organisations such as GP practices, 95% of the cost may be funded but this would rely on HEIs having non-levy places and registered to accept non-levy places. In this case, the employer would need to pay for 5% only (this was £750 as at November 2019). Levy transfer of unspent funding from FTs may be available at year end, but this would need to be arranged on an individual basis.

Some HEIs are approved by NMC to provide self-funded programmes and these would be paid for via the student loans system. Ad hoc incentives / funding had been made available to encourage uptake, and a total funding of £8,000 over two

years per TNA were offered by HEE for any trainees starting on programme between April 2021 and end of March 2022.

#### 1.4.1 The introduction of the NA role and its strategic purpose

The development of the NA role is in response to 'The Shape of Caring' Review (HEE, 2015), carried out by Lord Willis. The report intended to create a significant shift within the nursing and care workforce, to support delivery of high-quality care over the next few decades. There are 34 recommendations in the report, and recommendation 8 refers to '...a defined care role (NHS Agenda for Change band 3) that would act as a bridge between the unregulated care assistant workforce and the registered nursing workforce' (p63). This is where the inception of NA begins.

**Figure 1: Timeline of development of the Nursing Associate Role in England**

<b>2015</b>	Willis review (Health Education England, 2015) proposes developing a new role to bridge the gap between the registered and non-registered nursing workforce HEE agrees to pilot a “senior healthcare assistant role”
<b>2016</b>	HEE calls for volunteer sites to test the new role, termed nursing associate
<b>2017</b>	First students enter nursing associate training Nursing and Midwifery Council (NMC) agrees to regulate nursing associates Nursing Times reports “hostility” to the role in Scotland, Wales and Northern Ireland Government sets target of 5,000 trainees in 2018 and 7,500 per year from 2019

In 2016, HEE called for volunteer sites/partnerships to test the new role. Each site consisted of a lead partner, education partner/s, employment partners and placement partners, and a total of 11 sites were selected to provide training for 1000 NAs. In January 2017, the NMC agreed to become the regulator for NAs after a request by the then Secretary of State for Health and Social Care the Rt Hon Jeremy Hunt MP (NMC, 2018). In the same year, 2,000 TNAs started their training at 35 sites as part of an HEE pilot. In October 2017, the Health Secretary announced an expansion of the training programme, with plans to see 5,000 NAs commence training through the apprentice route in 2018 and 7,500 in 2019 (Halse et al., 2018). Currently there is no



NA programme in the rest of UK except England. A summary of the timeline of development is provided in Figure 1.

The introduction of NAs has three policy intentions: (1) To provide a new route into nursing; (2) To fill the skill gaps between HCAs and RNs; and (3) To retain a motivated workforce. Amongst other strategies to address the supply and demand gap in the Interim NHS People Plan (NHSE, 2019a), one focus is to grow the domestic supply by providing a clear progression pathway into nursing and the NA qualification is one of the additional entry routes. It offers a stepping stone and a career framework to facilitate those in care support roles to progress into nursing careers. There is also the wider objective to address other issues of nursing shortages, and it is intended that NAs will fill the skill gaps between RNs and HCAs (Halse et al., 2018). By offering a career progression for the skilled HCAs, the third aim is to retain experience and lead to a motivated workforce .

**Table 2: Table 2: Breakdown of national target - Trainee Nursing Associates by region (June 2021)**

Region	North West	North East & Yorkshire	Midlands	East of England	London	South West	South East	Total
Capita % of total Population	12.10	15.50	18.70	11.70	16.10	10.00	15.90	100%
National target of 5,000	605	775	935	585	805	500	795	5,000

The national target for TNAs commencing their 2-year training in 2019/20 was 7,500. This was translated to 537 for NE and North Cumbria, included 33 for GP practices in this area. Organisations were asked to adopt a systemwide approach to training NAs as part of a strategic response to the nursing workforce challenge. In June 2021, a national target of 5,000 TNAs for the year of 2021 was issued together with the funding offers. Table 2 provides a breakdown of targets by region.

To encourage the uptake of the new NA role in primary care, further financial incentives have been provided in addition to funding for the training programme. As part of the new 5-year contract framework in 2019 for general practices in England, ARRS has been introduced to support the recruitment of 26,000 additional non-medical clinical roles by 2023/24 (Baird et al., 2020). As a result of a

multidisciplinary approach in service delivery, the aim is to enhance service delivery and patient access. Under the ARRS, 13 roles are eligible for full reimbursement of salary and on-cost from NHSE, and NAs and TNAs is one of the staff groups. On average each PCN has allocated funding for approximately 20 FTE roles (Baird et al., 2020), and it is up to each PCN to decide on the type of roles and numbers of people to be recruited.

To date, most Nursing Associates in England are working in a hospital setting.

## **1.5 Rationale for the chosen topic**

The motivation for and interest in this research topic came from my professional curiosity and practice experience.

Professionally, the introduction of NA in England can be regarded as ‘the’ single biggest development in the nursing profession in recent years. When the announcement was made during the planning stage, there were mixed views and some strong scepticism amongst the nursing profession regarding the NA role. As a nurse myself, I am curious to find out how the role has been implemented and established so far, and what the early impacts are. I would like to contribute to the knowledge base of my profession in this very important area, particularly at this early stage of development. By focusing on the area of NA, I am able to play an active role in doing that.

At a practice level, I was involved in some of the early work to promote the NA role to GP practices in my Clinical Commissioning Group area, which is in the NE region. From my experience, GP practices seemed to be hesitant or possibly unsure of taking on the role. Despite different incentives, only a handful of GP practices had introduced the NA role. Taking into account the highly skilled HCA workforce and the different ways of working in GP practices as well, shows the complexities and challenges of implementation of the NA role in primary care. While there is a clear desire and strong drive from the government to recruit and train more NAs, there is currently a lack of empirical evidence at both national and local levels to

inform decision-making and the implementation process in primary care. It is my intention that this study will provide that early evidence to inform and support future planning, adoption and implementation of NAs in GP practices in the NE of England and beyond. Moreover, I will help to build knowledge and enable further research to advance the understanding of the implementation of the NA and other non-medical clinical roles in the primary care setting.

## **1.6 Research aim and objectives**

This research study aims to understand how, why, and to what extent the NA role has been implemented in general practice. Through qualitative comparisons, the enablers and barriers for role change and institutionalisation are to be examined. In turn, this will provide transferrable learning for clinicians and stakeholders who may be involved in the introduction of the NA and other non-medical clinical roles in the English primary care system. To do that, the study will focus mainly on the following three research questions in relation to whether the NA role is able to fill the skill gaps between RNs and HCAs:

1. What processes does the institutionalisation of a new work role follow?
2. How does professional role identity affect the legitimisation process?
3. How are the efforts of actors defined in the institutionalisation of a new work role and its successes?

The study also attempts to identify the intended impacts at this early stage. To do that, the study will focus mainly on the following three questions in relation to whether the NA role is able to fill the skill gaps between the RNs and HCAs:

1. How is the NA role used in GP practices?
2. What are the tasks and responsibilities that are delegated from the RNs to NAs?
3. What is the impact of the new way of working on service delivery, the GPNs themselves, the practice team as a whole and other team members?

Due to the relatively small numbers of qualified NAs in GP practices and as a clinician working in a Clinical Commissioning Group in the NE region, NE is chosen as the footprint for the investigation. More details are provided in section 4.5 (research method).

## **1.7 Structure of the thesis**

Following this introduction, the rest of the thesis is structured in six chapters. Chapter Two explores the practice literature and topical research surrounding role introduction and changing skill-mix. It begins with a summary of the literature review process as context. In recent years, a number of new work roles have been brought into the NHS. I examine the lessons learnt from these implementation processes, and focus on one of these new roles, NA. Emerging evidence of implementation of the NA role in hospital and social care settings will be considered in the second part of the chapter. I review three of the existing institutionalisation models of new work roles (Goretzki et al., 2013; Kessler et al., 2017; Reay et al., 2006). The last part of this chapter is an evaluation of the institutionalisation model by Kessler et al (2017). To achieve that I bring together 13 pieces of empirical evidence on role implementation in eight countries and across six sectors, and compare them with the stages and micro-processes in the model.

Chapter Three examines the literature related to the theoretical framework for this study, which is the institutional theory. The first part of this chapter examines the key concepts in the theory that are specifically relevant to role implementation. Applying a hierarchical approach, I first examine structure (institution), then its constituent parts: actors and their behaviour (institutional work); work roles and identity; and role legitimacy. A summary of key research gaps from the literature review of practice literature and the theoretical framework (institutional theory) is provided next. Using the approach of Ravitch and Riggan (2017), the final section of the chapter illustrates the stage-by-stage development of the conceptual framework.

Chapter Four sets out the methodological approach and methods that have been adopted to carry out this research, and provides the justifications for doing so. It begins with a discussion on the nature of reality and knowledge and research philosophical position: a relativism ontology and a constructionist epistemology. It is followed by a closer examination of the case study methodology and semi-structured interview as the research method, before describing the design and implementation of the data collection process. Finally the last section in this chapter focuses on data analysis. Template Analysis (TA) based on the procedures by Professor Nigel King (University of Huddersfield) is used, and a priori codes are drawn from the EIM (Kessler et al., 2017), literature reviewed and themes in the interview schedules. I have included a detailed description of the template development process. NVivo is used to assist with data analysis, and the rationale for choosing TA and NVivo are also discussed. This chapter ends with an explanation of the intricate process of individual and cross-case analysis, and the strategies to ensure the quality of the research design.

Chapter Five presents the findings from the analysis of 20 sets of transcripts from interviews and focus groups. The findings of the five case studies are presented at two levels: case-based and cross-case, and the micro-processes in the EIM for a new work role (Kessler et al., 2017) are used as a structure to present the findings. The final template for each case study is included. To begin the section on cross-case synthesis, there is a summary of the characteristics of the GP practices as context setting. Comparison of findings of the five GP practices is carried out using tables at appropriate places to bring out the differences, as well as written narratives.

Chapter Six discusses the research findings, contributions of this study, and its limitations. Using the structure in the final templates developed from the EIM, I draw on the empirical evidence and concepts in the institutional theory in relation to role institutionalisation and discuss the findings in this study. I show where they contradict or support other research findings and established theories. Through this process, I will illustrate where this study adds to current evidence and offers new insights in areas of role implementation and legitimisation. The next section of this chapter sets out in detail the significant contributions of this study to practice and empirical research. This study contributes to under-researched areas, namely new

work roles in healthcare and primary care. From the practice perspective, NA is a new professional nursing role and there is currently limited evidence on role implementation. More specifically, I believe this study is the first that has taken place in GP practices, providing valuable insights into implementation of the NA role. I make 16 recommendations. The last section of this chapter outlines potential limitations, reflecting the constraints of student-research carried out during the COVID period.

Chapter Seven concludes the thesis. A summary of the recommendations is provided, followed by suggestions for future research. To end this chapter, I have included a personal reflection and will recapitulate the contributions of my study to professional practices at both policy and practice levels.

## **Chapter 2 Literature Review: topical research and empirical work**

### **2.1 Introduction**

Chapters Two and Three consider the research and literature related to the aim and objectives of the study: to understand how, why, and to what extent the NA role has been implemented in general practice. This chapter will evaluate the topical research and practice literature associated with role introduction and changing skill-mix. Literature associated with the relevant element of the theoretical framework will be discussed in chapter three.

The literature review process has been dynamic and ongoing throughout the duration of this study. A range of resources were accessed mostly electronically such as books, journals and webpages, coinciding with the COVID pandemic. Initially, the focus was specifically on the role of NA and its impact. During the course of this study, the search and review has expanded and modified to include healthcare and non-healthcare settings with a focus on role implementation. Due to the topic and setting of my study, most of the literature reviewed associated with skill-mix and healthcare or the nursing profession are 'atheoretical'. This created some initial challenges to identify the appropriate underpinning theories. I summarise the development of my literature review journey in section 2.2.

After a section on skill-mix as scene setting, the literature on recent introduction of new roles in the NHS and the lessons learnt are reviewed in two ways. Firstly, I identify the organisational and/or operational issues highlighted in these publications and compare them with factors for considerations in another recent systemic review of new work roles in healthcare (Halse et al., 2018). I then focus on one of these new work roles, NA, which is also the focus of my study.

## **2.2 Literature review – the ongoing journey**

### **2.2.1 Phase one**

I took a thorough, structured approach to carrying out the initial literature review. Using the key words of 'Nursing Associate(s)' and 'impact' via the facility on the University's library portal, I carried out a search. Perhaps unsurprisingly, only 13 were found at this early stage of introduction and none of them were centred on the implementation process. The analysis of this review, mainly related to early concerns and scepticism of the role, were included in thesis. I then broadened the search and looked for implementation of other assistive roles in healthcare settings e.g. assistant practitioners and physician associates. After initial screening, a total of 18 publications were included for a detailed review. Organisational and/or operational characteristics related to role implementation were identified and grouped together by themes. Electronic notes were made against each of the characteristics in the literature, for reference. An overview is provided in Appendix A.

### **2.2.2 Phase two – HRM literature on role institutionalisation**

From this point onward, the scope of review was further extended from healthcare to Human Resource Management (HRM) in particular. I also found different disciplines use different language and terminology. For example, 'legitimation' is not a terminology commonly used in healthcare literature, but by using a different key word and search engine e.g. Google Scholar, other literature on role implementation in non-healthcare sector were then identified. Amongst these HRM literature, the most significant article is arguably 'HRM innovation (HRMI) in healthcare: the institutionalisation of new support roles' (Kessler et al., 2017). This is because it is the only one which appeared within the last five year in an HRM journal relating to implementation of new healthcare work roles. After initial screening, and with 12 from phase one, a total of 27 articles were examined in comparison to the stages and microprocesses in the Elaborated Institutionalisation Model (EIM) by Kessler et al. (2017). Section 2.6.3 will provide more details on the EIM model. Additional characteristics were also identified. This ended the second



milestone of the literature review process, and an example of the working template is provided in Appendix B.

The other activity at this stage was to identify the theoretical literature. To do that, I changed strategy and adopted a snowballing approach (Wohlin et al., 2020). This is because considering the different terminologies used in healthcare and HRM, and after advice from my supervisors, I concluded this would be an effective approach to track down the relevant references. However, I am very aware that the references identified this way can be quite dated and therefore, I needed to be selective.

### 2.2.3 Phase three – Elaborated Institutionalisation Model

The objective in this phase was to ensure a wide range of role implementation literature from different industries and countries are considered and included in the review. After further detailed review of each article, 13 out of the 27 research and publications were included in the final comparison with key features in the EIM (Kessler et al., 2017). Relevant features were noted against the relevant microprocesses, and where new other features were identified. Appendix C shows the reorganisation and the mapping of features against the EIM.

Although the others contain relevant information in relation to role implementation, these 13 selected have more features of role evaluation or are evaluations, hence justifying the process to condense further. The output of this activity has provided a framework to support the discussion of the findings after analysis.

### 2.2.4 Phase four – Updating and confirmation of literature

The last stage started mainly after data analysis when findings emerged. These themes and sub-themes provided new lines of enquiry for further literature review. An example of one such area is changing skill-mix, and an extensive literature review was carried out and incorporated into the final thesis. As a result, this new information was added to the original resource, and together, they have supported the interpretation, analysis, discussion and ultimately completion of this thesis.

One ongoing challenge is to keep up to date with the references, as new evidence and information appears. This process of refreshing literature has been maintained to the point of submission of the thesis at the end of March 2023.

### **2.3 Changing skill-mix in the NHS**

The policy intention to radically change the skill-mix in the NHS can be traced back over 20 years to the Wanless report (Wanless, 2002). Derek Wanless carried out a review of the long-term trends affecting the health service in UK, and projected a significant gap in demand and supply and resources needed. Four areas were identified with the most potential to improve healthcare productivity, and of these, one was better use of the skilled workforce by breaking down professional boundaries. This means some work from doctors is to be shifted to nurses, and healthcare assistants (HCAs) will be doing some nurses' current work (Wright, 2002). The trend of workforce reform has continued and as discussed in the last chapter, the innovation agenda in recent years is driven by new models of care, workforce shortages, and the need to contain the significant pay expenditure associated with a sizable workforce.

Skill-mix is an overarching term and can include changes to the skills, competencies, roles or tasks within and across different health professional groups (Wismar et al., 2022). Changing the skill-mix is one approach aiming to improve the efficiency and effectiveness of healthcare (Sibbald et al., 2004). Indeed, it is emerging as a 'common-sense' response in GP practices in order to address GP shortages (Nelson et al., 2018). According to Sibbald et al. (2004), skill-mix can be introduced through four ways:

- (1) Enhancement – increasing the depth of the job
- (2) Substitution – expanding the breadth of the job depth
- (3) Delegation – moving a task up or down a role
- (4) Innovation – creating a new type of worker / job

The above classifications have informed future investigations and research, and indeed, the publication continues to be cited in many past and current studies, as

recently as 2023. For example, based on this earlier work, Wismar et al. (2022) had offered a condensed typology of skill-mix from four groups to three: (1) re-allocating tasks; (2) introducing or changing team work; and (3) adding new tasks or roles.

As a result of creating new roles, this leads to a change of the ratio of senior to junior staff in the team within a particular discipline, or the mix of different types of staff within a multidisciplinary setting (Sibbald et al., 2004). Kessler et al. (2017) agrees with the earlier view of Sibbald et al. (2004) that introduction of a new work role is a form of HRMI. Another way to introduce new clinical roles into multidisciplinary teams is by bringing in professionals from other settings, such as physiotherapists into primary care. Using a combination of both approaches, a number of new clinical roles have been introduced to the NHS in recent years in response to service needs and rising workload pressures (BMA, 2022).

To accelerate the pace of change, policy and contractual enablers and incentives are utilised to encourage skill-mix change in primary care. Maximising the opportunity of the new contract framework in 2019 for GP practices in England, this came with the introduction of Primary Care Network (PCN) with an emphasis on the multidisciplinary approach to care delivery (Shembavnekar et al., 2022). To encourage the introduction of additional non-medical clinical roles and broadening of skill-mix in GP practices, the Additional Roles Reimbursement Scheme (ARRS) has been introduced to provide financial support (Baird et al., 2020; Francetic et al., 2022). The findings in Sibbald et al. (2004) indicated a positive and direct relationship between the payment system and successful implementation of change. By contrast, despite a rapid uptake by some PCNs, evidence shows these non-medical clinical roles are not being implemented effectively (Baird et al., 2020).

One reason for this is because skill-mix change is not straightforward, and requires considerable effort and investment by the adopting organisations. Moreover, evidence shows failure in skill mix change is associated with the inability to achieve desired outcomes due to a lack of clarity of objectives of change (Sibbald et al., 2004). Indeed, the complexity of the associated organisational processes have also been highlighted in recent studies of implementations of new work roles in the NHS (Francetic et al., 2022; Spooner et al., 2022). In addition, there is also a need for

organisations to recognise and address the challenges at both the individual and organisational levels (Nelson et al., 2019). Amongst others, role definition, professional tensions and closing the training-practice gaps have been identified as implementation challenges, and these are pertinent issues for the professionals themselves. Moreover, there is a view that issues related to how and why a HRMI, such as a new work role, emerged and developed from within an organisation has been overlooked (Reay et al., 2006), and HRMI is not a well-researched area (Shipton et al., 2017). This echoes an earlier finding from Sibbald et al. (2004) that there is a lack of review of new roles. Subsequent researchers (Goodrick & Reay, 2010) also share this opinion and specifically, highlight that there has been little attention to processes of legitimising a new professional role identity. Taken together, the literature indicates and supports the need for further studies on implementation and legitimisation of new work roles, and I believe this is where my study on NA will contribute.

In addition, the review by Sibbald et al. (2004) has informed this NA study in a number of ways. As well as providing clarity on the category of skill-mix change and the focus on literature search, other findings in this study have informed the data analysis and interpretation. They include the need to be clear of the objective / motivation for change; the potential restriction of opportunities for role enhancement; the need to discontinue old ways of working; the importance to consult key stakeholders to avoid conflicts and confusion; the requirement of additional training; and importance of leadership. There is also the role of the payment system discussed earlier. Together, they have provided me with the themes / a priori themes to be used in the preliminary template for Template Analysis. More details will be discussed in section 4.6 in chapter four.

## **2.4 Recent Introduction of new roles in NHS**

Recently, there are a number of new clinical roles emerging in the NHS (BMA, 2022):

- Advanced clinical practitioners (ACPs)

- Clinical pharmacists
- First contact practitioner for MSK services (FCPs)
- GP assistants
- Medical associate professions (MAPs) and they include:
  - Advanced critical care practitioners (ACCPs)
  - Physician associates (PAs)
  - Anaesthesia associates (AAs)
  - Surgical care practitioners (SCPs)
- Mental health therapists
- Nursing Associates (NAs)

As can be seen in Table 3 below, currently NA is the only role regulated by a professional regulator.

**Table 3: Regulation of new clinical roles in the NHS (Source: BMA, 2022)**

<b>New Roles</b>	<b>Regulation</b>
ACPs	Practitioners are subject to their respective professional regulation, but there is no role specific regulation.
Clinical Pharmacists	Pharmacists are regulated by the General Pharmaceutical Council, but there is no role specific regulation.
FCPs	These are physiotherapists and the individual is registered with the HCPC (Health and Care Professions Council). No
GP Assistants	Not qualified clinicians and therefore, not subject to professional / role regulation
ACCPs	Practitioners are subject to their respective professional regulation, but there is no role specific regulation
PA	Due to be regulated by GMC in the near future
AAs	Due to be regulated by GMC in the near future
SCPs	Practitioners are subject to their respective professional regulation, but there is no role specific regulation.
Mental health therapists	No role-specific regulation
NAs	New nursing role regulated by Nursing Midwifery Council

#### 2.4.1 Factors contributing to successful implementation

Literature review shows most of the recent empirical evidence in relation to the above new work roles are related to ACPs and PAs. This is likely because these roles are more established than others. Amongst these publications are two National

Institute for Health Research (NIHR) funded research on PAs (Drennan et al., 2014; Drennan et al., 2019) and recent publications for an ongoing NIHR research on NAs (Kessler et al., 2022; Kessler et al., 2020). They perhaps indicate the political significance of these roles in changing the skill-mix of the healthcare workforce.

From the analysis of the first group of 18 literature and reports reviewed in relation to implementation / evaluation of clinical and non-clinical roles (see section 1.2.1 and Appendix A) , I have identified a range of organisational and/or operational issues. Broadly speaking, they fall into four main areas in the order of change management, work role e.g. scope and education, planning (workforce and service needs), and local context.

In another recent systemic literature review of empirical studies on the introduction of new roles in healthcare (Halse et al., 2018), seven areas are highlighted for healthcare leaders to consider when introducing new roles: robust workforce planning; well-defined scope of practice; wide consultation and engagement with stakeholders; strong leadership; an education programme that mirrors patient need; adequate resources for work-based learning; and supervision by a skilled clinical educator. It is perhaps surprising to see 'service needs' missing from this list, as this is expected to be a key rationale for introducing case-mix change as shown in Gibson et al (2023).

**Table 4: Comparison of literature review themes**

	Change management	Work Role	Planning (workforce and service)	Local context
Robust workforce planning			X	
Well-defined scope of practice		X		
Wide consultation and engagement with stakeholders	X			
Strong leadership	X			
An education programme that mirrors patient need	X		X	X
Adequate resources for work-based learning	X			X
Supervision by a skilled clinical educator	X			

As can be seen in Table 4, the seven areas identified by Halse et al. (2018) broadly fall into four groups of findings from my review of the 18 literature on role implementation in Appendix A. For the remainder of this subsection, I will therefore take a close look at each of these four areas in turn, and draw in wider evidence from other literature as appropriate.

a) Change management

There are explicit critical factors and lessons learnt related to elements of change management in nearly all of the literature reviewed, and they include resources, communications, leadership, training capacity and culture for change (Drennan et al., 2014; Drennan et al., 2019; Evans et al., 2020; Greenhalgh et al., 2020; Imison et al., 2016; Morris et al., 2021; Spilsbury et al., 2009). Most importantly, it is clear from the evidence that the change management nature of role introduction requires skills to win 'hearts and minds' rather than just technical HR competence.

In particular, understanding of and attitudes towards the new role are being recognised as key factors in both the introduction and integration of new roles (Drennan et al., 2014; Drennan et al., 2019; Evans et al., 2020; Spilsbury et al., 2009). Indeed, construction of the new professional identity is said to be dependent on the stakeholders' acceptance of the role (Kennedy et al., 2015). Quite often the decision to introduce a new role is based on the individuals prior experience of working with someone in the same role elsewhere and/or perception of the new role (Stewart-Lord et al., 2011; van der Biezen et al., 2017). In some settings, the professional hierarchy also comes in to play and consultants in a hospital setting for example, ultimately decide how the new role is being progressed (Kilpatrick et al., 2019). All these point to the importance of effective communication and involvement of stakeholders, in order to secure acceptance of the role by multi professionals. The wider understanding by the public of the new role is also critical, as this endorsement will provide the enabling environment for organisations to embrace and maximise the potential of the new role (Evans et al., 2020).

Leadership is a critical factor at both local and strategic levels. As well as personal commitment and enthusiasm, managers alike in organisations where the new role has

been embedded also have skills in workforce needs analysis and expertise in leading change (Bungay et al., 2013). At an organisation level, visible senior executive leadership, organisational statement and commitment of resources are all important as ongoing support innovation and change (Drennan et al., 2019).

#### b) Planning – workforce and service needs

Workforce planning is about making sure the right people with the right skills are meeting patient needs in the most appropriate settings (Addicott et al., 2015), and this feature can be seen in the literature (Imison et al., 2016; Kennedy et al., 2015; Kessler & Nath, 2019; van der Biezen et al., 2017; Vas, 2010). It is also clear that any new role cannot be seen in isolation, and the investment should be considered as part of the team and wider workforce planning (Bungay et al., 2013; Imison et al., 2016). The importance of role clarity in terms of purpose and place is being emphasised (Morris et al., 2021), as well as the need for a longer term focus (van der Biezen et al., 2017). This is because changing skill-mix is a real opportunity to enable wider service transformation (Evans et al., 2020).

Many literature and evaluations identified that service needs, in terms of meeting the demand and sustaining/improving quality, are key drivers for workforce redesign (Imison et al., 2016; Kessler & Nath, 2019; Moran et al., 2011; Spilsbury et al., 2009; Vas, 2010). However, decisions to introduce new roles is often locally driven by local assessment and leadership but not as part of an explicit strategy (Drennan et al., 2019). This means workforce planning and skill-mix change can be 'bottom up' or 'top down, depending on the type of roles and scale of changes. There is also a suggestion that inadequate planning is commonly found in general practices (van der Biezen et al., 2017).

#### c) Work Role

Role definitions, scope and boundaries are important issues in role implementations and team integrations, and their relevance can be seen in a number of past and recent studies (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Halse et al., 2018; van der Biezen et al., 2017). A clarity on the role definition before



implementation will also help gain acceptance by other professionals (Griffin & Melby, 2006). At operational level, managing role related issues often time and energy consuming, especially during the initial introduction stage. For example, a lack of national guidance on role clarity of APs caused confusion about the role, and as result, this led to strong resistance from hospital staff and adverse impact on the transition process (Spilsbury et al., 2011). There is also a view that role standardisation through regulation is essential and indeed positive, such as PAs (Drennan et al., 2019).

The importance of training to reflect patient needs is also highlighted in creating new roles (Greenhalgh et al., 2020; Halse et al., 2018; Kennedy et al., 2015), as well as the resources and capacity required (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Kilpatrick et al., 2019; Patriotta & Lanzara, 2006).

#### d) Local context

The last area is local context and organisational characteristics, and they associate with culture for change, model of care and service delivery, and professional relationship and support. This is particularly relevant for GP practices as individual businesses that often operate very differently. In particular, team working and relationships in primary care settings have key roles in role implementation (Drennan et al., 2014; van der Biezen et al., 2017).

In a study investigating the contribution of PAs to primary care in England (Drennan et al., 2014), the findings showed differences amongst practices in decisions of role adoption were related to internal and external organisational factors as well as the characteristics of the innovation. They were supported by later studies of implementing new roles in primary care. In one (van der Biezen et al., 2017) looking at decisions in primary care to train and employ a nurse practitioner or PA, organisational factors, professionals relationship and GPs' experience of the PA/NP profession are some of the influencing factors in the decision-making process. Similar findings also came up in Morris et al. (2021) on acceptability of the FCP model in primary care, and it was concluded that contextual factors at micro level will make an impact and must be considered. All the above empirical evidence

further illustrates the importance of attending to contextual conditions in case studies as stressed by Yin (2018).

## **2.5 Introduction of Nursing Associates**

This section homes in on one of the new work roles recently introduced in the NHS, NA, which is also the focus of my study. Before doing that, I will first briefly look at the role of healthcare support worker. This is because the development of the new NA role is a direct result of reviews of this role and indeed, many of the newly qualified NAs to date were HCAs previously.

### **2.5.1 The role of healthcare support worker**

Healthcare support workers are unregulated, and over 300 job titles are used to describe this role (Moran et al., 2011). In the NHS nowadays, they are often referred to as HCAs and carry out routine tasks and core nursing duties previously provided by registered nurses (RNs) (Kessler et al., 2010). HCAs in the NHS are placed at the pay band one to four, with band four the most experienced. There is evidence that this large and flexible support workforce can provide good-quality, patient-focused care, as well as reducing the workload of more highly qualified staff (Imison et al., 2016). For this reason, HCAs have been the focus of recent workforce reform in the NHS with policies aiming to increase their numbers and expand their roles (Moran et al., 2011).

In 2013, a review into HCAs in the NHS and social care settings (Cavendish, 2013) identified a lack of career ladder and opportunities for progression. One of the 18 recommendations was the development of new bridging programmes into pre-registration nursing and other health degrees for support staff in health and social care (Cavendish, 2013). This can be argued as the inception of the NA role. This was followed by the Shape of Caring Review (HEE, 2015) in 2015. The focus of this was to determine whether the training and education for support workers and RNs are fit for purpose to meet the challenges and new service model described in the Five Year Forward View (NHSE, 2014). The report echoed the sentiments in the

earlier Shape of Caring Review and acknowledged the significant contributions from support workers in the health and care setting. Two of the 34 recommendations made provided the basis to develop the NA role. Recommendation eight proposed a bridging role between the unregulated care assistant and the registered nursing workforce, and recommendation 12 indicated the need to create a simpler and work-based route into nursing for care assistants. In response to these recommendations, the NA was created to fulfil three purposes: support the career progression of care assistants; increase the supply of nurses; and enable qualified nurses to undertake more advanced roles.

### 2.5.2 Early reactions

Most of the literature related to the NA role were written before the introduction in 2019. Although NAs have the potential to make a significant contribution to care (Foster, 2016), the reception of this new role was mixed, with a high level of scepticism and concerns.

The first issue is its 'ill-defined role'. The Royal College of Nursing cautioned that this would lead to NAs being asked to perform duties outside the remit of a support role, and as a result, adversely impact on patient care (Gilroy, 2018). Questions were also raised as to whether the NA role differed sufficiently from the role of 'abolished' Enrolled Nurse and the existing nursing practitioner (Kendall-Raynor, 2016). However, the main concern over the introduction of NAs was that of risk to patient safety due to a dilution of expertise on the front line, with strong opinions expressed (Falconer, 2016; Foster, 2016; Kendall-Raynor, 2016; Longhurst, 2017; Stephenson, 2019; Trueland, 2018). With the growing global evidence to show more nurses with the right skills and support are needed in order to reduce patient mortality and improve nurses' wellbeing (Aiken et al., 2017; Griffiths et al., 2019; RCN, 2019), this further fuelled the early debates. Some critics also believed the motivation to introduce the NA was cost cutting (Trueland, 2018) and nursing experts warned against the substitution of nurses with less qualified staff (Lintern, 2019). Comparing these concerns with the situational factors in Hurley (2012) model of building of trust, the perceived risk of patient safety, potential erosion of professional boundary, and uncertainty of the capabilities of the new NA role in the

absence of evidence have all contributed to a lack of trust at the beginning of implementation process. Moreover, they may also indicate that the early communication was not effective, given that communication is said to be the most important trust building tool available (Hurley, 2012).

On the other hand, there was some welcome for the new development, (Glasper, 2017). There was a recognition that the NA role would complement the existing registered nursing workforce, and free up the nurses to become advanced practitioners (Mortimer, 2019; Rosser, 2016). It was also seen as widening access to the nursing profession (Morgan, 2017; Williams, 2017), and overall, help address the current needs and pressures of the NHS as a consequence of staff shortages.

### 2.5.3 Emerging evidence of implementing the NA role

There was one evaluation commissioned by Health Education England (HEE) in 2017 to look at the first two years of the NA training programme up to June 2019. An interim report was available to a restricted list of stakeholders and the year 2 (final report) (HEE, 2019) was issued in October 2019. In 2019, the NIHR Policy Research Unit in Health and Social Care Workforce at King's College London was commissioned to carry out a study on the introduction of the NA role in the NHS and social care services in England by the Department of Health and Social Care. This is a follow-on evaluation from the HEE education review, and focuses on how those trainee NAs qualified in early 2019 have been deployed by the NHS and social care employers.

At time of finalising this thesis, an interim report (Kessler et al., 2020) and other emerging findings associated with this on-going evaluation have been published on the website of King's College London. In relation to role implementation, challenges included integration into established ways of working, finding a distinctive role for the NAs, and gaining acceptance from RNs and HCAs (Kessler et al., 2020). Other on-going issues of introduction were also highlighted by hospital trusts, such as lack of organisational capacity to support e.g. mentoring and supervision, and difficulty to find suitable trainee NA recruits. In social care settings with smaller and dispersed organisations, barriers found were lack of infrastructure and capacity for

training, difficulties in organising placements and challenges to co-ordinate academic and pastoral support (Kessler et al., 2022). One key finding is uncertainty and constraints of current scope of practice, and policy makers and practitioners in health and social care settings highlighted the impact on legitimacy and development of the NA role (Kessler, Harris, et al., 2021; Kessler et al., 2022). This view was echoed by the postholders themselves, and as a result, the scope of practice amongst the NAs is described as 'uneven' and many have continued to carry out HCA duties (Kessler, Steils, et al., 2021a). Although a small number of participants in the King's College research were from the primary care setting, none of the published findings specifically focused on GP practices and the gap of knowledge in this area remains.

## **2.6 Institutionalisation Models for A New Work Role**

The above two sections examined the literature related to skill-mix and new work roles. This section and the next will introduce the theoretical literature which allows an analysis of role implementation.

Over the years, institutional change and the role of actors in the process of role legitimisation have been the subject of many studies. As a result, some models have been developed to show how new work roles are legitimised and institutionalised. Amongst them, the model of institutionalising new ways of working by Reay et al. (2006) is influential, as it has provided a basis and has informed the work of other scholars and researchers including Goretzki et al. (2013) and Kessler et al. (2017).

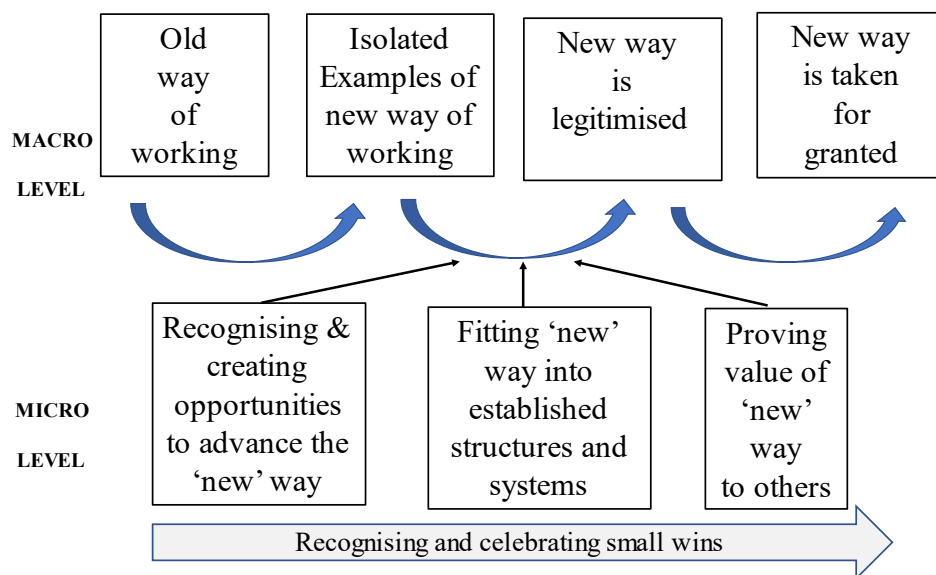
This section will examine three of these conceptual models (all underpinned by institutional theory) in more detail, as they are considered to be significant and relevant to the study on NA: two models are related to new roles in healthcare setting; and the other is developed from the institutionalisation of a new role for management accountants. There are two other reasons I have included the latter one. The first and main reason is that this study is said to be the first to focus on the link between professional role and role identity in the context of change (Goretzki et al., 2013). As my study is about NA as a new professional role, this is extremely

relevant. Secondly as an approach, I want to bring in a non-healthcare model to provide a balance.

### 2.6.1 Model of Institutionalizing – Reay et al. (2006)

This model (Figure 2) was based on the findings of a study of a new nursing role. The study was a 4-year investigation of the introduction of a new nurse practitioner role into a well-established health system in Canada. Although it is nearly two decades old, this is one of the few studies available on the institutionalisation of a new role in healthcare setting (Kessler et al., 2017).

**Figure 2: Model of Institutionalising – Reay et al. (2006)**



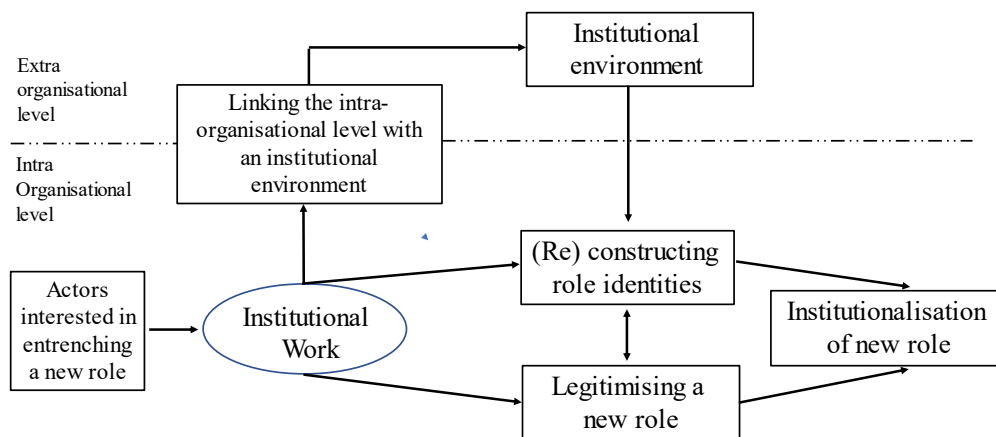
This study showed embeddedness is an opportunity for change and individuals / actors used their established positions in the organisation to legitimise the new work role as a new way of working. Rather than be reliant on external triggers or jolts, the middle managers particularly drew on their experience and knowledge of the work environment to steer their efforts to implement change. This is a significant study as its findings challenged the previous thinking that embeddedness is a constraint for the change agents (Reay et al., 2006).

In this model, Reay et al. outlined three independent and repetitive microprocesses at service level in relation to the actors' purposive actions to legitimise the new work role: (1) cultivating opportunities for change; (2) fitting a new role into prevailing systems; and (3) proving the value of the new role. The changes at this level in turn led to visible characteristics / impact at macro / system level. As part of the overall strategy, there was also the creation of small wins to consolidate gains along the way.

### 2.6.2 Institutionalisation of a new role for a professional- (Goretzki et al., 2013)

This case study of a German manufacturing firm examined the institutionalisation of a new role (business partner) for management accountants (professionals) as business partner. Focusing on embeddedness of actors in institutional change and building on the work of Reay et al. (2006), this study further examined the institutional work carried out by the actors.

**Figure 3: Institutional work and the institutionalisation of a new role (Extracted from Goretzki et al., 2013)**



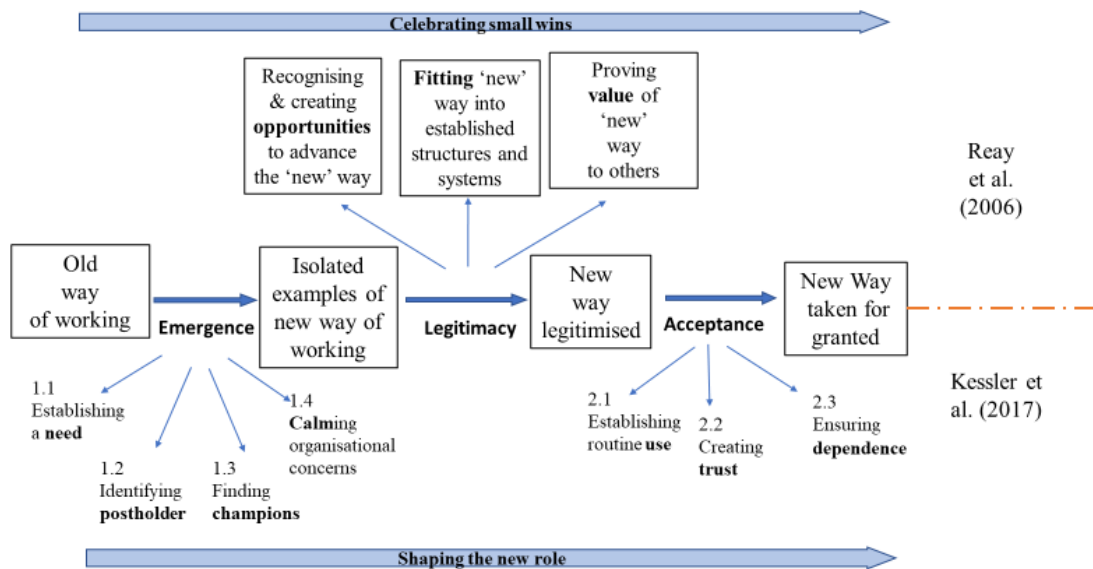
The study showed that there is a link between a role and the owner's identity, and professional role change also requires professional role identity change. In order to achieve institutionalisation of a new role, (re)construction of role identity is needed as part of the process to legitimise a new role (see Figure 3). As well as internal

efforts, the study showed the role of the outsiders (other actors) to help construct the identities of the members of a specific professional group. There were also the purposive efforts as part of the institutional work to link up at intra-organisational level, so as to facilitate the institutionalisation of a new role. Putting this into the context of the NHS as an organisation, this suggests the opportunity for different parts within it such as GP practices, to work together in role institutionalisation.

### 2.6.3 Elaborated Institutionalisation Model for a New Role – Kessler et al. (2017)

This last model was a result of a study of two new roles in the healthcare setting: surgical assistant practitioner and the colorectal support worker. Both of these roles are undertaken by healthcare support workers.

**Figure 4: An Elaborated Institutionalisation Model for a New Role (Source: Kessler et al., 2017)**



Kessler et al. (2017) argued that establishing a new role is associated with a distinctive set of drivers, processes and outcomes. To deepen the understanding on how new work roles are being established, the researchers broadened and refined on what they described as the 'incomplete' institutionalisation model for new work role by Reay et al. (2006). As well as the legitimisation stage, the researchers studied the processes before and after, i.e. how a new role emerges in the first place and how it becomes taken for granted.



The elaborated model in Figure 4 is a fuller one, including a first and third stage: emergence and acceptance. These two stages had seven microprocesses which are closely related to those three identified by Reay et al. (2006), and were described as underpinning the initial stage of legitimacy. The initiations of the new roles in this study were bottom-up, 'below the radar', and organisational level was less of a driver for change and more constraints and barriers that the actors had to navigate round. The study highlighted the intertwined relationship between the role and postholder, and therefore a threat on long term sustainability. This also shows the challenges to establish a new work role and adopt an objective approach, as most likely, it is inseparable from the individual concerned. Finally the model has a cross-cutting process: shaping the new role, highlighting an ongoing process of 'moulding' and developing the new role from the initiation to embedding stage. It was the aim of Kessler et al. (2017) that this 'more complete' model would act as a guide to the development of future new roles.

## **2.7 Evaluation of the institutionalisation model**

Earlier in this chapter in section 2.4, the findings from studies of introduction of new roles were reviewed. The structured review process that led to the choice of these publications has also been explained in section 2.2. Amongst them, 13 (as shown in Appendix C) are evaluations and studies of new work roles in eight different countries, covering six sectors: healthcare, manufacturing, education, construction, motor / automotive and the voluntary sector. In this section, I will be bringing together the evidence from these empirical studies and comparing them against the stages and micro-processes in the EIM by Kessler et al. (2017). The Kessler model is used because it covers the lifecycle of a new work role, incorporating the stages before and after role legitimacy i.e. emergence and acceptance. In addition, this also allows me to apply the healthcare rooted EIM, which incorporated the study by Reay et al. (2006), to other settings as identified by Kessler et al. (2017) as an area for further development .

Due to the diverse nature of the literature, varying type and level of information can be found in the 13 literature relates directly to the three stages in the EIM: emergence; legitimisation; and acceptance. As can be seen in Appendix C, relevant features have been noted and I have also identified other features not discussed in the EIM. I will now draw on all of them and discuss them using the EIM as a structure.

### 2.7.1 Emergence

This stage has four micro-processes, characterised by a job role designed explicitly to meet service needs, a postholder with personal and technical qualities and abilities, a champion to help to address the barriers, and conscious efforts to deal with the concerns (Kessler et al., 2017).

A clear indication of need can be seen in all the 13 literature referred to. All these new roles were developed against a backdrop of strong and established strategic arguments. In some cases, there is also a wealth of international evidence to demonstrate the value of such a new role (Drennan et al., 2014; Drennan et al., 2019). This confirms the theory that an external jolt, as highlighted by Reay et al. (2006), is often required to initiate a role change at local level. In practice, some organisations indeed reported that they would not be prepared to invest in a new and untested role without a strategic driver (Bungay et al., 2013). This may be in contrast to some thinking that bottom-up initiatives by embedded actors on role change have a better chance to succeed. Despite that political enabler, this is no replacement for local communication and engagement, and the need to convince the actors at organisational and operational levels to adopt the change (Evans et al., 2020; Spilsbury et al., 2009). On the other hand, it can be seen that some changes were initiated and driven by operational level needs with no external influence or external jolt (Spilsbury et al., 2011). Indeed, the role and value of embedded actors as described by Reay et al. (2006) were explicitly displayed. One regional study described their leaders where the new role was embedded as highly committed and enthusiastic, with expertise skills in analysis and leading change (Bungay et al., 2013).

The importance and careful recruitment of appropriate people is evident in some studies (Allen et al., 2013; Farmer et al., 2011; Kilpatrick et al., 2019), and their initial cohorts of postholders were experienced workers and clinicians from other units and abroad. In one study, the fact that the organisation had already access to a significant part of the target recruits in the country could definitely be regarded as an advantage and enabler for change (Xu, 2012).

The need for champions at both strategic and operational levels were recognised and advocated in many studies examined. One study described the role of mentor to include change agent to support implementation (Evans et al., 2020), but this would depend on the setting and organisation. In order to drive change, studies showed the champions themselves need to be prepared and supported in order to be an effective (Spilsbury et al., 2011). To drive forward change, champion will also need to draw on wider support and resources, and this is seen in the study of institutionalising the new of management accountant (Goretzki et al., 2013).

As part of change management, the importance to calm emerging concerns and the role of champions in this stage were also illustrated (Evans et al., 2020). Indeed the apparent lack of attention and actions to solve these issues at this emergence stage had been cited as a reason for failing to implement the new work role successfully in some cases (Bungay et al., 2013; Spilsbury et al., 2011). Other related elements particularly effective communications at national and local levels were also highlighted (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Evans et al., 2020; Kilpatrick et al., 2019; Spilsbury et al., 2011). The consequence as a result of ineffective communication regarding the role remit and boundary, for example, could be seen as a reason for reluctance to change due to misunderstanding (Spilsbury et al., 2011).

It is clear that evidence of success and impact is needed at the emergence stage (Bungay et al., 2013; Drennan et al., 2014). In the study of PAs in primary care, team members could see the potential need but were looking for evidence of impact as part of the initial decision-making process.

Issues and concerns regarding the role clarity and boundary can be seen in many of studies (Bungay et al., 2013; Drennan et al., 2019; Kilpatrick et al., 2019; Spilsbury et al., 2011). Other barriers of introduction included financial constraints (Bungay et al., 2013) and financial incentives were used to encourage uptake (Drennan et al., 2019). Finally, the investment in training was identified (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Kilpatrick et al., 2019; Patriotta & Lanzara, 2006).

### 2.7.2 Legitimacy

This stage consists of three micro-processes: recognising and creating the opportunities for change, 'hooking' the new role into the operation of the organisation, and finally demonstrating the value of the new role to other actors. Based on the studies reviewed, these micro-processes are often intertwined and are not linear and distinctive as described.

In order to create and advance an opportunity for change, evidence showed that this was highly dependent on the individual concerned (Allen et al., 2013; Evans et al., 2020), but not just the purposive actions by the embedded actor or champion. As well as skills and experience, the ability for the individual to assimilate the culture of the organisation (Farmer et al., 2011; Goretzki et al., 2013) and embrace its vision and ambition (Patriotta & Lanzara, 2006) were described as an important factor to secure legitimacy of the new role. Local knowledge of the postholder was also a facilitator (Goretzki et al., 2013; Patriotta & Lanzara, 2006). The uncertainty and concerns of the other professionals were barriers in role change and hampered the successful utilisation of a new role (Drennan et al., 2019). One of them was accountability and issues were raised in a number of studies (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Spilsbury et al., 2011).

Relationship with the champions or trust (Farmer et al., 2011; Spilsbury et al., 2011) were highlighted as a determinant to help to recognise and advance opportunities. This perhaps shows the social and subjective element of legitimising process, and the facilitating factors that advance change faster and quicker. There is also the opportunity to accelerate the pace of change and amplify the impact through partnership working outside the organisational boundary (Drennan et al., 2019).

One of the underpinning concepts of a new role is that embedded actors / champions drive forward the change and legitimisation as part of the process. In a study looking at new roles and identity in a car factory, it was shown that the whole workforce was affected and they collectively implemented and legitimised the new identity in a self-sufficient way (Patriotta & Lanzara, 2006). This would suggest that in certain situations, once a concept was planted and accepted by the majority, legitimising and institutionalising a new work role could be done without dedicated embedded champions. Finally, there is also the authoritarian approach to legitimise a role through power and authority (Xu, 2012) and as a result of superior knowledge (Akintola et al., 2017). Particularly for the latter, the legitimacy will be transient and will last as long as other actors do not have the proficiency concerned.

Proving value to others is an important element in the process of legitimisation, and one known barrier is a perception that the role is untested (Bungay et al., 2013). The importance of users' acceptance was also key (Drennan et al., 2019; Evans et al., 2020; Farmer et al., 2011; Kilpatrick et al., 2019). One study cited that some patients considered it to be more appropriate and/or preferable to be seen by a doctor instead of a PA (Drennan et al., 2014).

Issues related to role identity were brought up. Studies showed that often the benefits of new roles cannot be realised due to a perceived lack of role clarity, in another words, role identity. The identity could be manifested itself as registration and regulation by professional body or just a job description (Altshuler & Webb, 2009; Drennan et al., 2014; Drennan et al., 2019; Spilsbury et al., 2011). In addition, identify construction and the need to de-legitimise the old role were emphasised (Allen et al., 2013; Goretzki et al., 2013; Patriotta & Lanzara, 2006), for example, the challenges of changing their status from HCAs to APs were highlighted. To do that, intra-organisational level activity across the same institution was taken and in Bungay (2013), stakeholder events put in place to encourage dialogue between organisations in the NHS.

### 2.7.3 Acceptance

This is the final stage in the model of institutionalisation to ensure a new role is embedded and accepted. In the literature reviewed, there is comparatively less information provided regarding the acceptance stage. In part, this could be explained by the fact that some of these roles are at their early stage of development. Perhaps, this also confirms that evidence on HRMI of new work roles is relatively sparse.

Trusted relationships have been referenced in many healthcare studies explicitly (Allen et al., 2013; Drennan et al., 2014; Farmer et al., 2011; Spilsbury et al., 2011), although much earlier on in the role implementation process. While this could be related to the nature of healthcare, trust is also important in other businesses for example, the breakdown of the relationship between the workers and the management was the reason for the failure to institutionalise the new work role in an organisation in the automotive industry (Patriotta & Lanzara, 2006). According to Hurley (2012), the decision to trust or not to trust is dependent on two components: decision making factors and situational factors. While the decision-making factors are concerned with the trustor's personality, culture and experience, the trustee ability to effectively address the situational factors in order to gain confidence of others is highlighted. Putting this into the context of role implementation, this illustrates the dynamics in establishing a trusting relationship and the efforts needed from both the postholders of the new roles and other professionals and service users affected.

Political influence was cited as an enabler to promote acceptance of new work role in Evans (2020), and participants suggested the need to educate and raise public awareness at national level.

## 2.8 Chapter conclusion

The chapter has reviewed the practice literature and topical research in relation to skill-mix and introduction of new work roles.

Increasingly changing skill-mix has become a popular intervention in order to respond to workforce shortages, as well as meeting the service transformation and productivity agendas. Many new roles have been introduced to the NHS in recent years and one of them is NA. However, evidence shows many of these skill-mix changes failing and not achieving the desired outcomes or effects on quality (Francetic et al., 2022; Sibbald et al., 2004). This is because introducing a new role needs to be well thought-out. For example, the reception for the new NA role was mixed, attracting scepticisms and concerns. Amongst other reasons, the failure to build and communicate effectively contributed to the situation.

While the process of changing skill-mix can be very challenging, it also brings real opportunities for transformation with significant benefits to patient care. Evidence from the healthcare literature showed robust workforce planning is key. This needs to be looking at longer term and the whole team, but not the new role in isolation. Service and patient needs are key drivers for introduction of new clinical roles in the NHS. However without a solid understanding of that, conducting workforce transformation could lead to fragmented care as well as proving costly, and ultimately threaten patient safety and the quality of care (Price et al., 2014). Empirical findings also illustrated that introduction of a new role is much more than simply overlaying it on the old/current organisational structure. Strong leadership together with a change management methodology is critical to ensure success. In particular, effective communication is paramount to engage the people affected, and ensure they understand and accept the new role. This is because in most cases, it is the human factors and local context that determine the success of implementation and the integration of a new role into the organisation.

There are models on legitimisation and institutionalisation of new work roles, and three of them have been examined. In particular, the EIM (Kessler et al., 2017) is an expansion of the influential model of institutionalising by Reay et al. (2006). This fuller model adopted an end-to-end approach and attempted to provide a practical guide to implementation of new work role. This chapter also tested this model out,

by comparing and contrasting the evidence from the empirical studies of new role across eight countries and six business sectors. From these studies, features and characteristics of the different micro-processes in the three stages of the model can be found. At the same time, other factors and potential microprocesses have also been identified.



## **Chapter 3 Literature review – theoretical framework**

### **3.1 Introduction**

This chapter explores the relevant literature in relation to the theoretical framework for this research, which is institutional theory. Based on the literature review of both practice literature in relation to implementation of new work roles (chapter two) and formal theory in this chapter, I have provided a summary of key research gaps in section 3.4. The last section of this chapter will show the step-by-step development of the conceptual framework to guide the collection, analysis and understanding of findings.

### **3.2 Theoretical framework**

Theory attempts to explain why things work in a certain way by finding, analysing and examining the relationships between the different elements in research (Ravitch & Riggan, 2017). Suddaby (2010) describes theories as tools, and argues that they should be specific to central research questions. A theoretical framework provides a structure to hold or support the concepts that are relevant to the topic and relate to the areas of knowledge being considered (Abend, 2008; Ravitch & Riggan, 2017). The theory for this study is institutional theory. Using institutional theory as a theoretical lens, how actors support the institutionalisation of the new NA role within GP practices will be analysed. This theoretical framework or formal theory is identified through literature review of empirical research and literature of role implementation, and in particular, the institutionalisation models for new roles discussed in section 2.6 are all underpinned by institutional theory. My study on NA aims to add and/or advance the knowledge of role implementation, and as supported by Ravitch & Riggan (2017) as an acceptable approach, the use of the same theory is adopted in this study.

However, institutional theory is a broad area with many concepts. My study will only focus on those relevant to role change: institutions, institutional work, work role, identity, legitimacy and institutionalisation. Similarly, the selection of these

interlinked concepts is informed by the literature review of other empirical studies of role implementation where these concepts were examined. The section below examines these concepts using a hierarchical approach, starting with structure (institution) and then its components: actors and their behaviour (institutional work); work roles and identity; and role legitimacy.

### **3.3 Institutional Theory**

Institutional theory is a prominent paradigm in modern organisational research, and is often used to explain adoption and spread of formal organisational practices (David et al., 2019). It uses a social approach to understand organisations and management practices and explains organisational behaviours (Suddaby, 2013). This is particularly relevant to the NHS as a business of people. The key idea of the theory is that conformity and legitimacy are often more dependent on social pressures than efficiency or technical forces (Suddaby, 2013). Tracing back its history, there have been many influential founders and scholars such as Scott, Zucker, DiMaggio, Lawrence and Zilber, and their classic literature continues to be cited by current researchers.

As part of this phenomena, the term 'actor' has been used by scholars as short hand for an entity that can take action, which can be an individual or organisation (Voronov & Weber, 2020). Traditionally, organisational studies were focused on macro sociological analysis of social systems and organisations at the structure level (Lawrence & Suddaby, 2006). As part of this approach, research on institutional change primarily looked at the diffusion of new ideas from one organisation to another (Reay et al., 2013). Amongst other contributions, this led to understanding of the role of organisational structure in enabling and constraining organisational behaviours, and generation of core concepts as a result such as institutionalisation, institutional change and institutional logics (Lawrence et al., 2011).

One criticism of this institutional approach is the loss of the lived experience of the individuals / actors, and some have argued the importance of understanding its relationships with the institutions / organisations (Lawrence et al., 2011). As a

dominance theoretical tool, the risk of losing the variety and complexity of the real empirical world through a single lens has also been highlighted (Suddaby, 2010). In recent years, there has been a broader focus and the emergence of institutional studies to understand the role of actors in effecting, transforming and maintaining institutions (Lawrence et al., 2011). In the systemic literature review of Human Resource Management (HRM) implementation carried out by Trullen et al. (2020), there is call for further research for a practice-based approach to HRM in general, such as the role of middle managers in adoption and variation of HRM ideas.

The remainder of this section will examine those concepts under institutional theory that are of relevance to role change and legitimacy and have been adopted in this study.

### 3.3.1 Institution / organisation

Before discussion on other concepts, it will be useful to first review the concepts in relation to an institution. This is important as institutions are at the heart of all organisational research using an institutional approach, as well as having a significant impact on the emotions, thoughts and behaviour of the actors at both an individual and collective levels (Lawrence & Suddaby, 2006).

*'Institutions comprise regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life'*

(Scott, 2013, p. 56)

Under the above definition, institutions are complex and multilayer social structures with different behaviours, activities, values, habits, customs and ways of thinking. In turn, the cultural norms, beliefs, symbols and rituals create the dynamic of an institution (Suchman, 1995). Scott (2013) emphasises the contrasting capacity of an institution to control and constraint behaviour, and to support and empower the actors and activities. On the other hand, he also highlighted that institutions are the product (intentional or otherwise) of purposive actions of actors. Together with the view that actors have the ability to use their lived experience to structure an institution (Lawrence et al., 2011), they illustrate a dynamic and dependent

relationship between an institution and its actors / individuals. This interpretation also confirms the mutual necessity of people and institutions as advocated by Voronov & Webster (2020).

Based on different underlying philosophical assumptions, three pillars or systems (regulative, normative, and cultural-cognitive) are identified by the social theorists in an institution (Scott, 2013). These three independent elements have varying assumptions in relation to different dimensions such as basis of legitimacy, order, compliance and logic. Each pillar complements and reinforces the other, and together they provide a powerful social framework. They also represent a continuum of behaviour ranging from conscious to unconscious, and legally enforced to taken for granted. Bearing in mind its wide spectrum, in practice, an institution is likely to be in different part of this framework at any one time, depending on the particular issue.

### 3.3.2 Actors and Institutional Work

Institutional work is defined as the 'broad category of purposive action of individuals (actors) and organisations aimed at creating, maintaining, and disrupting institutions' (Lawrence & Suddaby, 2006, p. 216). There are different categories, types and definitions of institutional work (Table 5), and those activities under creating strategies are most relevant to introduction of new work roles. There is also the cumulative impact of the separate activities of role implementation on institutional change. Perkmann & Spicer (2008) highlighted a higher success rate of role institutionalisation with more types of activities taking place together, and the collective influence on relatively junior actors is shown in Labelle & Rouleau (2017) through combined actions. However Scott (2013) pointed out that institutions are relatively resistant to change, and this suggests that institutional change such as role change can be subject to significant levels of challenge.

The term 'institutional entrepreneurs' was introduced by Paul DiMaggio to describe the individuals and groups, often command the necessary resources, carry out purposive activities that lead to adoption of change and new practices (David et al., 2019).

**Table 5: Types of Institutional work (Source: Giezen, 2018)**

<b>Category</b>	<b>Type</b>	<b>Definition</b>
Creating Strategies	Advocacy	The mobilisation of political and regulatory support through direct and deliberate techniques of social suasion
	Defining	The construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field
	Vesting	The creation of rule structures that confer property rights
	Constructing identities	Defining the relationship between an actor and the field in which that actor operates
	Changing normative associations	Re-making the connections between sets of practices and the moral and cultural foundations for those practices
	Constructing normative networks	Constructing of interorganisational connections through which practices become normatively sanctioned and which form the relevant peer group with respect to compliance, monitoring and evaluation
	Mimicry	Associating new practices with existing sets of taken-for-granted practices technologies and rules in order to ease adoption
	Theorising	The development and specification of abstract categories and the elaboration of chains of cause and effect
	Educating	The educating of actors in skills and knowledge necessary to support the new institution
Maintaining strategies	Enabling Work	The creation of rules that facilitate, supplement and support institutions, such as the creation of authorizing agents or diverting resources
	Policing	Ensuring compliance through enforcement, auditing and monitoring
	Deterring	Establishing coercive barriers to institutional change
	Valourizing and demonizing	Providing for public consumption positive and negative examples that illustrates the normative foundations of an institution
	Mythologizing	Preserving the normative underpinnings of an institution by creating and sustaining myths regarding its history
	Embedding and routinizing	Actively infusing the normative foundations of an institution into the participants' day to day routines and organisational practices
Disrupting strategies	Disconnecting sanctions	Working through state apparatus to disconnect rewards and sanctions from some set of practices, technologies or rules
	Disassociating moral foundations	Disassociating the practice, rule or technology from its moral foundation as appropriate within a specific cultural context
	Undermining assumptions and beliefs	Decreasing the perceived risks of innovation and differentiation by undermining core assumptions and beliefs

In this interpretation, the role of the entrepreneurs is central to institutional processes and likely to rest on a few individuals in an organisation. Scott (2014) describes this power to have effect on the social world such as altering rules and distributing resources as 'agency'. Under this organic bottom-up model, studies show development of the new roles only requires a light touch support from senior managers in the organisations, rather than directing (Kessler et al., 2017; Reay et al., 2006)). To do that, these institutional entrepreneurs (agencies) are also equipped with particular social skills in order to carry out institutional work, including motivating others to co-operate with each other (Fligstein, 1997). However, it is demonstrated that a wide range of actors with different and multiple skillsets are needed to involve and drive the change process, undertaking different kinds of work (Perkmann & Spicer, 2008). This view is also later echoed by Kessler et al. (2017), highlighting institutional change (the development of a new role in that case) was dependent on the input of a range of stakeholders including managers, co-workers and postholders themselves. The evidence illustrates the multiple and broad range of skills needed by many actors in the organisations in institutional change, ranging from the ability to build networks to technical capabilities. Some also felt the bottom-up collective effort by the actors in fostering outcomes and driving forward innovations is an area that has been neglected (Shipton et al., 2017; Zilber, 2002), and perhaps should be further investigated.

There are different types of embeddedness: structural, cognitive, cultural, and political (Dacin et al., 1999). The views on whether 'embeddness' of actors is a constraint or facilitator of change vary, although much of the focus by institutional theorists is said to be on its restriction to act (Reay et al., 2006). One of the significant and influential studies on embeddedness was a four-year investigation of the introduction of a new work role (nurse practitioner) into a well established health care system in Canada. In this study by Reay et al. (2006), embeddedness provides an distinctive advantage to actors and this allows them to take action and implement the desired change in the organisation. Using their established networks and inside knowledge of the work environments, actors (particularly the middle managers) are able to act at the right time. The finding is further confirmed in other studies (Goretzki et al., 2013; Kessler et al., 2017) to show embeddedness is an advantage in change initiatives. However, Kessler et al. (2017) highlighted the role of other actors

in institutional change including the postholders themselves, as well as those in middle management positions.

### 3.3.3 Work Role

The concept of work role is associated with the normative pillar in an institution. In this pillar, the institution defines its goal and objectives and the ways to achieve them. In terms of values (preferred or desirable standards) and norms (how things are to be done), some of them will apply to all its members / actors while others are only related to selected positions or actors. The latter is to do with where the work roles come from and Scott (2013) defined them as 'conceptions of appropriate goals and activities for particular individuals or specified social positions' (p. 79). These conceptions are not just anticipations but actual prescriptions of how the actor should behave, and in practice, they are formally described in the role or job descriptions for example. Therefore, work roles act as a common language to some extent and provide that shared expectations and understanding for actors within the organisation and beyond.

Roles are also associated with specific social status and different levels of remuneration to reflect the responsibilities and potentially power as a result of associated resources e.g, knowledge and position (Beckert, 1999; Goretzki et al., 2013). Therefore, actors may work towards a particular role and acquire new skills to increase their own status as well as the ability to influence in the institution or particular social setting (Goretzki et al., 2013). The concept of role is said to be one of most popular areas in social science research, and role theory explains roles by assuming people have positions in the social world that come along with expectations for their own behaviour and that of others (Biddle, 1986). To expand on this, role theories examine how an individual's behaviour is shaped by their social status and provide understandings of how others perceive these behaviours in relation to roles (Anglin et al., 2022). Begun as a theatrical metaphor, the presumption is that actors play their specific parts with written scripts and this boundary explains why performances are predictable and the audiences know what to expect (Biddle, 1986). Putting role theory into the context of workplace, work roles affect how people behave and see themselves, and how others predict their

behaviours as there are expectations tied to that role (Anglin et al., 2022). This is certainly true in a professional world where different job titles give a clear indication of what one can expect such as doctor, nurse, solicitor and accountant and so on.

In terms of role development, this can emerge informally over time as a result of repetitive actions which lead to a different expectation within an organisation (Scott, 2013), and eventually, the role substitutes or merge with existing ones (Goretzki et al., 2013). This means roles can respond to the changes of the prevailing understandings and legitimacy of the norms of a specific group of actors. On the other hand, work roles can be created formally by an organisation (Scott, 2013) and in some cases, as a result of introduction of new institutional frameworks or templates (Goretzki et al., 2013). The latter can be associated with new positions in an organisation to meet a particular requirement such as the NA role in England. A new role could also be introduced based on business needs and levered by superior resources, as can be seen in some very specialised industries (Akintola et al., 2017). However Goretzki et al. (2013) argue that the traditional approach to understanding the relationship between institutions / organisations and its actors is no longer adequate, and instead of institutions influencing actors, actors in fact have an active and influential role in institutionalised elements such as role creation and change.

Considering work role as an institutional element, role change is being regarded as a form of institutional change (Chreim et al., 2007; Goodrick & Reay, 2010; Goretzki et al., 2013; Reay et al., 2006). Although the numbers of studies in relation to institutional theory are now focusing on organisational micro-processes, the understanding on initiation and implementation of role change within an organisation is comparatively limited (Goretzki et al., 2013). There have been only few studies to focus on the establishment of a new role in healthcare from the perspective of Human Resource Management, and amongst them are Reay et al. (2006) and Kessler et al. (2017). In addition to the findings in relation to actor embeddedness, Reay et al. (2006) disproved the theory that an external jolt is essential in change initiation to transform and mobilise actors, as found in established literature previously. This study was also the first to attempt linking the process and impact at micro and macro levels. The model of institutionalisation



developed in this study was later further expanded by Kessler et al. (2017), and this will be examined in more detailed in later sections.

### 3.3.4 Role identity

As described above, the concept of role came from the theatre world, and it associates with scripts and parts. Following from that is identity, describing the relationship between an actor and the field of acting (Bourdieu & Wacquant, 1992). The term 'identity' has also been found to be closely linked to practices in the 'field', and 'fields' in this context are defined as 'networks of social relationship and a totality of relevant actors' (Covaleski et al., 1998; Oakes et al., 1998). Role and identity are being described as two sides of the same coin, with role facing outward and identity looking inward and concerning self-definition (Chreim et al., 2007). This means role change has a knock-on impact on identity and vice versa.

Identity is particularly relevant in the professional world. Putting this into the context, role identity associates with role enactment and particular set of values, beliefs related to the role (Chreim et al., 2007). This means by enacting a role in practice, this gives rise to role identity and role identity ultimately determines how professionals behave in clinical settings. This may also explain why changes to professional roles often face strong resistance (Chreim et al., 2007), and legitimising role change in clinical professionals can face more challenges and requires different strategies (Goodrick & Reay, 2010). The power of the professional group as a whole in institutional change was illustrated in a comparative case study of 12 Italian hospitals, where managers hold back from introducing radical innovations or changes if they consider professional resistance is too great to overcome (Labelle & Rouleau, 2017). The role identity, in part, and the associated values and beliefs can be seen translated into Code of Conduct or Practices by Professional Bodies. Goretzki et al. (2013) showed the link between (re)constructing role identities and legitimising new roles in order to achieve institutionalisation. As well as purposive activities from others, efforts are needed from the role owners themselves to accept and internalise the new role script / description as part of constructing new identities (Goretzki et al., 2013). While identity is primarily intrinsic and inward looking, Goretzki et al. (2013) showed the value of linking the intra and extra levels of

activities, and success of using external actors outside the organisation to support the internal effort of (re)-construction of an identity (in this case, the role of management accountant). This findings echoed the earlier views of other researchers as an approach to support the institutionalisation of a new role (Alvesson & Willmott, 2002; Chreim et al., 2007). It is also a relevant strategy for a role for GP practices working as part of a wider system.

Patriotta & Lanzara (2006) defined institutionalisation of an identity as a process where the knowledgeable actors generate and repeat that self-image of work over time, and gradually, this gains approval and is taken for granted. This interpretation implies that an individual creates, develops and embeds an identity, but in practice, an identity could be established externally in a short space of time and given to an individual, such as the role of NA. In general, there is limited research examining the process of legitimising a new professional role identity (Goodrick & Reay, 2010).

Focusing on the nursing profession, Goodrick & Reay (2010) found legitimising the professional identity over the decades has been incremental and evolutionary with different rhetorical strategies, without delegitimising the past. The latter appears to be different from the findings by Goretzki et al. (2013) where a potential need for identity change in professional role change is highlighted. One explanation for this difference is the timeframe for implementation and benefits realisation, as evolution takes a long time and, in some cases, may never happen. Goodrick & Reay (2010) also identified a strong link between the professional task environment and the wider institutional environment. This strategy is evident in the business case of skill-mix change where the introduction of non-medical roles is associated with workforce shortage and efficiency.

### 3.3.5 Legitimacy of new work role

#### Defining legitimacy

Legitimacy as a phenomenon is not a single concept and over the years, there has been multiple perspectives by researchers and scholars. Suchman (1995) offered a

broad and inclusive approach, encompassing both the cognition and evaluative elements of the dynamic process. He described legitimacy as a 'generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions' (Suchman, 1995, p. 574). This view of a generalised but not an event specific evaluation is shared by Scott (2013) and this broad perspective may also explain the amount and richness of the thoughts and theories generated.

Suchman (1995) identified three forms of legitimacy: pragmatic (based on audience self-interest), moral (based on normative approval) and cognitive (based on comprehensibility and taken-for-grantedness). All of them exist together in the real world, complementing each other although capable of conflict too (Suchman, 1995). Organisations with strong technical and skill environments are said to have a higher need for legitimacy for different types of things in general (Suchman, 1995), such as the NHS. Within this context, some suggest that nursing is an excellent setting to examine the process of legitimising a new role, as it has evolved on a journey from the Dickens character Mrs Gamp, to Florence Nightingale, and then forward to the current era (Goodrick & Reay, 2010).

### Gaining legitimacy

Legitimacy is defined as a perception or assumption, a reaction of observers to the organisation and other actors (Suchman, 1995). This means legitimacy is a collective reflection of those in a group or organisation and by the nature of an institution, these people have similar behaviours and values and beliefs. In fact, the importance to converge the views of multiple stakeholders as part of the process to legitimise role change is also emphasised by Chreim et al. (2007). However, this definition seems passive when compared to the one offered by Goretzki et al. (2013). They regard legitimising a role as a conscious act by the actors within the organisation as a result of institutional work to take steps towards achieving institutionalisation of a new role. However the one thing in common across these two interpretations is the external element and the role of actors and their views in the legitimacy process. On the other hand, this is not always seen as a one-way process. In the study by Kessler et al. (2017), those taking up the new roles

influenced the perceptions of the stakeholders and as a result, these healthcare workers secured acceptance and gained legitimisation.

Goretzki et al. (2013) consider role legitimisation as the crucial step to accomplish the institutional change process, so innovations or changes such as new roles can be deemed as appropriate, desirable or proper in the institution or organisation (Goodrick & Reay, 2010; Greenwood et al., 2002; Suchman, 1995). This implies legitimisation has a wider meaning and is a validation of the change, both to the postholders and their organisations. There is also a top down approach of validation such as in the case of NA, where some argue that legitimacy can be granted by political or cultural authorities such as state politicians or professional associations (Greenwood et al., 2002). Together, they illustrate different level of innovation activity and perhaps the need to have a better understanding of relationships between workplace, organisational and system in innovation transfer (Kessler et al., 2017).

While legitimacy has a strong external perspective, it not only affects how others behave towards the postholder but also how the individual understands herself or himself (Suchman, 1995). As discussed, Goretzki et al. (2013) confirm the close close relationship of role and identity, and a need to address both as part of the role legitimisation process. In terms of the owner of the new role, local knowledge gained over time is also a source of legitimacy, as this has added value to the operation of the organisation (Goretzki et al., 2013). A similar finding can be seen in Kessler et al. (2017) where the postholders of the new roles had been working in the respective hospitals for many years, and this supports the finding that cultural alignment can enhance legitimacy (Goretzki et al., 2013).

Legitimacy can be a facilitator for both institutional stability and change (Chreim et al., 2007; Goodrick & Reay, 2010; Reay et al., 2006). Patriotta & Lanzara (2006) highlight the need for repeated processes of creating, establishing and embedding role identities in organisations to ensure the new role is accepted. On the other hand, Kessler et al. (2017) points out the fragility of job boundaries leading to ongoing challenges. This confirms the legitimising process is not a coincidence, and is the outcome of purposive and continual actions by the actors (Reay et al., 2006). One

element of this is to act upon and change the expectations of others which may involve intensive efforts (Alvesson & Willmott, 2002; Goretzki et al., 2013).

According to Greenwood et al. (2002), legitimisation is part of a bigger framework and one of the four stages of institutionalisation: old way of working, isolated examples of new ways of working, new way is legitimised, new way is taken for granted. This means institutionalisation of a new role is a process but not an end point.

### Embedding legitimacy

This is last stage of the institutionalisation process where a new role is no longer considered new and becomes institutionalised or taken-for-granted (Greenwood et al., 2002). Using the interpretation by Goretzki et al. (2013), institutionalisation of a new role is the product of purposive actions carried out by actors to support a specific institutional arrangement with the organisation. To explain this further, the process is being described as efforts in stages to first legitimise a new role and re-construct role identity, and then de-legitimise the old role.

The institutionalisation process is not linear, and Kessler et al. (2017) points out the dynamic nature of the different stages with recurrent activities as part of institutional work. This echoes an earlier view by Patriotta & Lanzara (2006). There are also different but related levels, and the emergence of a new role at organisational level may not be easily re-created at system level (Kessler et al., 2017). With the same principle, this suggests that transferring new roles such as NA from system to organisational level is not straightforward.

### **3.4 Key research gaps**

From the topical and theoretical literatures reviewed, it would appear that there are a number of under-researched areas in relation to my research topic. They are healthcare, primary care and innovation implementation, and I now summarise them in turn.

Firstly, Kessler et al. (2017) has highlighted the limited numbers of studies on the establishment of new work roles in healthcare. Although a handful of studies continue to emerge regarding healthcare roles in the NHS such as the recent one by Kessler et al. (2017), it is still the case that as with previous ones, these were mainly in a hospital setting and were bottom-up initiatives. Moreover, the lack of evidence for primary care has been highlighted recently with the situation described as patchy (Nelson et al., 2018; Spooner et al., 2022).

'New work roles' is a type of human resource management innovation (Kessler et al., 2017). However, innovation implementation has also been identified as an important area but with limited research and is underdeveloped. (Shipton et al., 2017; Trullen et al., 2020). In recent years, there is a growing body of research investigating skill-mix changes in primary care in relation to the ARRS roles. However, none of these studies have yet included NAs. More specifically, the NA is a new professional nursing role. At the time of writing this thesis, there is limited empirical evidence available as part of ongoing research examining the introduction of the NA role. These papers primarily relate to care home and hospital settings, and there has been no other published reports or papers looking at the implementation of NA in GP practices or its impact.

In terms of institutional theory, the EIM for a new role by Kessler et al. (2017) has not been widely tested in a healthcare setting or beyond. There is also limited evidence investigating the processes of legitimizing a new professional role identity (Goodrick & Reay, 2010), including nursing. In addition, there is also a lack of study focusing on the link between professional role and role identity in the context of change (Goretzki et al., 2013).

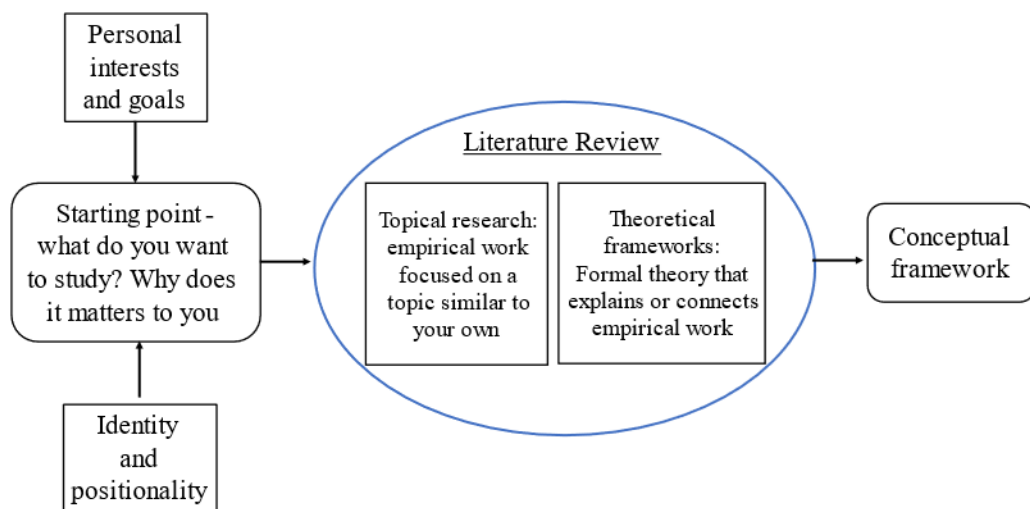
Altogether, the above confirms that my research will potentially help to fill the evidence gap to an extent. To do that, I will be using the institutionalisation models discussed in section 2.6 as the sensitising framework to explore role implementation. In particular, this will also allow me to test out further the EIM model in healthcare but in a different setting.

### 3.5 Building the conceptual framework

This section focuses on the development of the conceptual framework to guide the collection, analysis and understanding of findings.

There are different perspectives of the term conceptual framework. Some treat conceptual and theoretical frameworks the same, hence they can be seen interchangeably in literature (Ravitch & Riggan, 2017). In this study, I follow the approach of Ravitch and Riggan (2017) and Figure 5 shows the elements in the conceptual framework.

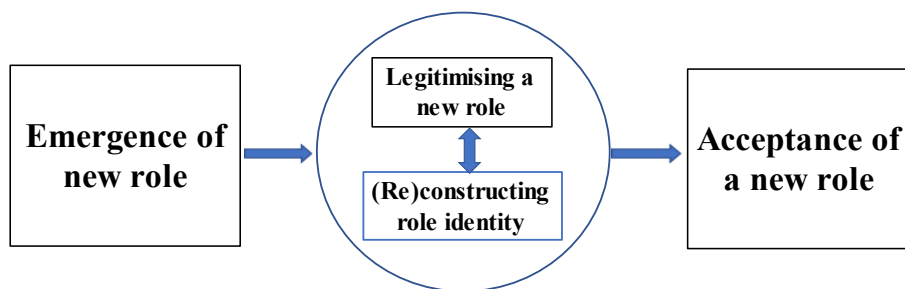
**Figure 5: Elements of a Conceptual Framework (Source: Ravitch & Riggan, 2017)**



My personal interests and goals for this study are the starting points and I articulated them in section 1.5. Literature review is the second component, and the review of topical research has been discussed in chapter two. Those publications relating to the relevant concepts in the theoretical framework (i.e. . institutional theory) for my study have been explored earlier in this chapter. I will now bring together all the components to show the final conceptual framework constructed for the study of Nursing Associate (NA).

The first component of the conceptual framework is drawn from the review of topical research of new work roles. The three institutionalisation models reviewed in section 2.6 provide structures to guide the development of new work roles as part of skill-mix change, and Figure 6 shows the elements adopted from these models to form the emerging framework. The Elaborated Institutionalisation Model (EIM) is an expanded model by Reay et al. (2006), and the evaluation in section 2.7 shows the presence of its characteristics in other empirical studies of role introduction. Therefore, I believe that the stages in this model offer a reasonable foundation to build the conceptual framework. Goretzki et al. (2013) illustrated the importance of role identity during the process to legitimise a new role. The discussion on role identity in section 3.3.4 above further confirms the relevance of this in professional roles particularly, hence the expansion of the second stage.

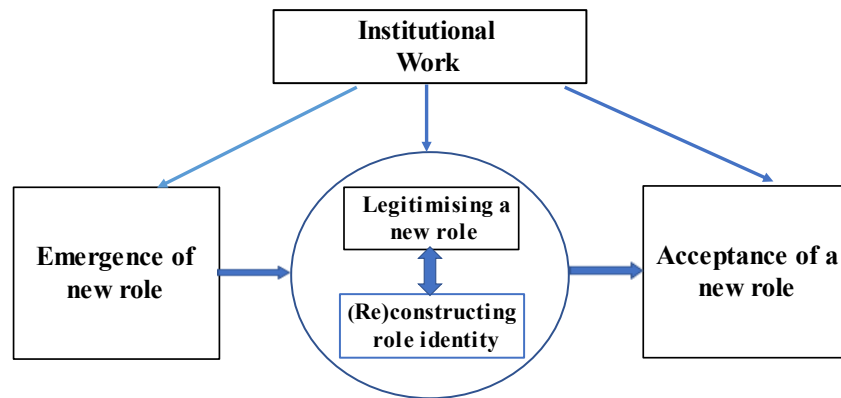
**Figure 6: Conceptual framework – Stage 1**



As explained in section 3.2, I have adopted institutional theory as the theoretical framework for my study. From the review of the framework and the relevant concepts, role change, legitimisation and institutionalisation of new work roles are all part of institutional work by actors. In addition, institutional work was the key concept in the three institutionalisation models (Goretzki et al., 2013; Kessler et al., 2017; Reay et al., 2006). To ensure the conceptual framework reflects the outputs from both parts of the literature review process, institutional work is included. Adding this explicitly into the framework will also act as a prompt to guide the analysis and discussion of the findings. Figure 7 shows the complete framework.



**Figure 7: Complete conceptual framework**



The complete conceptual framework is a result of literature reviews of both topical research and theoretical framework. In turn this has provided me with the initial themes / codes (also known as a priori themes) to develop the preliminary coding template (Figure 11 on page 84 ) for data analysis using the Template Analysis method. Section 4.6 in the following chapter on methodology and methods includes step-by-step details on the development of the final template from the preliminary coding template using the a priori themes.

### **3.6 Chapter conclusion**

This chapter has examined relevant key concepts in relation to institutional theory: institutional work, work role and identity, and role legitimacy and institutionalisation. Institutional theory provides a useful approach to understand adoption of innovations and change from the social perspective, and the role of actors in the initiation and development of work roles. Indeed, this theoretical framework is also used by other empirical studies of new work roles (Goretzki et al., 2013; Kessler et al., 2017; Reay et al., 2006), and I argue this demonstrates its appropriateness for this type of studies and further adds weight to my decision to adopt.

Work roles are part of the normative pillar of an institution or organisation. They have scripts, translated to job description, which defines the behaviours of the individuals and frames the expectations of the others. There is mixed evidence of whether external triggers are needed to initiate role change, and studies (Kessler et al., 2017; Reay et al., 2006) show embedded actors make this happen. This is one area that my research intends to understand more fully. There is also role identity which is a key element in role change, and this link is particularly strong and explicit in professionals such as doctors and nurses. Goretzki et al. (2013) show the importance of putting efforts in (re)constructing identity as part of role legitimisation, hence identity is included as an element in the conceptual framework.

This chapter has also examined role legitimacy, a perception of other people and a validation from the external world. This is a result of purposive actions by the actors employing different strategies over time, and legitimacy is not the end point but part of the journey to ensure the new role becomes taken-for-granted. There is also a question about the transferability of new work roles from organisational to system level, and the same argument may apply the other way round.

From the review of topical and theoretical literature, there are a number of under-researched areas in relation to my topic. These areas have stimulated my curiosity to find out more, and one of them is role identity, as it is most relevant in professions, including nursing.

Finally building on the emerging concepts from the literature review, this chapter also has presented the conceptual framework to inform and organise the development of my research. The literature review of the topical research (chapter two) has identified the EIM (Kessler et al., 2017) as a foundation for the conceptual framework. I have adopted institutional theory as the theoretical framework and together, they form the conceptual framework to inform and organise the development of my research. The conceptual framework has provided me with the initial codes / themes to construct the preliminary template for Template Analysis.

I now turn to using it as a mechanism for research design and methodology and the details of this are provided in the following chapter.

## **Chapter 4    Research Methodology and Methods**

### **4. 1 Introduction**

The purpose of this chapter is to set out the methodological approach, methods and techniques for my research, and the justifications for doing so. To do that, I use the conceptual framework to guide the development.

Any research requires an understanding of the relationship between theory, philosophy (ontology and epistemology), methodology and methods (Howell, 2013). This chapter begins by describing the research philosophical position: a relativism ontology and a constructionist epistemology. This is followed by a closer examination of the chosen methodology (case study in this case) to meet the aims and objectives of the research, and the reasons for considering this as the most appropriate design.

The chapter then covers the design and implementation of the data collection process, where the data collection methodologies included sampling, recruitment of participants, use of semi-structured interviews and focus groups. The robustness and limitations of using case study as a research method will be discussed. Finally the last section focuses on data analysis using template analysis as an approach assisted by NVivo, and explains the rationale for the choices.

This research into Nursing Associates (NAs) is a qualitative study, aiming to understand how, why, and to what extent the NA role has been implemented in general practice. Through comparisons of case studies, the enablers and barriers for role change and institutionalisation are to be examined. I have chosen this method as it allows me to generate a subjective understanding of 'hows' and 'whys' in relation to people's behaviours (Baker & Edwards, 2012). There are also many methods associated with this method for collecting and analysing the data that I am able to consider (Easterby-Smith et al., 2018).

## 4.2 Research Process

Exploring my philosophical approach is necessary because the researcher's experience and world view influences and shapes the design and selection of the methods intended to achieve the aims and objectives (Creswell, 2014). Indeed, Easterby-Smith et al. (2018) reiterate the need to think through and understand the philosophical factors in relation to the actual research.

To do that, I have used the 'tree metaphor' from Easterby-Smith et al. (2018) as the framework to set out and illustrate the key concepts behind my research process. This metaphor consists of four elements: roots (research traditions); trunk (research design: ontology, epistemology, methodology, methods and techniques); leaves (collection and analysis of data) and fruit (writing up and dissemination of the research). Other scholars (Crotty, 1998; Saunders et al., 2019) conceptualise these key components differently, but the tree metaphor is chosen because this logical approach mirrors my personal style of reasoning. Table 6 shows the components of the tree in relation to the NA research, and each of these elements will be discussed in the following sections.

**Table 6: Applying the tree metaphor to the Nursing Associate research (Adopted from Easterby-Smith et al., 2018)**

<b>Tree Metaphor</b>	<b>Research Process</b>	<b>NA research</b>
<b>Fruits</b>	Writing up and dissemination	Enhanced institutionalisation model
<b>Leaves</b>	Data collection and analysis	Template Analysis
<b>Trunk</b>		
The bark	Methods and techniques	Interviews
Third ring	Methodology	Case Study
Second ring	Epistemology	Constructionism
Inner ring	Ontology	Relativism
<b>Roots</b>	Research tradition	Nominalism

## 4.3 Philosophical Underpinnings

According to Mark Easterby-Smith et al. (2018), there are three main research traditions: realism; nominalism; and various third ways that blend realist and

nominalist traditions. Represented as the root of the tree, these traditions are drawn up and form the basis of the research process.

#### 4.3.1 Ontology

Ontology is the basic assumption about the nature of reality (Easterby-Smith et al., 2018). Crotty (1998) defines ontology as the study of being, concerning with ‘what is’. Putting this into the context of qualitative research, ontology is concerned with how the social world can be studied (Ritchie et al., 2014), and ‘how things really are’ and ‘how things really work’ (Denzin & Lincoln, 2018).

Easterby-Smith et al. (2018) set out three ontological positions in relation to social sciences: internal realism, relativism and nominalism. Table 7 shows their different characteristics.

**Table 7: Ontologies and Social Sciences (Source: Easterby-Smith et al., 2018)**

	<b>Internal Realism</b>	<b>Relativism</b>	<b>Nominalism</b>
Truth	Truth exists but is obscure	There are many truths	There is no truth
Facts	Facts are concrete, but cannot be accessed directly	Facts depend on viewpoint of observer	Facts are all human creation

I consider the research philosophy of this study is aligned to relativism. Putting this in the context of this NA study, the focus will be less on the technical implementation skills of the individuals but on their strategies, as well as the relationship between the NAs and the different stakeholders in the GP practices.

#### 4.3.2 Epistemology

As for epistemology, it is the study of knowledge and is about understanding ‘what it means to know’ (Crotty, 1998). It is concerning ways of knowing and learning about the world (Ritchie et al., 2014), and assumptions about the best way to do that (Easterby-Smith et al., 2018). For Crotty (1998), epistemology is a way of looking at the world and making sense of it, as echoed by Creswell (2014), who called that

the 'worldview'. In relation to the development of a research proposal, Creswell (2014) considered epistemology as 'a basic set of beliefs that guide action'. This is compatible with the view expressed by Crotty (1998) earlier, and means one's epistemology in turn influences the methodology adopted.

There are arguably two divergent views on ways of investigating the physical and social world: positivism and constructionism (Easterby-Smith et al., 2018).

Positivists believe that there is a social world and one can come to know it directly and objectively, rather than through subjective intuition. However, for those elements of human behaviours that could not be observed, such as feelings and emotions, they are ascribed as unimportant (Howell, 2013). Against this, constructionists consider reality is constructed, and what can be known has been interpreted through human senses and the brain.

According to Easterby-Smith et al. (2018), studies with 'relativism' ontologies are associated with a constructionism approach to epistemology. The assumption under this position is that there are many different realities, and therefore, the researcher needs to gather multiple perspectives and views and experiences of different people. Saunders et al. (2019) define this type of philosophy / paradigm in business and management research as 'interpretivism', and the aim is to 'create new or richer understandings and interpretations of social worlds and contexts' (p149). This indeed reflects the purpose of this NA research, aiming to better understand how, why and to what extent the new role has been implemented in general practice.

Interpretivist researchers look at organisations from the different perspectives of different groups of people (Saunders et al., 2019). This point is particularly relevant in the NHS and this study of NA, as there many different GP practices in primary care as well as professional and staff groups. Easterby-Smith et al. (2018) refer this activity of gathering multiple perspectives of diverse participants as triangulation, so to allow a more accurate understanding of the whole. In addition, interpretivists recognise the diversity of the social world we live in today, and that different people with different cultural backgrounds under different circumstances and at different times make different meanings. It is this interpretation of a complex organisation that makes interpretivism relevant and contemporary to the NHS, in the current

world of inclusion. To me, this also highlights and confirms the importance of context in change including new role and implementation. Some consider that an interpretivist perspective is highly appropriate for business and management research, as the social context for each organisation is unique and complex (Saunders et al., 2019).

Regarding the relationship between researcher and the actual research, interpretivists adopt an empathetic stance and their own values and beliefs play an important part in the data interpretation process (Saunders et al., 2019). Together with the need to understand that social world from the participants' point of view, one would argue the added value of being a researcher-practitioner (like me) in interpretivist research. However, I am mindful of the biases this may bring and propose to identify and manage them by applying reflexivity. More on reflexivity will be covered in section 4.8.

#### **4.4 Research methodology - Case Study**

This section will describe how the research methodology, methods and techniques are put together to provide a robust and coherent design for the research. The basis for selecting qualitative case study methodology for examining the introduction of NAs in GP practices is based on the nature of the research question. I lean towards the approach of Robert Yin and the rationale for this will be further discussed in later sections

##### **4.4.1 Study Aim and Objectives**

This research study aims to understand how, why, and to what extent the NA role has been implemented in general practice. Through qualitative comparisons, the enablers and barriers for role change and institutionalisation are to be examined. In turn, this will provide transferrable learning for clinicians and stakeholders who may be involved in the introduction of the NA and other non-medical clinical roles in the English primary care system. To do that, the study will focus mainly on the following three research questions in relation to whether the NA role is able to fill

the skill gaps between the Registered Nurses (RNs) and Healthcare Assistants (HCAs):

1. What processes does the institutionalisation of a new work role follow?
2. How does professional role identity affect the legitimisation process?
3. How are the efforts of actors defined in the institutionalisation of a new work role and its successes?

The study also attempts to identify the intended impact at this early stage. To do that, the study will focus mainly on the following three questions in relation to whether the NA role is able to fill the skill gaps between the RNs and HCAs:

1. How is the NA role used in GP practices?
2. What are the tasks and responsibilities that are delegated from the RNs to NAs?
3. What is the impact of the new way of working on service delivery, the GPNs themselves, the practice team as a whole and other team members?

#### 4.4.2 A brief history of case study research

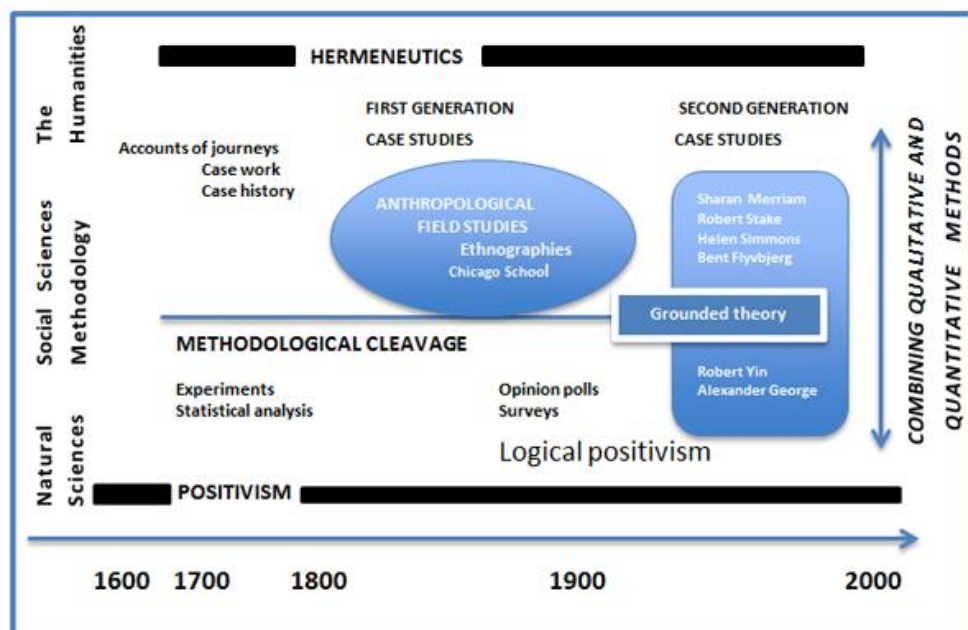
Case study designs have a long history, dating back to Charles Darwin, although they have gone through substantial development over the last 40 years (Harrison et al., 2017). They have been used in many disciplines to answer a wide range of research questions, particularly in social sciences, education, business, law, and health. Figure 8 shows the history and evolution of case study research, including key contributors and major contextual influences.

Early case studies were conducted in the social sciences and anthropology. With the emergence and dominance of positivism in science in the late 1940s and 1950s, there was a strong focus on quantitative methods for social sciences too. This led to criticisms about its weakness in generalisation and validity as a research design. A second generation of case study researchers emerged in the 1960's with the development of grounded theory methodology, resulting in an inductive methodology and detailed systematic procedures for data analysis. This revived the use of case study in the disciplines of social sciences, education, and the humanities.



Robert Yin continued this journey. With a social science background and experience of scientific approach in research, he injected experimental logic into qualitative methods and strengthened the quality of case study as a research methodology. The use of case study research in political sciences during the 1980's and 1990's had seen further integration of narrative and statistical methods in studies. In the 1970s, case studies were widely used in education to evaluate curriculum designs, although when compared to the approach taken by Yin, they were less structured.

**Figure 8: The history and evolution of case study research (Source: Cited in Harrison et al., 2017)**



Contemporary case study research has grown in popularity as well as sophistication. It is now widely accepted as a credible method to be used in a wide range of disciplines to explore a variety of complex issues.

#### 4.4.3 The choice of case study methodology for investigating new roles

There are a range of methods in social science research, and to decide on the methodology, I used the three elements indicated by Yin (2018): the form of research question; the control of the researcher over the actual events; and the focus on historical or contemporary events. Table 8 shows the five research methods to be used in relation to these three situations.

**Table 8: Five research methods (Source: Yin, 2018)**

	<b>Form of research question</b>	<b>Requires control over behavioural events</b>	<b>Focus on contemporary events</b>
Experiment	How, why	Yes	Yes
Survey	Who, what, where, how many, how much	No	Yes
Archival analysis	Who, what, where, how many, how much	No	Yes / No
History	How, why	No	No
Case study	How, why	No	Yes

The research question for the NA study is examining 'why' the new role of NA was introduced in GP practices and 'how' it has been implemented. I did not have any control over the behavioural events, and the focus of the study is therefore not about 'how many' and 'how much'. As can be seen in Table 8, only one, i.e. case study, will allow the investigation of 'how' and 'why' questions in situations where the researcher does not have any control of behaviours. In fact, case study research is commonly used in practicing professions including nursing. For these reasons, I consider case study as a methodology is a good fit with the research question.

The heart of any case study is to 'illuminate a decision or set of decisions: why they were taken, how they were implemented and with what results' (Schramm, 1971). Yin (2018) defines three different types of case study: explanatory, descriptive and exploratory. The primary question of my research is concerning what can be learnt from the experience of these GP practices, and this would fit into the exploratory category. However, there are also the how and why elements of the research question: how the new NA role was introduced and legitimised, and why it worked (or not) in GP practices. These aspects of the research question are better aligned to the explanatory type.

According to Yin (2018), a multiple-case study is also the preferred design for focusing on the 'why', as it is more compelling and robust overall. For this reason, I have designed this research with a maximum of seven case studies in mind, one for each Clinical Commissioning Group (CCG) area of the NE of England.

Having defined the case and being clear about the research question, the next step is 'bounding the case' to decide what is in and what is excluded, and other related clarifications. Creswell (2014) described case study as the study of a bounded system, and a case can be individual/s, some event or entity, or indeed a variety of topics (Yin, 2018). Saunders et al. (2019) expanded on this and highlighted on the understanding of the processes and discovering of context from case studies. To bound the case, I have considered three elements: what the case is; geographical area; and specific time boundary. According to Yin (2018), bounding the case in this way would help to determine the scope of data collection as well as tightening the connection between the case and the research question. For this study, only GP practices (case) in the seven CCGs areas in the NE of England (geography) with NAs qualified six months or more ago from the date of interview (time) were included. This information is then translated into a sampling strategy in section 4.5.2.

#### 4.4.4 Adopting Yin's approach to case study methodology

There are a number of definitions and descriptions on case study research, and the most common ones come from the work of Robert Yin, Robert Stake and Sharan Merriam (Harrison et al., 2017). As a result of their philosophical differences (Table 9), this has influenced how they define, describe, and apply the research in practice.

**Table 9: Philosophical variations of researchers (Summary of contents from Harrison et al., 2017)**

<b>Researcher</b>	<b>Ontological positions</b>	<b>Focuses</b>	<b>Critical Elements in research process</b>
Yin	Realist	maintaining objectivity in the methodological processes within the design.	Adherence to mechanisms that ensure rigor in data collection and analysis, and reporting.
Merriam	Constructivist	meanings and understandings developed socially and experientially	Utilize processes that help interpret, sort, and manage information and that adapt findings to convey clarity and applicability to the results.
Stake	Constructivist and interpretivist	disciplined approach to the process and a strong motivation for discovering meaning and understanding of experiences in context.	The interpretive role of the researcher is essential to understand and put meanings, and generate knowledge.

Harrison et al. (2017) described their approaches to case study research as a continuum from quantitative with Yin at this end, to qualitative with Stake at the other end, and Merriam in the middle. Yin has drawn on his scientific approaches to research gained from his background in the social sciences, and applies experimental logic to his qualitative methods (Harrison et al., 2017). Yin's realist approach to qualitative research provides a structured process for case study research, and I found this particularly appealing to my own philosophical position. Therefore, I have chosen Yin's case study approach.

## **4.5 Research Methods**

Some have argued that research method is of secondary significance (the first is methodology) to the questions of paradigm and the basic world view of the researcher (Denzin & Lincoln, 2018). Yin (2018) indicated six sources of evidence: documentation; archival records; interviews; direct observations; participant observation; and physical artifacts. I have chosen semi-structured interviews as the research method, and this section covers this and the justifications. It also discusses the sampling strategy and data collection process, and the ethical considerations and approval associated.

### **4.5.1 Semi-structured interviews**

Although different types of data are usually collected in case studies, due to the human focus of most case studies, Yin (2018) described interviews as being the most important source of evidence. Interviews enable purposeful discussion between two or more people (Saunders et al., 2019), and allow explanations (hows and whys) as well as providing insights of participants' perspectives (Yin, 2018). This illustrates the view by Pawson & Tilley (1997) that the subjects, participants and the researcher all have something different to offer in terms of interpreting the research question. Whereas structured interviews are commonly seen in descriptive research, semi-structured interviews are appropriate and frequently used in both exploratory and explanatory research (Saunders et al., 2019). For these reasons, I have chosen semi-interviews as the method for this exploratory and explanatory research. This method

would also allow me as the researcher to be closer to the objects (participants) being studied (see section 4.3.2) and this is preferable in social science studies.

I did consider observations as a source of evidence, but this was not possible or practical. This is because the data collection phase of this study began in October 2021 (shortly before further restrictions were put in place due to the spread of the Omicron variant of COVID), so on-site data collection was not possible. Regarding documents, management information such as duty rotas and clinic schedules were considered during the initial planning stage. Due to the different way of service delivery in primary care, they do not exist and so this activity had to be excluded from data collection.

#### 4.5.2 Sampling Strategy

To recruit the case study sites, a purposive sampling strategy was adopted, and according to Easterby-Smith et al. (2018), this is where the researcher has a clear idea of what sample units are needed, and invites the potential sample members. My role as a practitioner-researcher in the NHS system in the NE has given me both the knowledge and access to high level information in relation to the NA programme in GP practices. This information has informed my sampling strategy and more will be discussed in the paragraphs below.

As part of the scoping work to develop a research proposal to put to the University in 2019, I gathered information from Health Education England (HEE) regarding the numbers of trainee NAs (TNAs) in the NE of England and the commencement date of their training. Table 10 shows the breakdown by CCG. As shown, there had been four intakes of a total of 26 TNAs in GP practices across the seven CCGs in the NE at the time of designing this study. The training for a NA is 2-years long, and the assumption was that all of the trainees would have qualified by March 2021. Although the total number of GP practices involved was not known, the number would be 26 or less.

**Table 10: Numbers of trainee Nursing Associates in North East of England**

North East England	Intakes of TNAs				
	Apr 17	Mar 18	Dec 18	Mar 19	Total
CCG 1			3	2	6
CCG 2				1	1
CCG 3		5		1	6
CCG 4	2		3	1	7
CCG 5			3	1	4
CCG 6			2		1
CCG 7				2	1
<b>Total</b>	<b>2</b>	<b>5</b>	<b>11</b>	<b>8</b>	<b>26</b>

This study is to examine the introduction of NA in GP practices in the NE of England. Therefore, the inclusion criteria is GP practices in the NE of England employing qualified NAs. Some CCGs only had one or two trainees. In order to maximise the potential to include a case study site from each CCG area in this regional study, I decided to invite all the 26 practices to take part in the first instance.

#### 4.5.3 Recruitment

Recruitment of GP practices was carried out through the CCG Directors of Nursing (DoNs) with support from HEE Senior Workforce Regional Lead for Nursing & Midwifery, and Research Engagement Leads following the research protocol. This was because no details of GP practices with qualified NA were shared with me by HEE for data protection reasons. An invitation email (Appendix D) together with a Participant Information Sheet (PIS) (Appendix E) were initially emailed out to the DoNs of the seven CCGs in the NE of England for forwarding to the relevant GP practices in their area. Practices were asked to send their expressions of interest (EOIs) directly to me. A spreadsheet was set up to record EOIs received and support the sampling process. If more than one EOI was received from each CCG area, further screening would take place to ensure a mix of urban and rural GP practices to enhance the quality of data collected.

The design of this study was finalised in the summer of 2020 when the first COVID lockdown began to ease. Based on the initial schedule, invitations were to be sent out to all GP practices in January 2021. Unfortunately, COVID remained and

escalated, and the UK entered a second lockdown in November 2020 following by a third lockdown in January 2021. Throughout 2021, GP practices were extremely busy managing the consequences of COVID as individual organisations, as well as dealing with the additional demand such as the roll out of vaccination programmes. After discussion with my supervisors, the timing to send out the invitation email was postponed to May 2021 (see Table 11), in response to the rising service pressure due to COVID. Overall, the recruitment process was extremely challenging and the first EOI from GP practices did not come through until late summer 2021.

**Table 11: Recruitment and interview schedule for case study sites**

Cohort	Intake Date	Qualified	IRAS		Revised @Jan 2021	
			Invitation	Interview	Invitation to DoNs	Interviews
1	Apr 17	Mar 19	Jan 21	Mar/Apr 21	13/5/21	Jun – Sept 21
1	Mar 18	Mar 20	Jan 21	Mar/Apr 21	13/5/21	Jun – Sept 21
2	Dec 18	Dec 20	May 21	Jul/Aug 21	13/5/21	Jun – Sept 21
3	Mar 19	Mar 21	Aug 21	Oct/Nov 21	14/5/21	Oct – Nov 21

Once a practice expressed an interest to participate in the study, an onboarding meeting was arranged with the Practice Manager (PM) or Nurse Manager (NM). The objectives were to answer any further queries, seek consent from the GP practice (Appendix F), and discuss arrangements of interviews and focus groups. Appendix G shows a sample agenda. Case study sites were asked to identify the participants and also a convenient date for the interviews and focus groups. This list of participants with their work email addresses were then shared by the practice with me, where a PIS (Appendix H) and a consent form (appendix I) were sent out to participants in advance.

After a long period of waiting for EOIs, only five GP practices covering five CCG areas had agreed to take part in this study. All GP practices had more than one site, and Table 12 shows the characteristics of the GP practices. Replies from some GP practices that decided not to take part confirmed that this was due to the workload of the GP practices, and they could not afford to release clinical staff particularly from service delivery.

**Table 12: Characteristics of GP practices**

<b>GP practice</b>	<b>Registered Population (approx.)</b>	<b>Type</b>	<b>Location</b>
Site 1	16k	Medical Group	Urban
Site 2	26k	Alliance	City
Site 3	51k	Partnership	Town
Site 4	40k	Limited Company	Urban
Site 5	36k	Medical Group	Urban

#### 4.5.4 Data collection

Interviews and focus groups took place at least 6 months after the NAs qualified. This was to enable a period of time for the new role to embed into the nursing team, so members of participant groups were more able to appraise the role implementation process and the early contributions of NAs. The rationale for the choice of 6 months is because the recommended period of a preceptorship programme to support a new registrant by The Nursing and Midwifery Council (NMC) is about four months (NHSE, 2022). Therefore six months was considered as a reasonable timeframe.

**Table 13: Data collection summary**

<b>Intervention / procedure</b>	<b>Approx time</b>	<b>Person to conduct the activity</b>
Seek consent with each participant in advance of the 1:1 and focus group interviews.	10 min	The researcher sent out an email with a PIS and a blank consent form for information in advance. Consent was obtained immediately before interviews and focus group discussions.
1:1 interview with qualified Nursing Associate/s in each case study site	45 min	The researcher carried out this intervention in the participant's work place (GP Practice) via Microsoft Teams
1:1 interview with the Practice manager or Nurse Manager in each case study site	45 min	The researcher carried out this intervention in the participant's work place (GP Practice) via Microsoft Teams.
Focus group interview with Registered Nurses / Nursing Team in each case study site	60 min	The researcher carried out this intervention in the participants' work place (GP Practice) via Microsoft Teams except case study site 3.
Interview with GP in each case study site.	45 min	The researcher carried out this intervention in the participants' work place (GP Practice).



There were four groups of participants for each GP Practice case study site: NA, Nursing Team (one or more RN), PM or NM, and GP. Each participant was interviewed once. All interviews were initially planned to be carried out in the respective GP practice case study site. However other than one focus group with a nursing team, all others took place via Microsoft Teams due to COVID restrictions. RNs, GPs and PMs / NMs were chosen because they are the decision makers in determining what duties would be delegated to the NAs and ultimately, the appraisers as to the success of this role. Table 13 summarises the data collection.

There was a total of four sets of interview schedules (see Appendix J), one for each participant group: NA, RNs / Nursing Team, PM or NM, and GP. These questions were adapted from the ongoing NA study at King's College London to reflect GP practices as a setting. Broadly following the stages of institutionalisation of new work role (Kessler et al., 2017), these semi-structured questions focus on how and why the role of NA has emerged in respective GP practice; how the participant/s view and use the role in daily practice, and finally the contributions and impacts (if any) of NA role on co-workers and service delivery. The duties or tasks performed by the individuals in the GP practices before and after qualifying as a NA were also collected.

A total of 20 interviews and focus groups took place between October 2021 to October 2022. One NA qualified NA had left Case Study 4. Despite an attempt to invite the individual to take part in the study through the PM, no reply was received. Baker (2012) and Kessler et al. (2017) offer a rationale for fewer participants as qualitative studies capture a sufficient depth in data and analysis. Thus, rather than stipulating a minimum number of interviews, this case study design sought to ensure as many views as possible were included in all participating case study sites. Additionally, I adopted the pragmatic approach suggested by Baker (2012) where the numbers of interviews depend on the external determinants and issues such as time available to complete the study and access participants. This pragmatism is necessary in this study, as discussed above, as it had taken a long time to secure the case study sites and the participants during COVID. As with methodology and methods, the question of numbers of interviews will also depend on the researchers' ontological and epistemological viewpoint (Baker & Edwards, 2012). Taking into

account all of the above opinions and discussions with supervisors, I concluded that 20 sets of interviews would be sufficient for the intended analysis to meet the objectives of this study. This highlights that in case study research, the 'case' is the unit of analysis and not individual interviewees. Therefore, multiple interviews pertaining to one case offers increasing depth. Table 14 shows a total of 29 participants by type.

**Table 14: Numbers and type of participants**

Type	Site 1	Site 2	Site 3	Site 4	Site 5	Total
NA/s	1	1	2	0	1	5
Manager (nurse* / practice)	1*	1	1*	1	1*	5
Nursing Team (included RN/s and/or TNA/s and/or HCA/s)	1	3	4	1	5	14
GP	1	1	1	1	1	5
<b>Total participants</b>	<b>4</b>	<b>6</b>	<b>8</b>	<b>3</b>	<b>8</b>	<b>29</b>

\*Nurse manager

#### 4.5.5 Ethical considerations and approval

Research ethics is concerned with the design of the study to ensure it is both morally and methodologically sound and defensible (Saunders et al., 2019). As a Registered Nurse, I am also bound by the NMC professional Code to act with integrity and safeguard trust and confidence from the public. I had been involved in strategic level activities in the region to introduce this role, such as sharing communications from Health Education England (HEE) with GP practices. I had not been involved at practice level in role implementation and therefore declare no conflict of interest. I had secured an educational grant from Royal College of Nursing Foundation and some funding support from NHS England (NHSE) for personal development, and the funders had no role in the design of the study, data collection and interpretation process, and the publication of the result findings.

Two ethical approvals for the study were obtained. Firstly, an application was submitted to Northumbria University for approval in July 2020. No amendments were needed or queries raised, and the approval was granted in early August 2020. This followed by an application to the Health Research Authority (HRA), as required for all health and social care research in the UK. An application with supporting

documents was submitted via the single online portal 'Integrated Research Application System' (IRAS) in August 2020. After initial review, I was advised that the study would be better suited to a Full Research Ethics Committee review which is a lighter touch. At the end of September 2020, minor amendments were requested for the PISs, research protocol and organisation information document. One query was raised by the HRA regarding the use (or not) of an external transcription service. Updated documents and requested information were provided and an approval was given by the HRA in October 2020.

Informed consent had been obtained from the GP practices and all the participants. Consent from the GP practice as case study site was sought at the onboarding meeting after a PIS was sent in advance. A blank consent form was sent out to all participants together with the PIS – NHS staff in advance of interviews and focus groups for information, and written consent was obtained from each individual prior to the interviews. The participants had been given a minimum of 10 working days' notice before the interviews or focus groups took place. This was to ensure participants had sufficient time to consider the invitation to participate in the research, as well as raising any questions related to the research (if any). An electronic copy of the signed consent form was sent to all GP practices and participants for record. Participants could withdraw from the study at any time and no reasons were required to be given. Should this happen, identifiable data already collected with consent would be retained and used in the study. I can confirm that no participants withdrew from the study during the research.

#### 4.5.6 Confidentiality

All interviews were recorded on my iPhone initially, which is password protected. Audio recordings were destroyed once written transcription was completed within 21 working days. All research data and associated files such as consent forms, interview recordings and transcripts and data analysis have been stored electronically in the secure U drive of University of Northumbria, which enables real time back-up of all data files. Electronic files with confidential or personal data are password protected. Research data alongside files generated from analysis (Word / Excel /

NVivo) will be stored for 7 years from the completion date of the study at the University of Northumbria as per section 10 of the Records Retention Schedule.

Pseudonymisation of personal data was carried out to ensure the confidentiality of personal data, and the names and other identifiers (i.e. job title and place of work / name of GP practice) of participants had been replaced with a reference number. This pseudonymisation log is password protected and stored electronically in the secure central U drive of University of Northumbria. Reference numbers had been used in the written transcripts of 1:1 interview and focus group discussions. As this is educational research, only I had access to the participants' personal data during the study.

This study makes use of direct quotations from respondents. It is recognised that GP practices are small organisations with relatively small numbers of employees, so there is a high possibility that the participant could be indirectly identifiable when their place of work and job title / role are linked. Therefore, all geographical details of practices were removed in the reporting of the findings and quotes anonymised.

The interviews were transcribed and analysed by me, and therefore, no data was exported to a company inside or outside the UK. The transcripts of the interviews and focus groups and the analysis include participant reference numbers only. The research data generated by this study (included electronic scanned consent forms) will be stored in password protected electronic files safely and securely in my personal secure space on Northumbria University's U drive for 7 years from the completion date of the DBA programme. This will enable follow up research studies to be carried out in the future. All personal data will be destroyed as soon the viva has taken place and the DBA programme has completed.

A data management plan (Appendix K) was created using DMPonline. It was submitted alongside the two applications for ethical approval and no adverse feedback was received. Further details regarding data management, ethics and legal compliance, storage, backup, data sharing and preservation can be found in the plan.

In line with the NMC professional Code of Conduct section 10.6, I am required as a registrant to 'collect, treat and store all data and research findings appropriately'.

#### 4.6 Analysis of Data

The focus of the analysis was to identify organisational and/or operational factors affecting the introduction of the new NA role in each site and those common across all GP practices. There was a total of 20 sets of interviews and focus group discussions generated by the four participant groups from the five case study sites. Due to the workload of the GP practices in response to COVID (as discussed in earlier section), it has taken a year to conclude the data collection. Table 15 shows the start and completion date for each site.

**Table 15: Data collection period for each site**

<b>Case Study</b>	<b>First interview / focus group</b>	<b>Final interview / focus group</b>
Site 1	Dec 2021	Mar 2022
Site 2	Aug 2022	Aug 2022
Site 3	Oct 2021	Nov 2021
Site 4	Mar 2022	May 2022
Site 5	Jan 2022	Apr 2022

Transcription of these interviews was carried out using a commercial software application called 'Otter', which provides speech to text live transcription using artificial intelligence and machine learning. Overall the quality of the transcript was of sufficient quality, and they were reflective of the verbal exchange during the interview. Participants were not asked to review the transcripts, a process known as the Interview Transcript Review (ITR). There is considerable debate about the value of respondent feedback as well as ethical issues (King & Brooks, 2017). Studies indicate that the actual value of ITR in improving the accuracy of transcripts is minimal (Hagens et al., 2009) as well as raising wider concerns (Forbat & Henderson, 2005) including that of data integrity, where Hagens et al. (2009) argue that amended transcripts could be regarded as a different data source.

While interviews are insightful and targeted on the case study topic, I was very mindful of their weaknesses. These can include bias due to respondents' bias, inaccurate recall and poor or inarticulate articulation (Yin, 2018). One reasonable approach to mitigate some of these weaknesses is to corroborate the interview data (Yin, 2018), and I did this by triangulating the responses from different groups of participants in the same case study.

The next subsections explain the process to analyse the data collected from the interviews and focus groups, by using Template Analysis as a method and NVivo as an assistive software

#### 4.6.1 Analytical Method – Template Analysis

Template Analysis (TA) is a form of thematic analysis, and is widely used in organisational and management research across different disciplines including healthcare qualitative research (Brooks et al., 2015; King & Brooks, 2017). All thematic analysis share two features: identifying the recurrent themes in the data and organising them into some kind of structure (Tabari et al., 2020).

I have chosen TA as my analytical tool for a number of reasons. Firstly, it is a good fit to analyse and interpret interview transcripts (Tabari et al., 2020), and is ideal for handling a large amount of data and analysing textual research material (King & Brooks, 2017). Secondly, it is logical and systemic allowing me to drill deep into the data. TA uses hierarchical coding structure with narrower or more specific themes nesting within wider themes (Brooks et al., 2015). Compared to other forms of thematic analysis which usually restricts to three levels of coding only, one can deep dive into the data and it is not uncommon to see five or even more levels of coding in some templates (Tabari et al., 2020). Moreover, a core characteristic of TA is the ability to incorporate a priori themes and this allows me to identify them from the conceptual framework in advance of the research analysis (Brooks et al., 2015; Tabari et al., 2020). This option is very much in alignment with my personal philosophical stance. Although some have argued that this approach seems to be 'out of tune' with the mostly inductive nature of qualitative research, Tabari et al. (2020) pointed out that even as inductive in Ground Theory, it is recognised that researchers

may bring along 'sensitising concepts' as prior interests to the analytic process. This is definitely true and in the inductive exploratory research carried out by Kessler et al. (2017) on institutionalisation of two healthcare support roles, the legitimisation model by Reay et al.(2006) was being referenced as a strong 'sensitising framework' for the study. Finally philosophically speaking, TA is not inextricably bound to a particular viewpoint (Brooks et al., 2015; Tabari et al., 2020). According to King & Brooks (2017), this flexibility means that it can be used in a variety of research methodologies and adapted to suit the philosophical underpinnings of different studies. Altogether, TA is a perfect fit for my study.

Although TA offers me a number of positive features, I recognised that there are limitations too (King & Brooks, 2017), particularly fragmentation of accounts and risk of losing a holistic view. One strategy to compensate as suggested by King & Brooks (2017) is to present the findings by individual case study, and I have adopted this in the study.

#### 4.6.2 NVivo

To help with the data analysis, NVivo 12, a form of computer-assisted qualitative data analysis software (CAQDAS) had been used to organise all the data in a logical manner, and systemically explore the data from the transcripts. Evidence showed the use of NVivo is particular helpful in generating, refining and testing theories, and this helps to advance the robustness of qualitative research (Dalkin et al., 2021). The CAQDAS had not replaced the need for an analytic strategy for my study, and I used it as an administration tool to store and organise the data and assist with the analysis process.

There are debates on the pros and cons of using CAQDAS in qualitative data analysis. While some people believe that software is central to the process, others are concerned that it will distance the researcher from the data and 'guide' the researcher in a certain direction (Bazeley & Jackson, 2013). However, CAQDAS had been shown as a useful aid to researchers to provide a transparent and accurate picture on management, as well as an audit trail of the analysis process, which is

often missing in qualitative research (Welsh, 2002). As a person with a realist ontology, these features of CAQDAS are particularly attractive.

A template with nodes and sub nodes for each case study was set up on NVivo. More on the development of the templates will be discussed below. The transcripts were stored on NVivo and coding was carried electronically on NVivo. This way, the software enabled me to explore the data systemically from the transcripts and helped to enhance the quality, rigour and trustworthiness of the research (Welsh, 2002).

With no prior experience of using NVivo in the past, learning how to use the software and take the full advantage of this tool was a challenge. It has been a 'learn-as-you-go' experience. I acquired the basic skills via a variety of sources: support from other researchers, online training resources from NVivo and social media platforms, information from literature, text book (Bazeley & Jackson, 2013) and simply experimenting.

#### 4.6.3 Analytical Framework

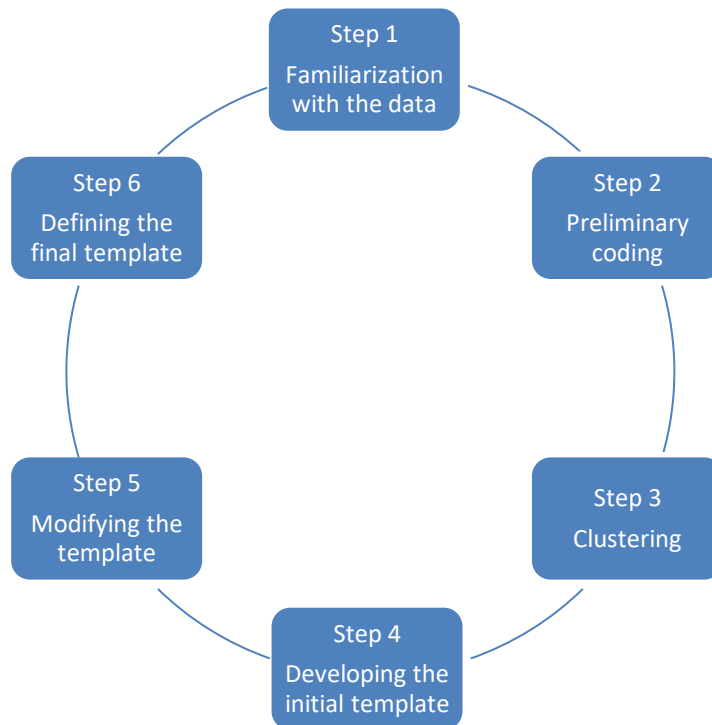
To carry out thematic analysis using the TA approach, the steps described by King & Brooks (2017) have been followed as a guide (Figure 9).

##### Step 1: Familiarising with the data

Firstly I read through the 20 sets of transcribed interviews data so as to be familiar with them. This also provided another opportunity for me to correct any errors which were not noticed before and at times, I had to listen back to sections of the recorded interviews. This process of engagement and reflection as described by King & Brooks (2017) was particularly helpful, especially as some of these interviews took place months before. I also adopted their advice of a structured process, and transcripts of different stakeholders in a case study were read together as a subset, to gain a cross-section.



**Figure 9: Procedural steps for Thematic Analysis**

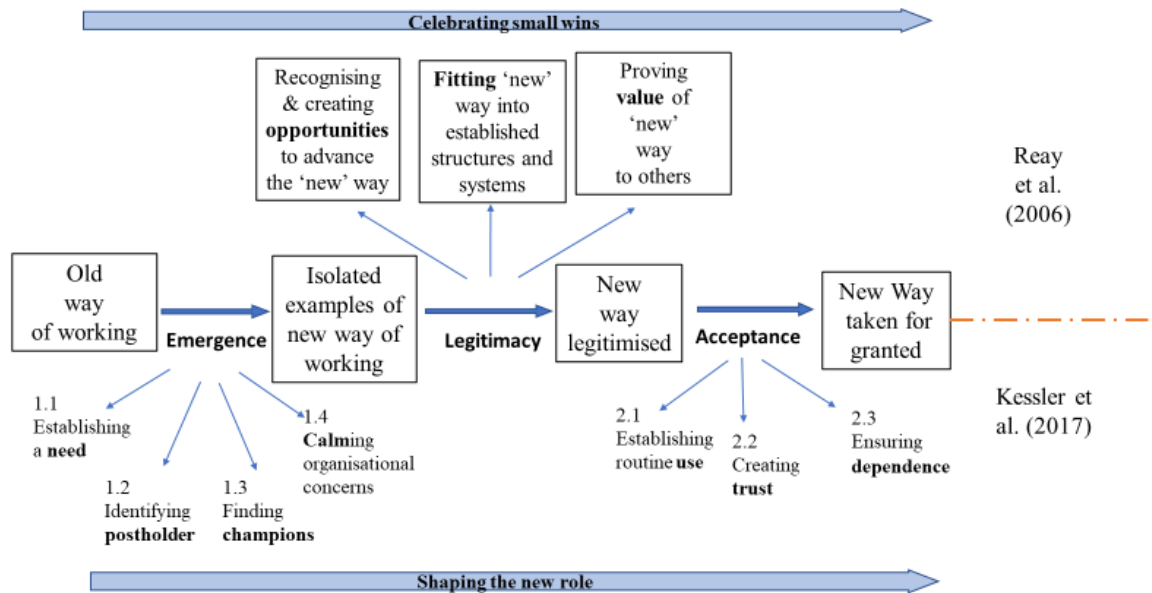


### Step 2: Preliminary Coding

King & Brooks (2017) defines a priori themes as 'themes in advance of code', and they were used as an approach in this study as preliminary codes. As an added advantage, the use of a priori themes had also speeded up the initial coding stage which according to King & Brooks (2017) can be very time-consuming.

The a priori themes were identified from the published research and theoretical framework, and research questions. This approach had been adopted because I intended to focus on the implementation process of a new work role. I created the first codes by adopting the 10 microprocesses in the Elaborated Institutionalisation Model (EIM) (Kessler et al., 2017) in Figure 10 and the associated empirical findings. Other codes such as accountability and role identity were also identified after a review of interview questions and the wider theoretical framework. Together, they provided clear and strong a priori themes as the preliminary codes.

**Figure 10: Elaborated Institutionalisation Model (Source: Kessler et al., 2017, p 242)**



### Step 3: Clustering

I then organised these a priori themes into meaningful clusters, and identified the lateral and hierarchical relationships. As the 10 microprocesses in the model are already categorised under the three stages of institutionalisation of a new role: emergence; legitimacy; and acceptance, the same clustering approach had been adopted to arrange these 10 themes in the same order, and they became the level one codes. The codes generated from the interview questions and the wider theoretical framework were included in level two. Altogether they formed the preliminary coding template (Figure 11) created on NVivo for use to code data from Case Study one.

### Step 4: Producing an initial template

To develop the initial template (Figure 12), I followed the guidance from King & Brooks (2017) for a sample size of 20 interviews. I applied the preliminary coding template to all the transcripts (four sets in total) in Case Study one. Indeed, a similar suggestion of coding approximately 20% of total numbers of transcripts was also provided by Brooks et al. (2015). Some changes had been made to the preliminary template, and they were captured in Table 16.

**Figure 11: Preliminary coding template with a priori themes after clustering**

<b>1.0 Establishing a need</b>
1.1 Service
1.2 Workforce / Nursing shortages
<b>2.0 Identifying post holders</b>
2.1 Person-centred qualities
2.2 Task-centred qualities
<b>3.0 Finding champions</b>
3.1 Support the role
3.2 Address the barriers
<b>4.0 Calming organisational concerns</b>
4.1 Training issues
4.2 Broader training needs
<b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b>
5.1 Accountability
5.2 Confidence and trust
5.3 Training and development
<b>6.0 Fitting new way into established structures &amp; systems</b>
6.1 Classifying the role / role identity
6.2 Develop a job description
<b>7.0 Proving value of new way to others</b>
7.1 Patients
7.2 Service delivery
7.3 Other team members
<b>8.0 Establishing routine use / establishing a distinctive contribution</b>
8.1 Contributions to other co-workers
8.1.1 Accessibility & Support
8.2 Contributions to patient services
8.2.1 Expertise of post holder
<b>9.0 Creating trust / ensuring the role is trusted</b>
9.1 Linkage to the individual
<b>10.0 Ensuring dependence / creating a dependence on the role</b>
10.1 Contribution of the new role
10.2 Routinely used and indispensable

The first NA qualified in the GP practices in the NE in April 2019, shortly before the COVID pandemic. During the process of developing the initial template, it was clear that the new role had not been embedded. Some of the microprocesses / a priori codes initially from acceptance stage were also raised by the participants earlier. Therefore, these codes were voided and some of its level two and three codes moved and incorporated into other parts of the coding template.

**Table 16: Changes made in initial template compared to preliminary template**

	Level 2	Level 3	Level 4
Additions	1.1 Catalyst for change	1.4.1 Bridging skill gap 1.4.2 Knowledge of the role 1.4.3 Nursing shortage 1.4.4. Workforce development	Under 1.4.4 • General needs • Individual needs
	1.2 Involvement and support	5.3.1 Concerns about the role	Under 6.2.2 • New way of working • Old way of working
	2.1 Established relationship	5.3.2 Impact of COVID	
	3.2 Encourage others to endorse change	5.3.3 Space	
	3.3 Institutional entrepreneurs	5.3.4 Others	
	4.1 Organising placements	6.1.2 Pay equity	
	4.2 Supervision	6.1.3 Role contents	
	4.3 Time out	6.2.1 NMC 6.2.2 Re(construct)	
	4.4 No resistance	7.3.1 Accessibility & support	
	5.3 Constraints 5.4 Opportunities	7.3.2 Mentoring	
	7.1 Confidence and expectations	7.3.3 Others	
Removal	8.0 Establishing routine use	8.1 Contributions to other co-workers	8.1.1 Accessibility & Support
	8.2 Contributions to patient services	8.2.1 Expertise of post holder	
	9.0 Creating trust		
	10.0 Ensuring dependence		
Other changes	4.0 'Calming organisational concerns' had changed to 'Overcoming barriers or concerns'		
	4.1 Training issues and 4.2 Broader training needs have been broadened to create four level 2 codes as indicated above.		

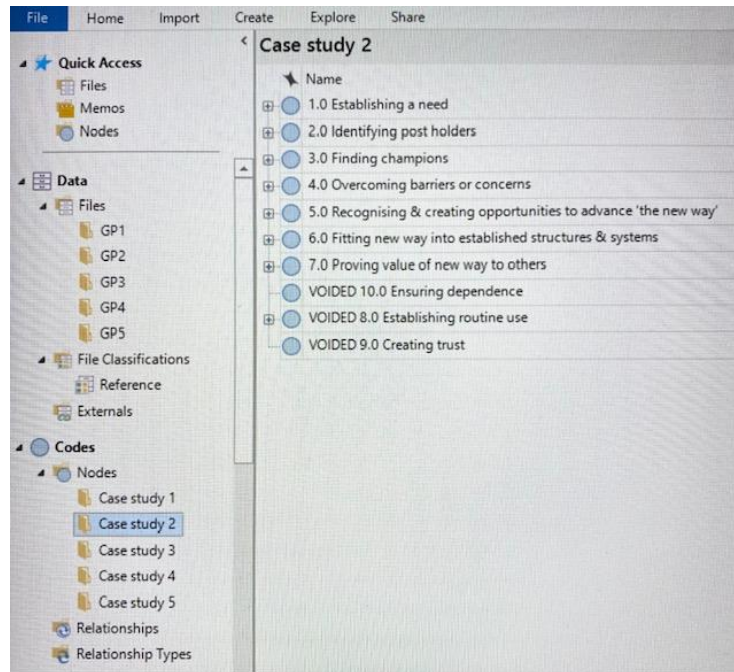
### Step 5 and 6 – Modifying the template and defining the final template

The data collected from each case study site was treated as a separate dataset and stored in separate files in NVivo. To further develop the template, I applied the initial template to the fresh material as advised by King & Brooks (2017). Using the nodes and child nodes facilities, a separate initial coding template was set up in NVivo for case studies two and five in different folders (Figure 13). Organising and analysing the data this way allowed generation of a separate final template for each case study for single case and cross-case synthesis.

**Figure 12: Initial template (after coding case study one)**

<p><b>1.0 Establishing a need</b></p> <ul style="list-style-type: none"><li>1.1 Catalyst for change</li><li>1.2 Involvement and support</li><li>1.3 Service</li><li>1.4 Workforce<ul style="list-style-type: none"><li>1.4.1 Bridging skill gap</li><li>1.4.2 Knowledge of the role</li><li>1.4.3 Nursing shortage</li><li>1.4.4. Workforce development<ul style="list-style-type: none"><li>General needs</li><li>Individual needs</li></ul></li></ul></li></ul> <p><b>2.0 Identifying post holders</b></p> <ul style="list-style-type: none"><li>2.1 Established relationship</li><li>2.2 Person-centred qualities</li><li>2.3 Task-centred qualities</li></ul> <p><b>3.0 Finding champions</b></p> <ul style="list-style-type: none"><li>3.1 Address the barriers</li><li>3.2 Encourage others to endorse change</li><li>3.3 Institutional entrepreneurs</li><li>3.4 Support the role</li></ul> <p><b>4.0 Overcoming barriers or concerns</b></p> <ul style="list-style-type: none"><li>4.1 Organising placements</li><li>4.2 Supervision</li><li>4.3 Time out</li><li>4.4 No resistance</li></ul> <p><b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b></p> <ul style="list-style-type: none"><li>5.1 Accountability</li><li>5.2 Confidence and trust</li><li>5.3 Constraints<ul style="list-style-type: none"><li>5.3.1 Concerns about the role</li><li>5.3.2 Impact of COVID</li><li>5.3.3 Space</li><li>5.3.4 Others</li></ul></li><li>5.4 Opportunities</li><li>5.5 Training and development</li></ul> <p><b>6.0 Fitting new way into established structures &amp; systems</b></p> <ul style="list-style-type: none"><li>6.1 Role boundary<ul style="list-style-type: none"><li>6.1.1 Job Description</li><li>6.1.2 Pay equity</li><li>6.1.3 Role contents</li></ul></li><li>6.2 Role identity<ul style="list-style-type: none"><li>6.2.1 NMC</li><li>6.2.2 Re(construct)<ul style="list-style-type: none"><li>New way of working</li><li>Old way of working</li></ul></li></ul></li></ul> <p><b>7.0 Proving value of new way to others</b></p> <ul style="list-style-type: none"><li>7.1 Confidence and expectations</li><li>7.2 Patients</li><li>7.3 Service delivery<ul style="list-style-type: none"><li>7.2.1 Additional capacity</li><li>7.2.2 Quality improvement</li></ul></li><li>7.4 Team members<ul style="list-style-type: none"><li>7.3.1 Accessibility &amp; support</li><li>7.3.2 Mentoring</li><li>7.3.3 Others</li></ul></li></ul> <p><b>VOIDED 8.0 Establishing routine use</b></p> <ul style="list-style-type: none"><li>8.1 Contributions to other co-workers<ul style="list-style-type: none"><li>8.1.1 Accessibility &amp; Support</li></ul></li><li>8.2 Contributions to patient services<ul style="list-style-type: none"><li>8.2.1 Expertise of post holder</li></ul></li></ul> <p><b>VOIDED 9.0 Creating trust</b></p> <p><b>VOIDED 10.0 Ensuring dependence</b></p>
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**Figure 13: NVivo files for NA research (screenshot)**



King & Brooks (2017) pointed out the template should continue to be refined throughout the analytical process where needed, in order to reflect the material of potential relevance. I was also mindful that the use of a priori themes in the initial coding stage should always be considered as tentative, and as highlighted by Tabari et al. (2020), the themes or codes were subjected to revision or removal should they prove to not fit. To apply the above into this study, I carried out three activities during the analysis process: inserting new themes; modifying existing themes; and changing the scope of the themes. No themes had been merged, but the code properties for some had been modified along the way to provide more clarity. Although the five final templates after analysis shared a lot of similarities, additional subthemes had been identified during the analysis and new subcodes had been created. This was to capture interesting or surprising themes from the interview transcripts which were not in the initial templates. Table 17 shows the additional codes in the final templates for case studies two to five when compared to the initial template (which was the final template of Case Study one). The final templates for the five case studies after analysis will be reviewed later in chapter five.

**Table 17: Additional codes in final templates compared to initial template**

	<b>Level One</b>	<b>Level Two</b>	<b>Level Three</b>	<b>Level Four</b>
Case study 2			1.4.4 GP shortage 1.5 Cost saving	
Case study 3		1.5 Cost saving 3.5 Autonomy	1.4.4.1 Planning	
Case study 4		1.5 Finance 2.4 Personal life	7.1.1 Benefits realisation 7.1.2 Formal agreement	1.4.4.1 Planning
Case study 5		4.4 Cost 4.6 Others	7.2.3 Release time from nurses	1.4.4.1 Planning 6.2.2.1 Challenges or issues.

#### 4.6.4 Analytical Process

To prepare for the analysis, each template with the nodes and excerpts were exported out from NVivo to Microsoft Word. Summary points were written for nodes underpinning by examples of quotes. According to Yin (2018), logic model is one of the most desirable approaches to analyse data from case studies. Using this approach, the findings and patterns from this empirical study were matched and compared to the predicted one, i.e. EIM and the micro-processes.

#### Case-based analysis

To analyse each case study, I applied the 3-stage approach as advised by King & Brooks (2017). Firstly, I examined the patterns of themes in the data. Particularly attention was paid to identifying if certain themes are featured more prominently in one type of stakeholder transcript. Sometimes, I revisited the coding of that particular transcript, to ensure nothing had been missed. However as pointed out by King & Brooks (2017), this was carried out for the purpose of taking a closer look at certain areas, as the frequency and pattern of theme distribution on their own do not necessarily reveal anything.

I then prioritised the themes and subthemes. Some of themes were related and therefore clustered from the perspective of analysis. My intention was that organising them this way would provide a deeper insight in some areas. For example, under 'establishing the need' theme, 1.3 'service' and 1.4 'workforce' are closely related and workforce shortage will impact on service delivery. To decide which themes to concentrate on, I took two approaches. Firstly, the main area of this research is on legitimisation of the new role, so the focus was put in the three themes in this area, i.e. 'recognising and creating opportunities to advance the new role'; 'fitting new role into established structures & systems'; and 'proving value of new role to others'. Secondly, the theme/s that contradict or differ from the existing literature. As an example, most of the literature in healthcare studies had indicated that an external jolt is not required for change. In this study, the presence of an external driver was very evident. More of this will be discussed in chapter 5: findings.

The last stage of the process is to find out and develop connections. Two types of relationship were identified: hierarchical within each theme; and with other themes in the template. For example in the theme of 'recognising and creating opportunities to advance the new way, the issues related to 'accountability' had a knock-on effect on the 'opportunities'. In terms of theme-to-theme relationship, 6.3.1 'role contents' could potentially be part of the 'constraints' (5.3) and also dictated to some extent the range of 'opportunities' the GP practice able to create.

And finally, tables and diagrams were used to illustrate relationships and emerging findings, and as a 'visual' person, I found this particularly helpful and some of these figures were also included in the thesis.

### Cross-case analysis

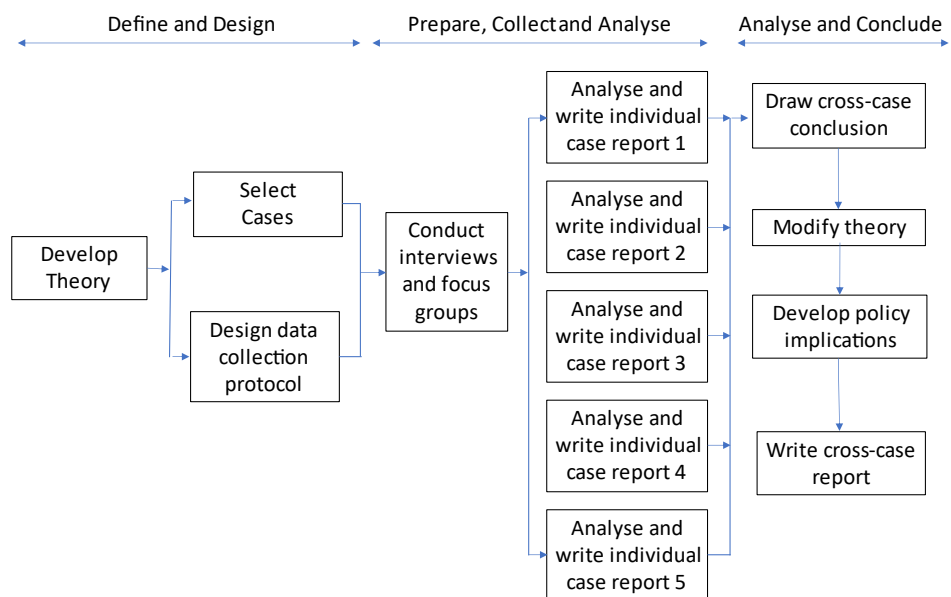
After identifying the patterns and drawing conclusions in each case, I carried out cross-case analysis to examine whether there was any replicative relationship between these cases. Particular attention was placed on the similarities and differences between these cases that might be related to rival interpretations. I did not aggregate and analyse the data from the same professional group, as would be



carried out in variable-based analysis. Instead, a case-based approach was adopted as it would be important for me to retain the integrity and holistic feature of each of the cases (Yin, 2018).

The final process was to synthesise the data for presenting and to draw conclusions. King & Brooks (2017) described three ways to write up findings from TA, and one of them is to report on a series of individual case studies with a discussion of their similarities and differences between cases. I was very mindful that this approach would take up more space in this thesis and be potentially repetitive. However, I decided to adopt this approach because it is holistic and allows the readers to get a deeper understanding of the participants' perspectives. This process is also in harmony with the multiple-case study procedure by Yin (2018). Following the approach shown in Figure 14, I first analysed and reported each case study separately, before drawing together the findings across all the five case studies and carrying out comparisons. In this study, the discussion on the cross-case synthesis is conducted in Chapter Six complementing the findings presented in Chapter Five.

**Figure 14: Multiple-Case Study Procedure (Adapted from Yin, 2018, p. 58)**



## 4.7 Methodological rigour

Saunders et al. (2019) argued that reliability and validity are key in order to 'reduce the possibility of getting the answer wrong', and Yin (2018) outlined four tests to establish the quality of most empirical social research. To assess and define the quality of qualitative research designs so to ensure the findings are credible, Saunders et al. (2019) noted that 'this has not been an easy exercise' (p270). Moreover, the meanings of reliability and validity also vary depending on the researchers' philosophical viewpoints (Saunders et al., 2019).

The above confirmed the previous view from Riege (2003) that, there is no single, coherent set of tests to determine the validity and reliability of qualitative data. However, there are different qualitative techniques that aim to correspond to those in quantitative research to enhance robustness. I have employed these techniques in the study to enhance quality of the design, and I now discuss them in turn.

### 4.7.1 Confirmability

Confirmability is about objectivity and neutrality, and resembles to construct validity in quantitative research (Riege, 2003). Saunders et al. (2019) defines validity as the relationship between two variables and whether the findings are really what they appear to be. To address this, one tactic suggested by Yin (2018) is to collect evidence through multiple sources, and this will increase the confidence of the audience of the research.

Quantitative data in relation to the context and practice characteristics such as practice size and workforce was collected for all case studies. There were four different participant groups to be interviewed in each case study site, and this provided four separate lines of inquiry. Together with the quantitative data, they served as multiple sources and satisfied the principle of 'convergence of evidence' (Yin, 2018, p. 129).

Another technique to is use of confirmability audit, including retention of field notes, raw data, tapes and versions of templates for later examination if required.

(Riege, 2003). Field notes were kept and interview transcripts were stored on NVivo. Together with successive versions of the template (also kept in NVivo), they allowed me to offer a history of processes, and illustrations of where changes were made and why (Brooks et al., 2015; Tabari et al., 2020).

#### 4.7.2 Credibility

This concerns with techniques to increase internal validity. This element is primarily concerned with explanatory case study, and Yin (2018) pointed out that specific tactics to achieve this requirement are difficult to identify in case study research. Nevertheless, he suggested four analytic tactics which can be used in data analysis.

One of them is pattern matching and is one of the most desirable technique for case study research (Yin, 2018). Logic models, a kind of pattern matching, involve matching empirical events to theoretically predicted events. In this study, I compared the complete analysis for each case with the microprocesses and characteristics of the legitimisation models of new work roles, and identified why the original sequences were affirmed, rejected or modified. In addition, a priori themes were used in Template Analysis for all cases which is also a form of pattern matching.

Use of triangulation technique was highlighted by Riege (2003). As outlined in above subsection, data is collected from different stakeholders as well as quantitative characteristics of GP practices. Together they have allowed cross references during data analysis phase of the research. In addition, constructive challenges by my supervisors during supervision meetings had also helped to enhance credibility.

Another way to enhance credibility is take into account of my own assumptions and worldview / philosophical stances (Riege, 2003). I have done that by adopting reflexivity and field diary through the research process, and more about this will be discussed in section 4.8 below.

#### 4.7.3 Transferability

This is also referred to as 'generalisability' and is concerned with whether the findings of a research can be applied to other settings or organisations (Saunders et al., 2019). This is particularly relevant to case study research, and in the past, the design was considered to have limited validity and value as a design, because its findings are not transferrable (Harrison et al., 2017). Saunders et al. (2019) argued the purpose of case study research is not to produce a theory to apply to all the population, but simply to try to explain what is going on in that particular setting.

Yin (2018) pointed out that research with no pressing 'how' and 'why' questions would find it difficult to generalise the analysis to the theory and/or policy levels. For this NA case study research, the 'how' and 'why' questions were at the centre of the research examining the introduction of a new work role for the nursing profession in England. Therefore, I considered that this test had been met.

Other techniques have also been highlighted by Riege (2003), and they include development of a case study database, use of cross-case analysis and pre-determined questions. All these three techniques are employed in this NA study.

#### 4.7.4 Dependability

The final test is dependability, aiming to minimise errors and bias in a study (Yin, 2018) and enhance reliability. Easterby-Smith et al. (2018) defines reliability as the extent to which the data collection techniques or analysis procedures will generate consistent findings, and this view was concurred with by Saunders et al. (2019).

Four factors that could threaten reliability were cited by Saunders et al. (2019) and they were participant bias, participant error, observer bias and observer error. Collins Dictionary defines bias as 'a tendency to prefer one person or thing to another, and to favour that person or thing', so one may argue that bias is an intrinsic element of any human activity, and it can never be removed or sought to be removed. However, Yin (2018) cautions the higher frequency of bias in case research and therefore, a need for greater attention. I increased my awareness and

paid attention to my views that might influence the research process, and therefore the findings of this study. To do that, I deployed reflexivity which will be discussed in section 4.8.

Dependability is also about stability and consistency in the process of inquiry (Riege, 2003). The use of NVivo and TA to analyse the data in this study has provided a structured and consistent approach, and in turn, they have enhanced coding reliability and transparency (Carcary, 2009).

**Table 18: Design techniques in qualitative research and strategies taken in the study (Source: Riege, 2003 & Yin, 2018)**

<b>Design Tests</b>	<b>Suggested techniques to enhance validity &amp; reliability in qualitative research including case study</b>	<b>Strategies taken in this study</b>
Confirmability	<ul style="list-style-type: none"> <li>• Use multiple sources of data.</li> </ul>	<ul style="list-style-type: none"> <li>• Interviewed multiple participant groups in each site.</li> <li>• Retention of field notes, raw data, tapes and versions of templates for later examination if required.</li> </ul>
Credibility	<ul style="list-style-type: none"> <li>• Do pattern matching.</li> <li>• Use logic models.</li> <li>• Triangulation of data.</li> <li>• Take into account researcher own assumptions.</li> </ul>	<ul style="list-style-type: none"> <li>• Pattern matching and logic models were included in the design.</li> <li>• Reflexivity and field diary were carried out.</li> </ul>
Transferability	<ul style="list-style-type: none"> <li>• Augmenting the study design with 'how' and 'why' questions.</li> <li>• Develop case study database.</li> <li>• Use of cross-case analysis.</li> <li>• Use of pre-determined questions.</li> </ul>	<ul style="list-style-type: none"> <li>• How and whys were the key research questions.</li> <li>• Case study database was developed.</li> <li>• The study carried out cross-case analysis.</li> <li>• Semi-structured questionnaires were used in interviews.</li> </ul>
Dependability	<ul style="list-style-type: none"> <li>• Use case study protocol.</li> <li>• Develop case study database.</li> <li>• Maintain a high chain of evidence and provide audit trail.</li> </ul>	<ul style="list-style-type: none"> <li>• Journal was in place.</li> <li>• Study protocol was in place.</li> <li>• Use of CAQDAS.</li> <li>• Use of Template Analysis.</li> <li>• Study database was established.</li> </ul>

## 4.8 Reflexivity

Reflexivity is one of the established ways that researchers can establish rigour and quality of their studies (Dodgson, 2019). Easterby-Smith et al. (2018) argued that the primary care focus of reflexivity is interpretation and research is about interpretation of interpretation. Reflexivity is the process to critically reflect and analyse oneself, and identify the personal values that could affect how the data is collected and interpreted (Polit, 2014). These personal values are shaped by our own social characteristics such as race, gender and class, which have to be taken into account throughout all different stages of the qualitative research process (Easterby-Smith et al., 2018).

In a way, reflexivity can be considered as a kind of personal reflection but with a focus on the research. As a nurse, reflective accounts are an integral part of my professional practice and indeed evidencing this is part of the requirement in order to achieve professional revalidation every 3-years. Recognising learning to be reflexive takes time (Dodgson, 2019), but I was able to draw on the transferrable experience to ensure this was carried out effectively.

I was very conscious that the practitioner-researcher role comes with advantages and disadvantages. I had assumptions and preconceptions of the NHS system in the NE that might hinder the exploration of certain issues during the analytical process. To address that, I took active steps to detect and compensate any possible researcher effects and bias and they were described in detailed in the applications to both the Northumbria University and HRA ethical committees.

As a positivist myself, I was also very mindful of its potential impact on this interpretivism research. Dodgson (2019) points out the researcher is the research instrument, and therefore, my own philosophical stances would inevitably inform my approach. For example, the choice of Yin's case study approach and the use of TA were as a result of that. However, I was very aware of the purpose of an interpretivist research is to capture and interpret the subjective understanding of the world from the participants' perspective (Easterby-Smith et al., 2018). To do that, I had tried hard not to impose the objective meaning of reality onto the analysis and interpretations.

I kept an electronic journal throughout the research process to enable reflections of how the nature of my involvement in the research process in any way had shaped the outcomes, as well as keeping track of development from ideas to project conclusions. Reflexivity as an important element of qualitative research was indeed referenced by many researchers including Easterby-Smith et al. (2018), King & Brooks (2017) and Carcary (2009). Throughout the DBA programme, I have also been working very closely with my supervisors, and through supervision meetings and the University's Annual Progression Review Panels, there were also opportunities to challenge and scrutinise potential issues in relation to bias.

Polit & Beck (2014) stressed the need to be transparent and reflexive about how the data was collected, analysed and presented. The importance of transparency was echoed by Yin (2018) and the requirement to make as many of the procedures as explicit as possible is promoted, including the use of research protocol and development of a case study database. A research protocol (Appendix L) was developed and was used to guide the research process. Using NVivo, a case study database was created to help organise the narrative data. The adoption of a CAQDAS such as NVivo was confirmed as a helpful tool to enhance the quality, rigour and trustworthiness of the research (Dalkin et al., 2021; Welsh, 2002).

#### **4.9 Chapter conclusion**

This chapter provided an overview of the research methodology and methods for this study, and the justifications for the choice.

With a focus on examining the introduction of the new NA role to GP practices in the NE of England, this research has been informed by a relativism philosophical assumption, where there are many truths and the facts depend on the observers' viewpoints (Easterby-Smith et al., 2018). In line with the ontological stance, a constructionism epistemology follows, with a view that knowledge about the social world is interpreted and combined through our senses and brains (Greenhalgh et al., 2015). Saunders et al. (2019) define this type of philosophy / paradigm in business and management research as 'interpretivism'.

I chose case study as a methodology for this study, because this design is most suited for studies with a strong desire to understand complex social phenomena concerning with 'how' and 'why' (Yin, 2018). In addition, the approach by Yin is in close alignment to my own philosophical stances. Cross-site case studies were carried out involving five purposively selected GP practices in the NE of England.

The data analysis stage consisted of 20 sets of interview transcripts collected from ethically conducted semi-structured interviews and focus groups. A CAQDAS was used to assist the process and all the transcripts were uploaded onto NVivo, which also acted as a research database to enhance reliability (Yin, 2018). The data was interpreted using the TA approach.

Finally, the rigour of the methodology was demonstrated using the four design tests for qualitative studies identified by Riege (2003): confirmability; credibility; transferability; and dependability.



## Chapter 5 Findings

### 5.1 Introduction

The purpose of this chapter is to examine why the Nursing Associate role (NA) was introduced in GP practices, and how it was implemented and legitimised. To do that, I will analyse the transcripts from interviews and focus groups.

The findings of the five case studies will be presented at two levels: case-based in sections 5.2 to 5.6 and cross-case in section 5.7. The final template for each case will also be included in the respective section. The micro-processes in the Elaborated Institutionalisation Model (EIM) for a new work role (Kessler et al., 2017) have provided the high-level themes in the template, and they will be used as a structure to present the findings.

Contextual conditions (i.e., the real world) are an integral part of the logic models underpinning Yin's case study approach and form the understanding of each case. Therefore an overview of the five GP practice is provided in the respective section before the presentation of the case study's findings. A summary and comparison of the five GP practices is included in section 5.7.1 as part of the cross-case synthesis.

Quotes are included in the findings and Table 19 shows the reference codes and types of participants.

**Table 19: Reference Code and type of participants**

Reference Code	Type of participants
NA	Nursing Associate
M	Nurse Manager or Practice Manager
GP	General Practitioner
NT- PN	Nursing Team – Practice Nurse/Nurse practitioner
NT - TNA	Nursing Team – Trainee Nursing Associate
NT - HCA	Nursing Team – Healthcare assistant

## 5.2 Case Study One

Case study one is a medium size practice group with two GP practices, It has a registration population of approximately 16k and employed around 51 clinical and non-clinical staff. The group is a medical training practice, providing clinical experiences in primary care for GP registrars and Foundation Year 2 doctors.

### 5.2.1 Final template

The final template (Figure 15) for this case study then formed the initial template for the other four case studies, and was developed after coding the transcripts against the preliminary template.

### 5.2.2 Findings

#### Establishing a need

While the development of the new NA role was led centrally by the government and the professional body The Nursing and Midwifery Council (NMC), local promotion by the Clinical Commissioning Group (CCG) had helped to introduce the idea into the GP practice. This top-down approach was then followed by visible leadership from senior members of the team to take forward the change.

The overwhelming need identified was to do with the workforce. In particular, shortage of practice nurses was the key reason due to difficulty in recruitment, high turnover rate, part time hours and sickness. Other workforce issues were staff development and service needs. The NA introduction appeared to be preceded by some planning, and the practice described the situation as '*...we did know where we wanted to go with this*' (M1).

**Figure 15: Final template for case study one**

<p><b>1.0 Establishing a need</b></p> <ul style="list-style-type: none"><li>1.1 Catalyst for change</li><li>1.2 Involvement and support</li><li>1.3 Service</li><li>1.4 Workforce<ul style="list-style-type: none"><li>1.4.1 Bridging skill gap</li><li>1.4.2 Knowledge of the role</li><li>1.4.3 Nursing shortage</li><li>1.4.4. Workforce development<ul style="list-style-type: none"><li>General needs</li><li>Individual needs</li></ul></li></ul></li></ul>
<p><b>2.0 Identifying post holders</b></p> <ul style="list-style-type: none"><li>2.1 Established relationship</li><li>2.2 Person-centred qualities</li><li>2.3 Task-centred qualities</li></ul>
<p><b>3.0 Finding champions</b></p> <ul style="list-style-type: none"><li>3.1 Address the barriers</li><li>3.2 Encourage others to endorse change</li><li>3.3 Institutional entrepreneurs</li><li>3.4 Support the role</li></ul>
<p><b>4.0 Overcoming barriers or concerns</b></p> <ul style="list-style-type: none"><li>4.1 Organising placements</li><li>4.2 Supervision</li><li>4.3 Time out</li><li>4.4 No resistance</li></ul>
<p><b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b></p> <ul style="list-style-type: none"><li>5.1 Accountability</li><li>5.2 Confidence and trust</li><li>5.3 Constraints<ul style="list-style-type: none"><li>5.3.1 Concerns about the role</li><li>5.3.2 Impact of COVID</li><li>5.3.3 Space</li><li>5.3.4 Others</li></ul></li><li>5.4 Opportunities</li><li>5.5 Training and development</li></ul>
<p><b>6.0 Fitting new way into established structures &amp; systems</b></p> <ul style="list-style-type: none"><li>6.1 Role boundary<ul style="list-style-type: none"><li>6.1.1 Job Description</li><li>6.1.2 Pay equity</li><li>6.1.3 Role contents</li></ul></li><li>6.2 Role identity<ul style="list-style-type: none"><li>6.2.1 NMC</li><li>6.2.2 Re(construct)<ul style="list-style-type: none"><li>New way of working</li><li>Old way of working</li></ul></li></ul></li></ul>
<p><b>7.0 Proving value of new way to others</b></p> <ul style="list-style-type: none"><li>7.1 Confidence and expectations</li><li>7.2 Patients</li><li>7.3 Service delivery<ul style="list-style-type: none"><li>7.2.1 Additional capacity</li><li>7.2.2 Quality improvement</li></ul></li><li>7.4 Team members<ul style="list-style-type: none"><li>7.3.1 Accessibility &amp; support</li><li>7.3.2 Mentoring</li><li>7.3.3 Others</li></ul></li></ul>
<p><b>VOIDED 8.0 Establishing routine use</b></p> <ul style="list-style-type: none"><li>8.1 Contributions to other co-workers<ul style="list-style-type: none"><li>8.1.1 Accessibility &amp; Support</li></ul></li><li>8.2 Contributions to patient services<ul style="list-style-type: none"><li>8.2.1 Expertise of post holder</li></ul></li></ul>
<p><b>VOIDED 9.0 Creating trust</b></p>
<p><b>VOIDED 10.0 Ensuring dependence</b></p>

Treatment room duties were identified as a service gap with duties such as smears, injections, travel vaccinations and wound care. The practice indicated that this was an area that could be taken on by the NA role, and in turn, free up experienced practice nurses to focus on long term conditions reviews.

The interviewees also referred to the struggle to meet service 'targets' such as cervical screening (smears) and other service demands such as leg ulcer dressing. Indeed smears was the most frequently referenced service area as both a gap and an opportunity for the new role during the interviews.

There was a view that some of the practice nurses' duties could be carried out by NAs instead, so *'the expert skills that the practice nurses have had could be used better'* (M1). This was to address nursing shortage, as *'they don't always stay very long, and they tend to work part time'* (M1). The motivation did not appear to be financial i.e., related to saving money.

It was clear that the practice had a very limited understanding of the new NA role at the outset, and could not envisage how it would be different from the HCA role. As time went on, this knowledge developed and the opportunity for bridging the skill gap became clearer.

*I didn't know a lot. I was learning with [NA] because [NA] was the first...so it was all very new.....it was hard to visualise how different her role is going to be from the role [HCA] she is doing. (NT1-PN1)*

The practice considered itself to be forward thinking and expressed a general intention to develop their people including experienced HCAs. There was a strong desire from the postholder to progress and this itself was the key driver for change.

*I just wanted to progress because I had gone as far as I could go as a healthcare assistant. So it is more about progression, just being able to do extra skills. (NA1).*

#### Identifying the post holder

There was no difficulty to identify postholders. More than one person had expressed an interest to take on the NA training, and they were all HCAs in the practice.

The NA was described as '*...very experienced anyway, because she was a healthcare assistant beforehand*' (M1). There was an established relationship between the postholder and the GP practice team, and the NA's person-centred qualities had been referenced positively, as well as her task-centred ones.

*It might just be the personality of [NA] rather than the role, is that she's quite an independent thinker at times and will question things. (GP1)*

### Finding the champion

The idea of NA was initially advocated by the '*forward thinking*' (NT1-PN1) Managing Partner who brought the proposal to the partnership meeting and encouraged the other GP Partners to endorse change. Once a decision was made, there was support from the nursing team to implement the new role by way of supervision.

### Overcoming barriers for change

Three barriers related to training were identified. '*Main concern...was the timeout of practice for training when we're [GP practice] very reliant on the need for healthcare assistant appointments*' (GP1). Others were arrangement of clinical placements, and dedicated time to provide supervision. However, the practice prepared to '*make that sacrifice to allow them [HCAs] to be released*' (GP1), and these were seen as a balancing act between managing today while creating tomorrow.

### Recognising & creating opportunities to advance the new role

The regulated status of NAs did not automatically increase people's confidence and willingness to delegate. The decision to delegate was dependant on the competencies, as '*[NA] had done the course, whether she's registered or not, she's had the training to do what she's doing now*' (NT1-PN1). In fact, the clinicians considered the accountability remained with the nursing team.

The NA, on the other hand, as a registrant felt the accountability would lie with her as a qualified practitioner. This would suggest that there were different expectations in the GP practice on the new professional identity and the associated responsibilities.

As the postholder was known to the GP practice, it was also clear that the individual and the post were intertwined as the team '*...know [NA] very well....know what she can do*' (M1). Building on the established relationship, the confidence of the NA role also grew and the initial uncertainties disappeared. The early impact also grew confidence to consider investing in more people to train to be NAs.

*And I suppose initially you think oh gosh, is this a good idea, because is this just creating more work for me..... But actually, she's great now. She's very competent. It's just initially there are those doubts. (GP1)*

A number of concerns or barriers were discussed in relation to recognising and advancing the opportunities for the new NA role. The GP practice described their expectations of more and speedier clarity by the regulator, including guidance on the tasks. This was partly compensated for by the positive experience of working with the new NA, and as a result, the GP practice remained positive about the new role.

*I think the only concern I have is the NMC moving so slowly.....[NA] is registered on the NMC register. She has completed the training, and we can't train her to do baby imms yet, because the NMC haven't said they can do that, she can't sign the PGD. So I think the red tape sounds a bit of a pain in the backside. (M1)*

*I've seen what they [NAs] can do. And I've seen the confidence of the nurse associates grown, you know, that they were working sort of independently.... [NA] is now very confident to taking smears when initially she wasn't.....So, yes, I am quite impressed with them. Yeah. (GP1)*

The pandemic had clearly negatively impacted on the development of the role, and the training '*has been put on the backburner a little bit because of COVID*' (M1). There were three aspects to this. Firstly, many routine appointments were stopped during COVID as priorities shifted to other areas such as vaccinations. Secondly some face-to-face consultations switched to telephone or remotely online. Thirdly, there was also a lack of practice nurses physically available during COVID to

provide supervisions, and this '*had been a struggle*' (M1). As a result the opportunities for clinical learning and practice were just not there.

As well as providing cover for practice nurses for smears and dressings during absences, a number of future opportunities and new tasks had been identified for the new NA role. These included compression dressings, childhood immunisation clinics, travel vaccinations, health promotions and mentoring newly qualified staff. There was also a plan to expand the range of long-term conditions reviews, and eventually, the NA would be able to complete a review from end to end without the need for the practice nurses to take over part two. For the NA currently in training, the practice also had plan to develop this person to take on the lead role for learning disabilities.

#### Fitting new role into established structures & systems

A job description (JD) was available for the NA role. A generic version from the NMC was adopted and adapted by the practice. A view was expressed regarding pay equity so as to reflect the comparable responsibilities of a newly qualified practice nurse.

*The only issue I have with it is I think the need to be banded in a band five across the board, instead of a four, I really do because they're actually doing band five work. (NT1-PN1)*

NAs carried out both HCAs and NAs duties and '*got their foot in both camps*' (M1). This was described as '*In between the healthcare assistants and the practice nurses, so [NA] not kind of one or the other*' (NA1). The work carried out by the NAs was considered as '*higher level of health care assistant work*' (M1-PN1). This description would suggest that the NA role was associated closer to the HCAs than the nurses. However, there was recognition that the NA training had provided enhanced knowledge. One participant called that as '*coming from a different mindset*' (M1-PN1), and an example given was cervical screening. The NA had also carried out initial visits of house bound patients, and the practice suggested that the actual remit of this role might vary from practice to practice.

The practice attempted to utilise the enhanced skills of the NAs appropriately and only allocate HCA tasks when absolutely necessary: *'we try to not book in just normal blood tests with her etc, unless we've got no appointments at all'* (GP1). The difficulty was not having *'.....enough nursing associate tasks to fill out full time per week'* (NT1-PN1), and this had made it challenging to construct the new role. In addition, some staff had known the NA as HCA for some time and found it difficult to visualise her new identity. Altogether, these created challenges for the NA to establish her new role. To help construct the new identity, the GP practice had *'taken the nurse associate off the healthcare assistant screen and put it on the practice nurse screen together, because a lot of what they do mirrors with nurses'* (GP1).

*I think some of the receptionists have been here a long time so I think they found it hard to see [NA] in a new role..... I think sometimes if they stuck with appointments, they will just stick it with [NA] like a healthcare [HCA]. (NT1-PN1)*

The role of NA was compared to the abolished State Enrolled Nurse (SEN) role by interviewees on many occasions. The practice was very unclear what the NA could do and had called for more guidance on role remit. Taken together, these points indicate that role identity and boundaries for the NA were not clear, and people found it difficult to interpret the new NA role and apply it in daily practices.

*But I think more clear guidance of what they [NAs] can do when they qualified. So at the minute we're looking at [NA] doing family planning in terms of depo injections and pill checks....., is that something within that role or something that is not within the role, and I think that needs to be a bit clearer. (NT1-PN1)*

#### Proving value of new role to others

As the first NA in the GP practice, the issues of confidence and trust were almost prerequisites during the emergence stage otherwise the postholder would not have been released to undertake the training in the first place. Overall, the practice team was pleased with progress and the way the role had worked out.

*And I'm surprised at how positive it has been actually, because initially all these new roles, you think well, what is it going to add. How are they going to fit it? But it has worked out really well. (GP1)*



Service delivery in the form of extra capacity was described as the area of greatest impact. The NA role had enabled additional appointments and better patient care as a result, and cervical screening was being singled out as the area of improvement where a backlog had been caught up. In addition, the NA role had also helped to improve service quality, such as the ability to identify risks to patients. The knowledge and overall confidence of the NA were growing and this was noticed by the practice.

*And since becoming an NA, she has highlighted areas of risk where she's been able to identify that a patient is at risk, or is experiencing, say domestic abuse. (M1)*

As well as clinical tasks, the NA role made contributions to others' working lives by being accessible for support and advice. Instead of the nurses, the HCAs now approached the NA for guidance. The NA also started to mentor other new practice staff such as phlebotomists. The impacts were also noticeable by the nursing team, and had '*certainly made the workload manageable having [NA] as an as a nursing associate*' (NT1).

*The healthcare assistants now, rather than coming straight to me, if there's a problem, they go to [NA] .....So [NA] sort of oversee in the informal sort of way the healthcare assistants. So I think it has changed the dynamic of the team. (NT1-PN1)*

Regarding patients, their understanding of the new role was reported to be low, and they '*... don't really notice any difference*' (NA1). However, the better availability of appointments had a direct positive impact on patients.

To summarise the role implementation, the practice found it hard to define the role remit, and lack of available training had been an issue. This had meant the NA continued to carry out all HCA duties and took on only a few new ones. The NA was unable to construct a new identity, although proactive efforts were made by the practice to facilitate. Despite this the NA had made positive contributions to service delivery in terms of capacity and quality improvement.

### 5.3 Case Study Two

Case study two is an alliance or confederation of GP practices. The alliance has three GP practices across four sites, and employs a total of over 100 non-clinical and clinical and staff, including allied health professionals. It covers a population of around 26k.

#### 5.3.1 Final template

The final template is shown in Figure 16. Compared to the initial template, there are two extra level three codes added: 1.4.4 GP shortage and 1.5 Cost saving.

#### 5.3.2 Findings

##### Establishing a need

The decision of the GP alliance to introduce the new NA role was encouraged by the financial support from the Additional Roles Reimbursement Scheme (ARRS) to the respective Primary Care Network (PCN). This arrangement had clearly positively influenced the local decision and encouraged the uptake.

*So it wasn't really something that we had to consider as strongly as we would have done other roles, because of the fact that it wasn't coming out of our core funding and general practice. (GP2)*

The clinical team gave the situation in terms of nursing shortages as the main motivation. The GP practice noted they '*struggled to recruit practice nurses*' (GP2) after several rounds of recruitment and '*the nursing associates are filling some of the role that the practice nurses obviously did before*' (GP2). The practice appeared to have a longer-term strategy behind the implementation, and a plan to '*... to have loads of different roles within that, to enable the patients to get a really good service*' (GP2). GP shortage and its knock-on impact on service delivery had played a part in moving towards a multidisciplinary approach.

**Figure 16: Final template for case study two**

<b>1.0 Establishing a need</b>
1.1 Catalyst for change
1.2 Involvement and support
1.3 Service
1.4 Workforce
1.4.1 Bridging skill gap
1.4.2 Knowledge of the role
1.4.3 Nursing shortage
1.4.4 GP shortage
1.4.5. Workforce development
General needs
Individual needs
1.5 Cost saving
<b>2.0 Identifying post holders</b>
2.1 Established relationship
2.2 Person-centred qualities
2.3 Task-centred qualities
<b>3.0 Finding champions</b>
3.1 Address the barriers
3.2 Encourage others to endorse change
3.3 Institutional entrepreneurs
3.4 Support the role
<b>4.0 Overcoming barriers or concerns</b>
4.1 Organising placements
4.2 Supervision
4.3 Time out
4.4 No resistance
<b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b>
5.1 Accountability
5.2 Confidence and trust
5.3 Constraints
5.3.1 Concerns about the role
5.3.2 Impact of COVID
5.3.3 Space
5.3.4 Others
5.4 Opportunities
5.5 Training and development
<b>6.0 Fitting new way into established structures &amp; systems</b>
6.1 Role boundary
6.1.1 Job Description
6.1.2 Pay equity
6.1.3 Role contents
6.2 Role identity
6.2.1 NMC
6.2.2 Re(construct)
New way of working
Old way of working
<b>7.0 Proving value of new way to others</b>
7.1 Confidence and expectations
7.2 Patients
7.3 Service delivery
7.2.1 Additional capacity
7.2.2 Quality improvement
7.4 Team members
7.3.1 Accessibility & support
7.3.2 Mentoring
7.3.3 Others
<b>VOIDED 8.0 Establishing routine use</b>
8.1 Contributions to other co-workers
8.1.1 Accessibility & Support
8.2 Contributions to patient services
8.2.1 Expertise of post holder
<b>VOIDED 9.0 Creating trust</b>
<b>VOIDED 10.0 Ensuring dependence</b>

The practice placed a strong focus on developing its HCA workforce, as they *'wanted to develop their skills further, and this is a pathway that has enabled them to do.... And it's been really good for actually development of our own staff'* (GP2).

The practice expected the NA role to fill the gap by *'doing what practice nurses would have traditionally done'* (GP2). This was not so much to increase additional 'like to like' capacity as such, but rather to redistribute available skillsets and remodel the staffing model. The NAs would also take on *'some of the more basic chronic disease management, the ones that are not too complex'* (GP2) and this in turn would free up the PNs to *'become more specialists, chronic disease nurses'* (GP2).

There was a mixed view from the nursing team regarding the need for the NA role. Moreover, all interviewees were sceptical of the real reason for introducing this role, and believed it was financial driven, as *'...they're going to be doing [PN] job for a fraction of the price really.* (NT2-PN2)

*I don't think there's a need, I think...it's possibly a cost thing. Obviously, they can do what we do to a great extent. Yeah, so I think it's a cost issue rather than filling the need within general practice.( NT2-PN1)*

With a higher skillset of HCAs in primary care, the NA role was also considered to be less useful when compared to secondary care. Surprisingly, this remark was made by a NA in training.

*I think the NA do have the extra knowledge..... but I can still do them as healthcare (assistant) as well..... So I think in hospital definitely, but in general practice, unless you are running smears, it isn't the service that the patients can go to for that. (NT2-TNA1)*

All the interviewees had limited understanding of the role and were unsure of what it could offer. The practice was trying this role out and described the situation as: *'just dipped our toe in the water really'* (M2). As time went on and through the trainees, the knowledge grew although there remained different views regarding the nature of the role.

### Identifying post holders

The NA was a HCA and the positive relationship with the practice team was evident.

*She's obviously well-respected member of the team. And she's very, very qualified. It's very, very good. (M2)*

For the individual, the NA role had provided a stepping stone to becoming a RN and fulfilling her initial career goal. Compared to other NAs, this person had a much higher level of academic knowledge as some years ago she had almost completed her nursing training.

It was clear that the postholder and the role itself were inseparable, and the personal qualities such as '*enthusiastic to develop and learn*' (GP2) were regarded as important by the GP practice.

*And there is an individual basis to that, we've got one excellent nurse associate and you can't differentiate it from that obviously. (GP2)*

### Finding the champion

The NA role '*was a combined decision...by the PCNs to take on those people rather than the practice*' (GP2). Therefore, the management team would seem to have taken on the role as change champions, for while the GPs were in favour of the NA role the same level of enthusiasm and support was not visible amongst all interviewees. Notably, there appeared to be a strong level of suspicion from the nurses that the new role was introduced for cost saving reasons.

The NA had a supervisor during her training but did not have any preceptorship after having qualified. However on a day-to-day basis, clinical huddles were in place to discuss issues as a team. The NA felt 'supported' by the PM and was being given time to develop into the role.

### Overcoming barriers or concerns

The participants identified three barriers to change associated with the training: arrangement of clinical placements; time out for the trainee; and time to supervise. The clinical placement challenge was said to have been improved with a dedicated placement co-ordinator from the university.

Time out for the training had led to a loss of capacity, as a business, and the concern was '*how do we accommodate them?*' (GP2). At operational level, one nurse described this as '*tough ... been on my own a lot here*' (NT2-PN2).

Lack of allocated time to supervise had clearly significantly impacted on both the mentor and mentee. One nurse gave an example of a very rushed meeting with the university assessor to sign off a trainee's assessment, and described the situation as '*not fair*' (NT2-PN1). This nurse indicated an intention to '*sort out something with the manager*' (NT2-PN2).

### Recognising & creating opportunities to advance the new role

The issue of accountability had dominated the discussion, particularly with the nursing team. Two levels of accountability were being described by the participants: practice and individual. Development and training were important underpinning elements and the GP practice considered that it was their responsibility to ensure the individual had '*enough training and support to do the role*' (GP2).

As a registrant, the NA was very clear where the accountability sits: '*It lies with me obviously, I'm the NMC registered nurse so that accountability lies with me*' (NA2). This was echoed by the RNs: '*as a registered nurse in her own right, it sits with [NA] because she's accepted that task*' (NT2-PN2). It was recognised that the NA '*got more knowledge because of uni and because of the role*' (NT2-TNA1), and there was confidence and a willingness to delegate.

However, the RNs expressed their unease in having the NA carry out childhood immunisations due to the responsibilities involved. There was a strong level of

anxiety and concerns amongst the RNs that if there were any issues, this would have a knock-on impact on their own professional registrations. This illustrated the level of confusion or myths at practice level, and it was highly likely that these uncertainties had hindered the development of the new NA role.

*And I have heard that potentially if you were to do an assessment of somebody doing the baby imms, it would be your PIN that would be under scrutiny if something went wrong in that clinic..... And if that is the case, then I would have concerns and I would not be happy to do an assessment for somebody to do that. (NT2-PN1)*

Although the regulated status of NAs offered some security to others, the decision to delegate was not dependent on this but rather confidence in the individual's competencies. The nursing team described the different ways of working in primary care had meant delegation was not a big feature of daily working. This situation had not encouraged the need to address the issue of accountability in the GP practice.

*I don't think we ever have to delegate anything to the nursing associates because they have their own clinic that they are running and leading. And we have our role. So there's no real overlap. (NT2-PN1)*

The restricted scope of the NA role appeared to have played a part in limiting the local development of the role. For certain procedures such as childhood immunisations, the NA had to work with a RN on that site. With multiple sites and lack of physical space, the logistical arrangement was highlighted as a challenge. In addition, COVID had discouraged some clinic attendances in the GP practice and this had further reduced the training opportunity e.g. cervical screening.

In terms of future opportunities, the NA was undergoing spirometry training. The RNs also envisaged that over a period of time, NAs would extend their responsibilities in chronic disease management and be able to interpret blood results.

#### Fitting new role into established structures & systems

The practice had a JD for the NA role. Remuneration for the NA role in relation to the responsibilities was raised as an issue by both the NA and RN.

*But if I had to pick one thing and it'll probably be.....the pay level.... So baby immunizations for instance, I think that's a lot of responsibility for a band 4. (NA2)*

In terms of role content, the NA role was '*just in that continuum between HCA and practice nurse*' (GP2) and the exact position would be dependent on the individual's prior experience. HCAs in primary care setting were highly experienced, and the difference between the HCA and NA roles was described as '*a difficult boundary*' (GP2). The practice gave an example of a very experienced HCA where '*apart from the tasks that she can't do, she's probably acting at the same level [as the NA]*' (GP2). This again suggests a lack of clarity on the NA role.

The NA had taken on two new additional tasks: cervical screening and childhood immunisations (shadowing stage). When compared to the previous HCA role, '*it's not that much different at all..... you can do smears and a few extra few things*' (NA2).

With the extra training, the NA had '*the knowledge base behind everything and understand why*' (NA2). The new way of working brought by the new NA role did not immediately manifest itself into performing extra tasks and was not visible straightaway. The additional knowledge acquired was translated into care improvement activities such as patient education to patients during one of chronic disease management reviews, meaning the patient care was more holistic.

*But I think it's around in the actual educational side that the nursing associates are doing a lot more than often HCA would have been doing, and then with the support of the practice nurses as well, they're getting the results back. (GP2)*

The abolished SEN role was brought up by the nursing team for comparison, and the introduction of the new NA role was described as '*going around in circles where we used to do that, now we're doing it again with the NAs*' (NT2- PN2). There was a strong sense of frustration on the current limited scope of the NA, particularly on the issue of not able to administer medication via PGD. One participant felt the challenge '*seems a bit unnecessary*' (GP2).



No challenges were highlighted in relation to the patient booking system, as receptionists were '*pretty good as what could go in [NA] clinic and what can go into ours [nurses]*' (NT2-PN1). Extra clinics and appointments were made possible due to extra skillsets. There was clear attempt from the GP practice to communicate the new NA role to patients and other team members, by putting information along the corridor in the GP practice.

GPs did not appear to notice the change in role and '*they all still called [NA] a HCA*' (NA2). The NA highlighted the challenge to construct her new identity as NA in primary care.

*It's not really established yet in general practice, NA role. I can see it could work in secondary care, that great, I think it's absolutely fantastic. But General Practice, it is not going to change, like they [NAs] were being the HCAs. (NA2)*

#### Proving value of new role to others

The awareness of the new role by patients was reported to be mixed. While some regular patients noticed the additional duties that were carried out by the NA in clinics, many did not appear to notice the difference when compared to the HCA role.

The GP practice was clearly frustrated over the limited scope of practice of the NA role, and suggested '*the need to look at the end result and how they can benefit primary care*' (M2).

*In the minute, [NA] is very, very knowledgeable. All she can do above [the HCA role] and with extensive training is cervical screening. It's limited. She couldn't sit down with a diabetic patient and prescribe or titrate their medication, because she can't do that within their NA role. (M2)*

The NA with additional skills had enabled more appointments and better patient access such as the cervical screening programme. However not everyone was convinced that NAs would free up the RNs, because '*the demand is just so high for appointments and things*' (NT2-TNA1). However, there was a recognition that the

NA capacity would allow business as usual in situations such as sickness as a good 'backup... and clinics would still be running' (NT2-TNA1).

One area where the NA had added value was quality improvement, as a multidisciplinary team was regarded as a better delivery model as '*all these people actually deliver better quality service to the patients than a general GP would do*' (GP2). In addition, longer appointments with the NA had enabled better long-term condition reviews with patients.

*They're having a half an hour appointments with them [patients] to do their part one chronic disease reviews, and they're going through everything with them and they've done it really competently. If that had been done by somebody else, particularly a GP, it would have just been all brushed over.*  
(GP2)

The new knowledge of the NA had also strengthened the resources in the clinical team, such as responding to patient queries about clinical care. Rather than reacting to current service demand, the practice had planned to divert the role to proactive medicine, and '*prevent people getting ill in the first place and to actually try to control their chronic diseases*'. (GP2)

In terms of impact on other team members, the NA provided support to other TNAs in training and this was positively received by those involved. The impact on the nurses' quality of working life was yet to be seen.

To summarise the role implementation, overall, the GP practice was very unsure about the purpose of the role and its remit. Despite a vision from top management of multidisciplinary working, there was a lack of buy-in particularly from the nurses. There appeared to be resistance in the nursing team for a range of reasons. This had made it hard for the NA to develop an identity. The NA made tangible contributions to services, primarily quality improvement through enhanced knowledge.

## 5.4 Case Study Three

Case study three is one of GP practices in a formal medical partnership. The total combined registered population of the partnership was over 51k and employed over 170 clinical and non-clinical staff across many sites.

### 5.4.1 Final template

The final template is shown in Figure 17. Compared to the initial template, there are two level two codes and one level three codes added: 1.5 Cost saving; 3.5 Autonomy; and 1.4.4.1 Planning.

### 5.4.2 Findings

#### Establishing a need

The introduction of the NA role was described as both top down by the PCN and bottom up. Local adoption had been encouraged by the ARRS. The senior management (medical and nursing) were heavily involved in bringing in the new NA role and the Nurse Board had played a key role in the planning process.

Workforce need was identified as the key reason to introduce the NA role. The practice had a vision of a multidisciplinary approach to move away from the old model of everyone seeing a GP or PN, to '*patients can see different clinicians with different skillsets to address their needs*' (GP3). To establish the needs, a strategic approach was evident aiming to '*help inform recruitment and future proofing*' (M3).

The nursing leadership team had carried out '*a three-year five-year Workforce Strategy....looking at activity demand, and what they see the nursing associates will be able to do*' (GP3). There was an expectation that changing skill mix in the nursing workforce would continue, and over time, the replacement of PNs by NAs.

**Figure 17: Final template for case study three**

<b>1.0 Establishing a need</b>
1.1 Catalyst for change
1.2 Involvement and support
1.3 Service
1.4 Workforce
1.4.1 Bridging skill gap
1.4.2 Knowledge of the role
1.4.3 Nursing shortage
1.4.4. Workforce development
General needs
Individual needs
Planning
1.5 Cost saving
<b>2.0 Identifying post holders</b>
2.1 Established relationship
2.2 Person-centred qualities
2.3 Task-centred qualities
<b>3.0 Finding champions</b>
3.1 Address the barriers
3.2 Encourage others to endorse change
3.3 Institutional entrepreneurs
3.4 Support the role
3.5 Autonomy
<b>4.0 Overcoming barriers or concerns</b>
4.1 Organising placements
4.2 Supervision
4.3 Time out
4.4 No resistance
<b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b>
5.1 Accountability
5.2 Confidence and trust
5.3 Constraints
5.3.1 Concerns about the role
5.3.2 Impact of COVID
5.3.3 Space
5.3.4 Others
5.4 Opportunities
5.5 Training and development
<b>6.0 Fitting new way into established structures &amp; systems</b>
6.1 Role boundary
6.1.1 Job Description
6.1.2 Pay equity
6.1.3 Role contents
6.2 Role identity
6.2.1 NMC
6.2.2 Re(construct)
New way of working
Old way of working
<b>7.0 Proving value of new way to others</b>
7.1 Confidence and expectations
7.2 Patients
7.3 Service delivery
7.2.1 Additional capacity
7.2.2 Quality improvement
7.4 Team members
7.3.1 Accessibility & support
7.3.2 Mentoring
7.3.3 Others
<b>VOIDED 8.0 Establishing routine use</b>
8.1 Contributions to other co-workers
8.1.1 Accessibility & Support
8.2 Contributions to patient services
8.2.1 Expertise of post holder
<b>VOIDED 9.0 Creating trust</b>
<b>VOIDED 10.0 Ensuring dependence</b>

Ageing workforce and difficulties in attracting new entrants were described as factors that had contributed to nursing shortage. With a *'dried up workforce....needed to strengthen the backbone of the skill mix of the nurse team...and plugging some of the gaps'* (M3), the role of NA was introduced. By doing that, the ambition was to attract younger nurses to primary care by providing a career progression framework, which traditionally had been absent. Therefore, there would be a *'need to make up the shortfall of the roles that the band 5 nurses were doing'* (NT3-PN2).

Professional development was another reason given for the new NA role, and it was described as *'first and foremost'* (M3) motivation. The practice appeared to be committed to investing in the HCA workforce and *'wanted them to feel that they were developing professionally'* (M3). The same enthusiasm was matched by the current postholders and they *'wanted to progress....thought was the best way to go about it'* (NA3) and *'would have like a bit more variety....get to know a lot about why you're doing things and the importance of them'* (NA4)

The knowledge of the new NA role was limited and one comment was *'I didn't know about it until the hour'* (NT3-PN1). The information was gathered through different sources: *'I heard about....read around it... .went on a conference'* (M3). In addition due to a lack of clarity, the GP practice *'made assumptions that they would be able to.....so it was a bit of an educated guess'* (GP3).

Cost saving was acknowledged but deemed as a positive by-product, as the NHS *'need to save money'* (NT3-PN1).

### Identifying post holders

All the NAs were experienced HCAs in the GP practices. Task-centred qualities were acknowledged and the postholders were regarded as *'very competent'* (GP3). Person-centred qualities were important criteria, and the need *'to wiggle out the right healthcare assistant to train up... need the right calibre of person'* (GP3) were

highlighted. It was also evident that a trusting relationship was in place between the NAs and the practice team.

*Yes, I would be confident in delegating to my two colleagues because I trust them. (NT3-PN1)*

*I have no qualms about at all because they're very very capable. We know these nursing associates, and I think it's to do with the quality of the person. (NT3-PN2)*

### Finding Champions

The champion role was undertaken by the senior nursing leadership team, and this had secured the support of the GP management in the Practice. In particular, the maturity of the nursing governance structure and the autonomy of the champions were noticeable.

*I think we did it at risk as well because....the nursing leadership, they tell us what they think we should do. You know, the nursing team has developed completely..... we trusted that they had a vision that they knew what they were doing. (GP3)*

The drive for change was from the top team. One champion in particular was a very experienced nurse and used her own knowledge of the organisation to advance the role change, as well as promoting the NA role.

*So I had like a kind of trajectory, and it was very informal discussion with a couple of the partners here, but kind of a timeline of the trajectory of the nurses and what was likely to happen here over the next five years. (M3)*

There was also a suggestion of a positive and supportive culture in the organisation to develop its people, and this had enabled the introduction of the new NA role to the GP practice. The team was described as '*very experienced... very well established...a good level of trust, good levels of support and want to...develop everybody, and stay ahead of the game*' (M3). The NA confirmed that and described it as '*a really good place*' (NA3) to work.

No preceptorship was in place to provide dedicated support to the NAs after they had qualified.

### Overcoming barriers or concerns

One barrier was identified as being time out for the trainees to undergo training. The biggest challenge was *'to backfill because we're really busy'* (NT3-PN2).

Other challenges discussed were related to a lack of available training, and this will be captured in the following section.

### Recognising & creating opportunities to advance the new role

Accountability was considered in the context of appropriateness, training and support / mentoring. The GP practice was mindful that *'people are given responsibilities or pressures put on them, to work at a level of competency above what they should be expected to work at'* (GP3). The need to *'make sure that the nursing associates are given the right delegated patients, they are given the right support, they are given the right training packages'* (M3) was emphasised for this transition period.

Three levels of accountability were articulated: practice; nursing team and the NAs. The clinical team was aware that the NAs were in transition and should not be put under pressure to work beyond their competency. A cautious approach had been taken during this stage, and NAs were compared to *'little cygnets that won't be swimming till...deemed them absolutely competent in that area'* (M3).

Training played an important part in enabling accountability and one nurse described how she took the responsibility to evaluate the individual *'really seriously'* ((NT3-PN1). Once the NAs were signed off as competent, they were then accountable to the tasks, and *'it's got to be them'* (NT3-PN1) that were being held to account. Registration with NMC was welcomed and viewed as a validation of the new role, *'gives that person accountability'* (NT3-PN1), and this had provided confidence to others. The NA was very clear of her accountability with the patient and the delegated tasks *'as long as it's within remit'* (NA3). In addition, confidence in the role also tied in with the individuals.

*I trust them because the person....If it was a different person and they just had a PIN, it would be probably much difference to my trust on that person. (NT3-PN1)*

'*Few grey areas*' (NT3-PN1) was used to describe the current status of accountability for both the NAs and RNs, and participants described searching for clearer guidance on role remit. Due to limited guidance, participants had to '*use common sense*' (M3) when it came to role boundary and development.

The demands on core services during COVID had limited the capacity to develop the NAs, and there had not been '*that nice, steady environment*' (GP3). As a result, the NAs were '*still doing a lot of that HCA work at that level*' (GP3). On the other hand, the pandemic had acted as an enabler that broadened the NA's role. COVID vaccination clinic was given as an example and because the work was '*needed*' (NT3-NA4), NAs were allowed to take consent as well as drawing up and administering the vaccine.

In terms of constraints to advance and utilise the NA role, '*actual physical space, really physical space*' was highlighted as a challenge.

Opportunities to develop the role were based on initial assumptions of what the NAs would be able to do, and '*it was a bit of an educated guess*' (GP3). There was also learning along the way as to what the NA could do or not, and this was '*probably a bit of a challenge*' (NT3-PN1). While the GP practice was optimistic of the future of the NA role, they were mindful of '*not pushing it too far*' (M3). Therefore, an approach where things were '*going to be done measured.....all be underpinned by the validated training*' was adopted. Moreover, emphasis was placed on the appropriateness of the tasks. The opportunities of the new role were received positively by the NAs and they were keen to learn and take on more responsibilities, and make their jobs '*more varied and more interesting*' (NA4).

The NAs had taken on cervical screening and going forward, the plan was for them to carry out childhood immunisations and some less complex part two long-term conditions reviews. It was envisaged that RNs would be operating at a higher level,



while the NAs would be '*the new band five nurse*' (NT3-PN1) and take on their current duties.

A lack of appropriate training programmes for the NA, both in terms of numbers and contents, was highlighted on many occasions. The HEIs were described as '*a bit slow*' and '*have not caught up*' (M3) in terms of provisions of validated courses. This was stressed as a major barrier for further advancement of the role. To compensate for the gaps, the practice had sourced the training from private providers, although they were described as at the wrong level as NAs were '*doing the same courses as the practice nurse we are doing, and is too detailed*' (NT3-PN1).

#### Fitting new role into established structures & systems

The practice had a JD for the NA role which was aligned to the NHS pay scale. This had provided a structure to develop competencies. Remuneration for NA was brought up as a sensitive issue, because the practice believed NAs would '*do essentially almost band 5 work but they're getting paid less*' (M3) in the future.

The development of the new NA role was seen as a gradual process, with its scope slowly being broadened. The NAs continued to carry out a lot of HCA tasks during '*transition*' (GP3) and were in '*both camps*' of HCAs and NAs, even though they had taken on some distinct responsibilities that separated the role of NA and HCA. This had been noticed by the HCAs. These duties were cervical screening, an extended role in long term conditions reviews, and some basic contraceptive reviews. The involvement in clinical decisions was regarded as a key marker to separate the NA and HCA roles, and exclusive for NAs as HCAs were '*doing things but not making clinical decisions*' (GP3)

When compared to State Enrolled Nurse (SEN), some regarded the NA role was '*very similar and been brought back in a different name*' (M3).

The development of NAs also came in the form of enhanced knowledge, and inquisitive minds and questioning, and had taken the HCA role '*to the next level*' (GP3). This was noticed by the clinical team, and one NA reported the extra

responsibilities had made her '*think a lot more for myself instead of just knocking on doors and asking questions*' (NA3).

The GP practice planned to use their website to raise awareness and promote understanding of the NA role to patients and the wider team.

### Proving value of new role to others

It was evident that GP practice was delighted by the progress of the NAs as individuals and professionals, and described the NA role as '*new and exciting*' (M3).

*And I was a bit like, okay, let's see how this goes, will they really be able to step up? Will they be able to step up and confidence? My God, you know, they have. So it's been the growth, the personal growth..... that just general confidence in themselves, and a pride actually in what they're doing as well. (GP3)*

Although patients noticed the new role from a change in uniform, they had never heard of it and their understanding of the NA role was based on the previous SEN.

The contributions of the NA role were reflected in service delivery. An increase in new capacity had allowed more appointments such as smears and COVID clinics, and practice nurses were '*able to help with their catch up with long term conditions*' (GP3). By taking on contraception reviews, it was suggested that this would release GP capacity as well.

However, the impact of NA on the individual RN's working life was yet to come through at this early stage, though nursing team level impacts were noticed, such as '*an added level of resilience*' (GP3).

The NA role and its contributions were not visible to the wider GP team, and '*a lot of them didn't really know the role*' (NA4). It was acknowledged that more should be done '*educating GPs*' (M3) once the role was more developed. Due to the nature of the role and the size of the practice, the NA role had little contact with the practice management team.

To summarise the role implementation, the practice appeared to have a clear idea of how this role would fit in, and worked with the role ambiguity. The development of the NAs was slow but steady, and plans were in place to extend the scope. The difficulty in accessing training was a constraint but the practice had exploited other opportunities such as COVID legislation to broaden the scope. Role identity remained an issue with little understanding from the clinical team and patients.

## **5.5 Case Study Four**

Case study four is one of GP practices in a primary care limited company in the North East (NE) of England. The parent company employed over 150 (headcount) non-clinical and clinical and staff, and had a registered population of around 45K.

At the time of interview, the NA had left her role 5 months after qualifying, and indeed the healthcare sector completely. I tried to reach out to the NA via the practice and invite her to take part in the study, but received no reply. Therefore, the findings below were based on interviews with the PM, RN and GP.

### **5.5.1 Final Template**

The final template is shown in Figure 18. Compared to the initial template, there are two level two codes and two level three codes and one level four code added: 1.5 Finance; 2.4 Personal life; 7.1.1 Benefits realisation; 7.1.2 Formal agreement and 1.4.4.1 Planning.

### **5.5.2 Findings**

#### **Establishing a need**

The practice was made aware of the new NA role by the CCG via the matron at the primary care limited company. In fact, it was the NA that approached the GP practice as she was said to be '*very interested in that*' (M5).

**Figure 18: Final template for case study four**

<b>1.0 Establishing a need</b>
1.1 Catalyst for change
1.2 Involvement and support
1.3 Service
1.4 Workforce
1.4.1 Bridging skill gap
1.4.2 Knowledge of the role
1.4.3 Nursing shortage
1.4.4. Workforce development
General needs
Individual needs
Planning
1.5 Finance
<b>2.0 Identifying post holders</b>
2.1 Established relationship
2.2 Person-centred qualities
2.3 Task-centred qualities
2.4 Personal life
<b>3.0 Finding champions</b>
3.1 Address the barriers
3.2 Encourage others to endorse change
3.3 Institutional entrepreneurs
3.4 Support the role
<b>4.0 Overcoming barriers or concerns</b>
4.1 Organising placements
4.2 Supervision
4.3 Time out
4.4 No resistance
<b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b>
5.1 Accountability
5.2 Confidence and trust
5.3 Constraints
5.3.1 Concerns about the role
5.3.2 Impact of COVID
5.3.3 Space
5.3.4 Others
5.4 Opportunities
5.5 Training and development
<b>6.0 Fitting new way into established structures &amp; systems</b>
6.1 Role boundary
6.1.1 Job Description
6.1.2 Pay equity
6.1.3 Role contents
6.2 Role identity
6.2.1 NMC
6.2.2 Re(construct)
New way of working
Old way of working
<b>7.0 Proving value of new way to others</b>
7.1 Confidence and expectations
7.1.1 Benefits realisation
7.1.2 Formal agreement
7.2 Patients
7.3 Service delivery
7.2.1 Additional capacity
7.2.2 Quality improvement
7.4 Team members
7.3.1 Accessibility & support
7.3.2 Mentoring
7.3.3 Others
<b>VOIDED 8.0 Establishing routine use</b>
8.1 Contributions to other co-workers
8.1.1 Accessibility & Support
8.2 Contributions to patient services
8.2.1 Expertise of post holder
<b>VOIDED 9.0 Creating trust</b>
<b>VOIDED 10.0 Ensuring dependence</b>

Workforce issues were the main reason for introducing the new role. Succession planning was the motivation, aiming to prepare for the imminent retirement of one of the nurses. The plan was to get the individual '*trained up, so she could start working into*' (M4). Other reasons were staff development and retention. The practice believed that the opportunity to develop would enhance job satisfaction and in turn, this would lead to retention. This was particularly relevant as at the time the practice had only one experienced HCA who had been there for some years.

There was limited knowledge of the NA role before introduction, and the practice did struggle '*to find something to tell [the practice] exactly what [NA] would be able to do afterwards*' (M4).

The practice recognised that the NA role initially would have a cost implication, but in the long run, there would be a return on investment to cover shortage in practice nurses.

#### Identifying post holders

Generally speaking, HCAs in GP practices '*do all sorts..... quite a varied role with a lot of responsibilities as well*' (M4). The postholder had been working in the practice for some years. This had meant a relationship and trust had already been established with the practice team. The NA's technical skills as an HCA were acknowledged and she was described as '*very good at it.....Amazing in her job*' (GP4). The person-centred qualities such as '*very, very popular with patients.....very, very popular in the surgery with other staff members*' (GP4) were also highlighted.

The participants highlighted that the NA had some challenges in her private life during the training. It was also suggested that '*the potential for increased responsibility was what actually put her off*' (GP4) and led to her departure. Going forward, the practice was keen to put in place a learning agreement with the individual to state '*you've completed this training and you have to stay for X amount of time*' (M4), so as to ensure a return in the investment.

### Finding Champions

The primary care limited company had a matron role with responsibility for training included NAs. A business case was prepared and submitted to the Board by the matron, and GP practices were encouraged to endorse and adopt the development.

This was followed by action at GP practice level to negotiate funding with the finance team to '*see is the money in the budget to do that*' (M4). The practice manager also had discussions with the nursing team, regarding the implication on service capacity due to time out for training. The outcome was reported as positive, and there was '*some discussion but no resistance*' (M4).

The matron was described as the '*driving force behind this*' (M4), and had regular check-ups with the NA in training. At the higher level, the GP practice questioned if there was support for the small numbers of NAs working in primary care, as well as the clarity of their roles. The practice believed more support should be provided to the NAs in training and particularly just after qualifying. It was also suggested that if the support were in place, the departure of NA5 might have been avoidable.

*I would recommend we need more support for people.....not just during the training, but afterwards, because I feel once [NA] qualified, she was just left to get on with it. You know, her leaving maybe was avoidable if she had that support around her..... these are the next steps or this is the options which are open to you. Don't feel that support was really there. I don't know if it should come from the university, the CCG, the trust, the practice or what? (M4).*

### Overcoming barriers or concerns

Only one area was identified as a key barrier and this was the '*significant chunks of time with the training that obviously impacted on appointments and service provision*' (GP4). However, the practice was prepared to accept the short-term inconvenience for the longer-term gain.

## Recognising & creating opportunities to advance the new role

The NA had continued to operate as an HCA since qualifying, and did not take on any additional tasks or duties.

In principle, the registration with NMC had inspired confidence and brought '*a level of competence and accountability for their role*' (NT4-PN1). Accountability was considered at two levels: organisational and individual, and appropriate delegation and training were key to ensure the individual has the required skills to carry out the task in the first place.

Physical space was one issue identified, with the situation described as '*very difficult.... limits [practice] a little bit to what we can put*' (NT4-PN1). However, the key barrier to advancing the role was the lack of role clarity. The practice '*did struggle to find...exactly what [NA] would be able to afterwards*' (M4), and had to apply their own interpretation.

*There was never any clear guidance to say a nurse associate is whatever and they can do X Y Z. It was always left a little bit blurry we found our own to interpretation. Now that might just be in general practice and it might be much more well established in hospital trusts and the like. But for us, it was it was more difficult. (M4)*

There was an absence of a development plan for the NA after she qualified, and it was likely that the role ambiguity and lack of guidance played a part in this. One participant suggested that the GP practice did not know '*what to do with the [NA] at the time.... this was the crux of it*' (NT4-PN1).

As a brand-new development, the practice had hoped that a greater scope and an increased level of responsibility offered by the NA role would complement the nursing team on a daily basis. The exact areas to be developed would have been discussed and identified with the nursing team, and potential areas referenced in the interviews were cervical screening, childhood immunisations, and COPD asthma reviews. It was also suggested that there was a mismatch between the expectations of the NA and the practice regarding the tasks to be taken on initially. Rather than

undergoing smear training, it was indicated that the NA felt other areas would be more relevant for her role such as health education and diabetes training.

The nurse was unsure of a role for NA in primary care setting in general, but more specific, her view was that HCA role was more needed in the practice than the NA role.

*Unfortunately, we don't...I am not actually clear what the NA role is within the primary care..... But I think the need for a healthcare assistant is more for this practice than a nursing associate at present. (NT4-PN1)*

There was a criticism on the current NA training programme, and the view was that the programme was not valid for primary care. It was suggested '*that was the big problem*' (NT4-PN1) in regard to the departed NA. Questions were also raised in relation to the practitioners' readiness to practise as NAs after completion of the 2-year training, as extra training was needed. Overall, the participant concluded that the current programme did not have enough relevance for primary care.

#### Fitting new role into established structures & systems

A JD was not available when the NA was qualified, although it was in place at the time of interview. This reflected the situation that most of the early NAs were in hospital settings in the NE, and NA5 was one of the first NAs in the primary care and the limited.

The qualified NA had never operated as a NA or taken on additional tasks or duties. The practice described the role as '*a bit of a compromise between the healthcare and the practice nurse*' (GP4), and envisaged that GP practices would use NAs differently. In the future, there would be little difference between the role of practice nurse and NA, and this was described as '*overlap*' (NT4-PN1).

The practice had been looking for clarity on the NA role and what the NA would be able to do, as there were '*huge grey areas*' (M4). The point on seeking clarity was reiterated on many occasions by participants during the interview.



Although NAs are registered with the NMC, in principle, this on its own did not mean the clinicians were more willing to delegate tasks to the NA. The decision would be based on '*the ability to perform that role*' (NT4-PN1) and it was the expectation that the NA would have awareness of her/his own level of competence.

The qualified NA had continued to carry out HCA tasks only, and it was suggested that she was concerned about not being able to change her role identity.

*I think that was what [NA5] feared that she wouldn't be recognised for the nursing associate and she would still be used as like healthcare, which she was when she finished her course obviously. Because there was no plan in fact, she was used as the healthcare assistant still. (NT4-PN1)*

#### Proving value of new way to others

The practice expressed their disappointment over the NA's departure, as the practice did not '*felt any of that benefit*' (GP4). Putting business costs aside, there was a genuine regret about the NA's departure from NHS, as this was '*a huge waste of [NA] fantastic skills and abilities*' (M4) and a loss to the primary care.

As a result, and perhaps to be expected, the practice had taken a much more cautious approach in considering future staff requests to undertake the NA training.

To summarise the role implementation, it was an unsuccessful experience for the practice. The buy in from the nursing team seemed low. It would appear that a lack of role clarity had negatively impacted on the practice's ability to plan for the role development. In turn, the work to construct a role identity could not have start and altogether these factors contributed to departure of the NA.

## **5.6 Case Study Five**

Case Study five is a medical group with a registered population of approximately 36k. It operates over two sites and employed around 40 clinical and non-clinical

staff. The medical group is a teaching and training practice where foundation doctors are taught and qualified doctors are trained to become GPs.

#### 5.6.1 Final template

The final template is shown in Figure 19. Compared to the initial template, there are two level two codes and one level three code and two level four codes added: 4.4 Cost; 4.6 Others; 7.2.3 Release time from nurses; 1.4.4.1 Planning and 6.2.2.1 Challenges or issues.

#### 5.6.2 Findings

##### Establishing a need

The practice was made aware of the NA role by CCG via the current postholder, and *'previously to that, anybody had really thought about it'* (NT5-PN1). The NA (was HCA then) was interested in doing the training, and *'wanted to expand her training and her skills.....brought it to the practice'* (GP5).

The main reason to introduce the NA role was workforce related. The practice was keen to develop the individual, and at the same time, conduct a review of the skills in the clinical team to match to service needs. The overall aim was to ensure human resources were used efficiently and it was envisaged that some current tasks could be delegated from GPs to nursing team.

There was little understanding of the NA role and the practice *'knew very little about it'* (M5). Indeed, some nurses *'never sort of really took a great deal of notice of it'* (NT5-PN3) and *'didn't really even really know there was a nursing associate programme out there'* (NT5-PN1).

**Figure 19: Final template for case study five**

<b>1.0 Establishing a need</b>
1.1 Catalyst for change
1.2 Involvement and support
1.3 Service
1.4 Workforce
1.4.1 Bridging skill gap
1.4.2 Knowledge of the role
1.4.3 Nursing shortage
1.4.4. Workforce development
General needs
Individual needs
Planning
<b>2.0 Identifying post holders</b>
2.1 Established relationship
2.2 Person-centred qualities
2.3 Task-centred qualities
<b>3.0 Finding champions</b>
3.1 Address the barriers
3.2 Encourage others to endorse change
3.3 Institutional entrepreneurs
3.4 Support the role
<b>4.0 Overcoming barriers or concerns</b>
4.1 Organising placements
4.2 Supervision
4.3 Time out
4.4 No resistance
4.5 Cost
4.6 Others
<b>5.0 Recognising &amp; creating opportunities to advance ‘the new way’</b>
5.1 Accountability
5.2 Confidence and trust
5.3 Constraints
5.3.1 Concerns about the role
5.3.2 Impact of COVID
5.3.3 Space
5.3.4 Others
5.4 Opportunities
5.5 Training and development
<b>6.0 Fitting new way into established structures &amp; systems</b>
6.1 Role boundary
6.1.1 Job Description
6.1.2 Pay equity
6.1.3 Role contents
6.2 Role identity
6.2.1 NMC
6.2.2 Re(construct)
Challenges or issues
New way of working
Old way of working
<b>7.0 Proving value of new way to others</b>
7.1 Confidence and expectations
7.2 Patients
7.3 Service delivery
7.2.1 Additional capacity
7.2.2 Quality improvement
7.2.3 Release time from nurses
7.4 Team members
7.3.1 Accessibility & support
7.3.2 Mentoring
7.3.3 Others
<b>VOIDED 8.0 Establishing routine use</b>
8.1 Contributions to other co-workers
8.1.1 Accessibility & Support
8.2 Contributions to patient services
8.2.1 Expertise of post holder
<b>VOIDED 9.0 Creating trust</b>
<b>VOIDED 10.0 Ensuring dependence</b>

It also came as a little surprise that nursing shortage was only explicitly mentioned very briefly in the context of '*the aging nursing workforce in primary care*' (M5). It was evident that the NA postholder was highly regarded and had a strong desire to '*learn new skills and get new knowledge*' (NA6). Retention was the main motivation for the introduction of the new role, as '*if we don't let her progress at some point in the future, then you know, she might move on*' (M5). There was also a wider commitment to staff development: '*It's encouraging young staff to stay and develop your staff*' (M5).

The introduction of the NA was said to be preceded by a skill-mix review. In the future, the practice could envisage a very different nursing structure where, '*instead of the practice nurse, ... ..could end up just having nursing associates and nurse practitioners*' (M5).

#### Identifying post holders

The practice did not have issues about identifying a trainee, and was keen to develop the individual, as it '*couldn't actually see any reason not to*' (M5). The postholder was a HCA in the GP practice prior to training, and was being described as '*proved her worth....really good.... very bright*' (M5). Personal qualities were identified such as '*very driven....very motivated*' (M5). A trusting relationship had already been established between the NA and the practice.

*I do think that generally even before my training, and they (GPs) trust my judgement a lot of the time so I do feel like that was the case even prior to my training. (NA6)*

#### Finding Champions

Once the idea was brought into the practice by the NA, the nurse manager championed and helped to encourage the GPs to accept the proposal. This willingness was probably due to the confidence and trust established between the nurse manager and the individual, rather than with the role.

Wider support was provided by the nursing team during and after training. The nurses described *'Everybody in the practice, kind of supported along the way with it'* (NT3-PN1). This was echoed by the NA and it was reported that *'the nurses have always been very supportive'* (NA6).

There were purposeful efforts from the champion to resolve issues, who *'just went absolutely as far as I could to try to sort out the issues that she's having with their training'* (M5).

### Overcoming barriers or concerns

The challenges identified were all related to training. The training was described as *'a bit disorganised and chaotic and un-supportive'* (GP5). The major difficulty was trying to arrange clinical placements for the NA, and the disparity between the experiences of trainees from primary care and secondary care was highlighted.

*I think because [NA] being on the course with other nurses who were from secondary care, obviously it was very different. They got lots of opportunities to go onto other wards and got different skills that they can take back to their area of practice within secondary care. I think [NA6] was very limited to what she got coming from primary care, she had to fight hard to get placements and to get to see things and learn certain aspects that you would need. (NT3-PN3)*

Indeed, the challenge was such that at one stage that the NA planned to defer the training, as she could not secure the hours needed to satisfy the requirement. As a result, the NA had a very negative opinion of the quality of the training programme. Challenges included finding time out for training and the need to cover gaps in clinics. The practice managed to overcome this with a comparatively bigger workforce as *'Fortunately, we're a big practice..... we managed to just mop it up because we have got bigger numbers'* (M5).

Finance was also pointed out as a challenge as *'there was a cost attached to the training'* (GP5).

## Recognising & creating opportunities to advance the new role

The practice considered accountability at two levels: practice and individual, with competence and appropriate delegation being the golden threads. Self-awareness of gaps in one's knowledge was also recognised by the NA as important.

With the training and registration with NMC, this had helped *'instil some confidence in in delegating things to them .....and they're accountable for their practice....the same as the same as all the registered nurses do'* (NT5-PN4). However, it was clear that willingness to delegate was largely influenced by the established trust and understanding of the individual's skillsets. This would be different if the NA was new to the practice.

There was also evidence that the established relationship had positively impacted on the pace and scope of development, as *'we know what she can do. So we're just happy for her to progress in what she wants to do ....Whereas someone comes into the practice as a newly qualified and hadn't worked here, then we probably would have had to sit down and say, this is what we expect of you '* (M5).

To enable appropriate delegation and creation of suitable opportunities, role clarity was needed.

*I would say the only issue with it is sort of clarifying where the boundaries lie for the nursing associates. (NT5-PN3)*

Additional training was given as key to underpinning further development of the role. Being a NA had enabled access to training otherwise open to qualified nurses only, such as cervical screening. In addition to professional advancement, this had also benefitted the practice by providing additional capacity.

It was also suggested that the widening scope of practice associated with the postholder's new identity was partly a result of *'increased in confidence...taken on other roles'* (GP5).

Regarding constraints, the COVID pandemic had a negative impact on the development of the role, as otherwise, the NA *'probably would be doing a bit more*

*than she is doing now. But I think that's more to do with access to training'* (GP5). Lack of physical space was another issue and the GP practice was '*absolutely bursting at the seams'* (M5). There were also competing training priorities. The GP practice had recently employed two new practice nurses, and their needs were described as '*the priority for training at the moment because they've kind of come in needing everything'* (NA6).

The practice had planned for the NA to take on '*nursing type tasks....previously being done by the practice nurses which then released them for other jobs'* (M5). This future NA role was described as '*treatment room nurse'* (NT5-PN4) with practical duties such as vaccinations, childhood immunisation, cervical screening, dressings, vaginal swabs and ear irrigation. In turn, the aim was to '*free up...nurse practitioners to do the nurse practitioner role....diagnosis, assessment, all of those sorts of things'* (NT5-PN4). The NA would also be supporting the roll-out of the 24 hours ambulatory ECG monitoring.

Since qualifying, the NA had undertaken additional training on compression bandaging and wound care, and vaccination, with more training planned. The practice had called for changes to the training programme to include more relevant content for primary care, and to '*make the content bit more structured, include more things that they [NAs] are going to be able to do once they've qualified'* (NT5-PN1).

#### Fitting new way into established structures & systems

The GP practice had a job description for the NA role and the NA had continued to carry out largely HCA duties since being qualified. Some new tasks had been taken on, such as COVID clinics, complex dressings, vaginal swabs, bariatric blood monitoring and an extended range of vaccinations. The NA described her involvement in care planning and '*got a little bit more freedom....can make more clinical decisions'*(NA6). The GP practice envisaged the NA role would stop '*at sort of the more practical elements of the job'* (GP5) whereas nurses would provide patient management and '*are carrying a more advanced task'* (GP5).

The NA had a primary care background and so was operating at much higher levels in some respects than new practice nurses, due to her breadth of knowledge gained over time. However, the development of the role itself was restricted by the professional license, and there were duties that the NA could not take on.

With a very experienced HCA team in the practice, there was some resentment from some individuals as the NA had started off at the same level and now progressed. This had created some challenges at professional boundaries fitting the new NA role into the current structure.

However the wider team (included the nurses) generally accepted the role. The lack of role clarity had caused some confusion in daily practices: *'sometimes a little bit of a mix of about what you can do in relation to actually [NA] can do'* (NT3-PN2). This had also led to a hesitation in delegation and adverse impact on role development.

*I just have a quick look on the NMC scope of practice. You can see it's just not actually very clear what they can do and where the boundaries lie. So probably a little bit of uncertainty, what the role and how much they can do without overstepping really. And we wouldn't obviously want to put somebody in that position. (NT5-PN2)*

This confusion could also be seen when the NA role was repeatedly compared to the SEN role which had not been abolished. Due to the different ways of working in primary care, some tasks were carried out by both registered and non-registered members in the team. Together with limited numbers of distinctive tasks or responsibilities for the NA role to *'stand out more from the healthcare assistant role'* (NT5-PN4), this had made it challenging for the post-holder to construct a new identity. One nurse described that as *'the biggest difficulty'* (NT5-PN4) for the current postholder.

However, action was taken to promote the new NA role. To help the receptionists to navigate amongst a big clinical team, they now *'got a list of all the different nursing staff, health care assistants and what jobs are capable of doing, so they know which patients to book with which'* (NT5-GP5). Moreover, the practice moved the NA's booking screen to be with the practice nurses so others could be more aware of her



new skillset. This was an active step by the practice to help establish the new identity of the NA.

The practice also tried to release the NA from HCA duties by backfilling some of the HCA capacity left behind. To do that, a receptionist and a secretary had been trained up and the practice also planned to employ a phlebotomist.

To further establish her identity the NA proactively reorganised the clinic lists across the nursing team, so her skillsets could be matched to patient needs and service demands.

There were early signs that the practice team was beginning to utilise the NA role differently. The GPs and receptionists had begun to pass on more complex duties to the postholder, which would not have happened if she was still in the HCA role. This change was attributed to the NA's different thinking process and ways of practising.

However, the NA described her struggle to establish her new identity.

*I do feel like though, overall, it's been very hard to shake the fact that I'm no longer a healthcare assistant with other members of staff..... Yeah, and I do feel like I have struggled to get out of the healthcare assistant box since I've qualified. (NA6)*

#### Proving value of new role to others

Although the practice knew little about the new NA role before introduction, the experience was seen as positive and that expectations had been exceeded. In particular, the practice commented on the NA's different ways of thinking. This early confidence had encouraged the practice to explore workforce planning differently in the future, and continue the changes in skill-mix. The GP practice had discussed the potential of replacing practices nurses or HCAs by NAs, as their remits overlapped.

The NA believed the confidence levels from GPs were increasing. Examples included '*come to me more now sort of knowing that I can give a little bit more holistic care... they know that if I've got any issues or concerns, I'll be able to flag them up quite competently*' (NA6).

Some patients noticed the NA had a different uniform and others were aware of the further training taken. However the view was that patients '*don't really know what that is...know what a nursing associate is*' (NA6). To explain the new role to some of the patients, the NA compared it with the SEN: '*So it's kind of like, well remember, state enrolled nurses. Well, it's kind of a similar thing*' (NA6). This might also suggest that the NA herself was struggling to describe the role and construct an identity.

Without the additional capacity provided by the NA the GP practice '*wouldn't have managed to keep on doing what we've been doing*' (M5). The nursing team also recognised that the NA was '*able to do so many extra things that can take the pressure off*' (NT5-PN5). As a result, nursing services e.g. relating to complex wounds had been strengthened. In addition, nurses '*can focus on more complex things. And consequently, somewhere further up the line can take some of the work off the GP workload*'(GP5). However, there was some uncertainty on whether this was simply expanding the same capacity, i.e. but not filling skill gap as '*the more service you provide, the more you fill it*'. (M5).

There was also a perceived quality improvement in providing continuity of care to patients. The NA now felt more able to plan and deliver care, and exercise her clinical judgement. The GP practice had also freed up nurses' time to focus on other complex duties.

The NA provided support to new practice nurses and they looked to the NA for '*advice about things... because she managed the workload really well ... But sometimes they go to her more about how things work within the practice, maybe more than clinical things*' (M5). Due to her in-depth understanding of the GP practice, the NA reported that she was often the most experienced person on duty.

On the other hand, the introduction of the NA role had brought some resentment to the HCA team: *'a few bumps along the road'* (NA6). The perceived promotion of the individual and closer alignment of the NA role to the qualified clinicians had caused tension in the team and *'there's a bit of backlash'* (NA6). Some HCAs had *'difficulties in sort of accepting her new role and also for the team in general.....taken a little bit of getting used to.'* (NT5-PN4).

To summarise the role implementation, the practice appeared to have a clear purpose of the role and had plans to broaden the scope. A lack of role clarity had impacted on role development and caused some professional tensions. The NA continued to carry out all the HCA duties and was struggling to establish a new identity, though there was proactive support by the practice. The NA had made tangible contributions to service delivery both in terms of capacity and continuity of care.

## **5.7 Cross-case synthesis**

Having identified the within-case patterns this section examines relationships across the five case studies. As all these studies began with the same theoretical propositions, i.e. the seven micro-processes of the Elaborated Institutionalisation Model (Kessler et al., 2017), a deductive approach will first be applied. However an inductive approach will be taken where necessary in order to uncover new meanings or patterns. The findings for the seven microprocesses / themes will be grouped and presented under the two stages of new role: emergence and legitimisation.

As shown in the last section, there were different experiences and varying levels of success in introducing the new NA role in GP practices. Yin (2018) stressed the importance of contextual conditions in case studies, and therefore, the need to retain their holistic features during cross-case synthesis. In the real-world context, each case or GP practice is expected to be different. However, it has been pointed out that their dissimilarities may be associated with plausible rival interpretations that undermine the findings of the synthesis (Yin, 2018). By the same token, their differences may also help to explain the different outcomes in each GP practice, hence their relevance in the analytical process. With this in mind, this section begins

by providing a brief summary and comparison of the five GP practices. The characteristics of the NAs themselves will be provided in 5.7.2 under the heading of 'identifying the post holders'.

### 5.7.1 Contextual conditions

A total of five GP practices took part in this study all of whom had staff that had completed the NA training at least six months before the interviews and focus groups took place. One GP practice had two NAs participating in the study at the time of data collection, while the NA of one GP practice had left her role. The discussions with the nursing teams consisted of two one-to-one interviews with a RN, and three focus groups with teams of RNs, HCAs and TNA. A combination of practice manager (PM) and nurse manager (NM) took part in the study. Information on participants is illustrated again in Table 20.

**Table 20: Numbers and type of participants**

GP practice	Study Participants						Total numbers
	GP	NA	Nursing Team			PM / NM*	
			RN	HCA	TNA		
Site 1	1	1	1	0	0	1*	4
Site 2	1	1	2	0	1	1	6
Site 3	1	2	2	2	0	1*	8
Site 4	1	0	1	0	0	1	3
Site 5	1	1	5	0	0	1*	8

The five GP practices are in different types of geographical locations and with varying levels of registered population from approximately 16,000 to 51,000. These practices also came from a broad range of organisations and therefore, have different sized workforces. A summary of the characteristics of the five GP practices are shown again in Table 21 with size of workforce. These features were included in the comparison because of their relevance to resources and activities, which in turn, influence the outputs and outcomes of local interventions and initiatives.

**Table 21: Characteristic of GP practices**

GP practice	Registered Population (approx.)	Type	Location	Staff employed (headcount) (approx)	Size of nursing team (approx)
Site 1	16k	Medical Group	Urban	51	11
Site 2	26k	Alliance	City	100	17
Site 3	51k	Partnership	Town	170	37
Site 4	40k	Limited Company	Urban	155	42
Site 5	36k	Medical Group	Urban	47	17

### 5.7.2 Findings

The EIM by Kessler et al. (2017) has 10 microprocesses and they were adopted as the a priori themes (codes) of this study and structure to present the findings. As an aide memoire, a summary of the stages and micro-processes is provided below in Table 22.

**Table 22: Elaborated Institutionalised Model (Kessler et al., 2017) – stages and micro-processes**

Stage	Micro-processes	
1.0 Emergence	1.1 Establishing a need	Shaping the new role
	1.2 Identifying post holders	
	1.3 Finding champions	
	1.4 Calming organisational concerns	
2.0 Legitimacy	2.1 Recognising / creating opportunities to advance new way	
	2.2 Fitting new into established structures / systems	
	2.3 Proving value of new way to others	
3.0 Acceptance	2.1 Establishing routine use	
	2.2 Creating trust	
	2.3 Ensuring dependence	

#### Establishing a need

The development of the NA role in England was a national initiative, promoted to all GP practices in the North East of England through the CCGs. There was also a regional implementation group across the whole of North East region which acted as a reference point across the hospitals, GP practices and care homes. Through the ARRS, the government made additional funding available to all GP practices to support workforce expansion in primary care. This was discussed by two practices

(Study 2 and Study 3), and it was clear that the extra incentives offered had encouraged the practices to introduce the role.

Knowledge of the NA role and its remit was consistently low across all case study sites. Three GP practices (Study 1, Study 4 and Study 5) explicitly referenced the CCGs as the source of their initial awareness. Two practices (Study 1 and Study 2) noted their knowledge had developed as time went on. One practice (Study 3) had to make assumptions on the role remit in order to develop it locally.

Workforce related issues were identified by all GP practices as the highest need driving introduction of the new NA role. The reasons included nursing shortage, succession planning, retention, aging workforce, difficulty to attract younger people, and workforce development at both general and individual levels. A combination of short and longer-term need had been articulated and a more strategic approach was evident in two practices (Study 2 and Study 3). In Case Study 2, a multi-disciplinary model was described for future delivery to address both GP and nursing shortages, and a detailed nursing workforce plan had been carried out by Case Study 3 to inform requirements. One practice (Case Study 5) had also carried out a skill-mix review and could envisage a future workforce model without practice nurses.

All the five GP practices expressed a strong desire to develop its experienced HCA workforce. This was matched by an eagerness of the NAs (HCAs at that time) to develop. Indeed, the idea to introduce the NA role was said to be initiated by the respective postholder in Case Studies 5 and 6, and described as 'driven' by NA6.

Service need was the second reason for bringing in the new NA, and this was communicated at different levels: strategic and service. One GP practice (Case Study 1) described a treatment room nurse role for the NA and a struggle to deliver some of the service target e.g. cervical screening. Case Study 5 considered the NA role would allow tasks to be passed on / delegated from GPs to RNs and then to NAs. Case Study 2 expected a multidisciplinary model in place where NA would take over basic duties from the practice nurses. It was notable that the service need was considered by Case Study 2 at a higher level and no specific service areas were cited.

While the issue of cost saving was prompted in the semi-structured interview question, this was only discussed in three case study sites (Studies 2, 3 and 4). In particular, the nursing team in Case Study 2 suspected that the real reason behind the introduction of the NA role was cost reduction. Moreover, the nursing team also felt the role of NA was less useful in GP practices. This was in contrast with the strategic vision of workforce planning and modelling expressed by another interviewee from the same practice. On the other hand, cost saving as a side benefit was welcomed by Case Study 2, and Case Study 3 regarded the initial cost as being recovered by the long-term gain.

### Identifying post holders

All the GP practices encountered no challenges in identifying suitable candidates to undertake the NA training. Indeed, two GP practices (Study 1 and Study 5) had more than one person who had shown interest initially.

**Table 23: Nursing Associate participants**

NA	Case study site	Previous role	Years in GP practice	Completed training	Interview date	Post qualified experience*
NA1	1	HCA	8.5	Jun-21	Dec-21	6 mth
NA2	2	HCA	3	Apr-21	Aug-22	17 mth
NA3	3	HCA	5	Dec-20	Oct-21	10 mth
NA4	3	HCA	1.5	Dec-20	Oct-21	10 mth
NA5	4	HCA	Not known	Sept-21	N/A	5 mth
NA6	5	HCA	7	Mar-21	Jan-22	10 mth

\*At the time of interview

All the NAs participating in this study were HCAs in the same practice. They qualified between Dec 2020 and Jun 2021, and had different length of post qualified experience at the time of the interviews (Table 23). HCAs are generally considered to be very experienced in primary care, and this was highlighted again by all five GP practices during the interviews. As the first cohort of trainees from primary care, all the NAs had a high level of task-orientated qualities. In addition, it was evident that the person-centred qualities of the postholders were very important to the GP practices. Except Study 4, all others spoke highly of their current postholders using phrases such as 'well respected' and 'high calibre'. Given the sub-optimal experience

in Study 4, the views of their NA were mixed, including 'not up to the challenge' and 'fantastic skills and abilities'.

All the NAs had already established a positive and trusting relationship with their teams in the GP practices. In fact, trust and confidence were a 'given' or otherwise, these individuals would not have been selected and supported to go through the training in the first place.

### Finding Champions

There were champions in all the GP practices (Table 24). Their influence was visible and instrumental in helping to introduce the new NA role. All these people were members of senior management teams with authority positions and access to resources to drive forward change.

**Table 24: Champions and positions**

<b>GP practice</b>	<b>Champions</b>	<b>Positions</b>
Study 1	1	Managing Director
Study 2	>1	GP management team in Primary Care Network
Study 3	2	GP partner and Lead Nurse
Study 4	1	Matron
Study 5	1	Nurse Manager

During the training, other nurses provided supervision and support to the NAs. In particular, there was a lot of effort from all the GP practices to try to overcome the challenges of arranging clinical placements. By comparison, there was notably lesser support to the NA role from the nursing team in Case Study 2. All GP practices did not have a formal preceptorship programme to integrate and support the newly qualified NAs into their place of work.

Regarding the wider support from the University, criticisms were strongly expressed by two practices. Studies 4 and 5 highlighted that the support for Trainees NA from primary care was severely lacking. NA6 described it as '*... like hitting a brick wall*



*every single step of the way...'* and Case Study 4 suggested that their NA might not have left if better support were available.

### Overcoming barriers or concerns

All GP practices had identified barriers to implementing the new role, and Table 25 provides a summary. Time out for the trainees was the common barrier across all GP practices, followed by arrangement of clinical placements.

At the time of interview, it was reported that the university now has a dedicated placement co-ordinator. The nursing team in Study 2 also indicated their intention to address the issue of lack of time for supervision with the practice management team.

**Table 25: Barriers of role implementation**

<b>GP practice</b>	<b>Numbers of barriers</b>	<b>Details</b>
Study 1	3	<ul style="list-style-type: none"> <li>• Arrangement of clinical placements</li> <li>• Dedicated time to provide supervisions</li> <li>• Time out for the trainee</li> </ul>
Study 2	3	<ul style="list-style-type: none"> <li>• Arrangement of clinical placements</li> <li>• Dedicated time to provide supervisions</li> <li>• Time out for the trainee</li> <li>• Physical space</li> </ul>
Study 3	1	<ul style="list-style-type: none"> <li>• Time out for the trainee</li> </ul>
Study 4	1	<ul style="list-style-type: none"> <li>• Time out for the trainee</li> </ul>
Study 5	4	<ul style="list-style-type: none"> <li>• Arrangement of clinical placements</li> <li>• Timeout for the trainee</li> <li>• Cost of the training</li> <li>• Quality of the training programme</li> </ul>

### Recognising & creating opportunities to advance the new role

Accountability is an integral element of delegation and is of particular significance in order to advance a new professional role. To develop the NA role will require transferring some of the current duties from RNs to the new NAs, and/or sharing some clinical responsibilities and tasks between them. As can be seen in Table 26, all GP practices had a multi-level view of accountability, sitting at the practice or team level as well as the individual concerned. The professional level of

responsibility as a registrant on the NMC was also acknowledged by all the NAs interviewed.

However, accountability was not considered in isolation and there were also other underpinning factors which set the context. In particular, training and competency as two related factors were identified by all the five GP practices.

**Table 26: Accountability framework**

GP practice	Levels of accountability	Where			Associated factors
		Practice	Nursing Team	Individual	
Study 1	2		X	X	Competencies, training
Study 2	2	X		X	Competencies
Study 3	3	X	X	X	Appropriateness, training and support / mentoring
Study 4	2	X		X	Appropriate delegation and training
Study 5	2	X		X	Competencies and appropriate delegation

While the registration with NMC had instilled confidence in all the GP practices, four of GP practices (Case Studies 1,2,3 and 5) confirmed that this did not equate to automatic delegation. Three practices (Case Studies 1,2,5) highlighted the matter of competency, while the confidence and trust of the individuals were regarded by other two (Case Studies 3, 4) as more important elements. Except Study 4, all other GP practices explicitly expressed their confidence in their NAs and this illustrated that perceptions of the role and the postholders were intertwined.

**Table 27: Constraints / challenges of role development**

Constraints / challenges	Study 1	Study 2	Study 3	Study 4	Study 5
Lack of role clarity / limited scope	X	X	X	X	X
Impact of COVID	X	X	X	X	X
Not totally committed		X			
Lack of training programmes			X		X
Physical space			X	X	

All GP practices highlighted the lack of role clarity and remit and called for further guidance, the absence of which was seen as negatively impacting on the scope and

pace of developing the NA role at local level. In particular, the nursing team in Study 2 had a real concern for the consequences for their own registrations, for example, as a result of the NA taking on childhood immunisation. Other constraints or challenges of advancing the NA role are shown in Table 27.

In terms of ideas for future opportunities to develop the NA role which were 'explicitly' stated by the practices, these are summarised in Table 28. An extended role with additional tasks was included in the plans of all GP practices, and most of these practical tasks would be classified as 'Treatment Room' duties.

**Table 28: Opportunities to advance the Nursing Associate role (explicitly stated at interviews)**

<b>Opportunities to advance the NA role</b>	<b>Study1</b>	<b>Study 2</b>	<b>Study 3</b>	<b>Study 4</b>	<b>Study 5</b>
Cervical screening	*	*	*	X	X
Childhood immunisation	X	X	X	X	X
Compression dressing	X				X
Travel vaccination		X	X		
Stage 2 LTC reviews	X	X	X	X	
Family planning clinic	X				
Spirometry		X	X		
Ear syringing					X
Vaginal swabs					X
Learning Disability Lead	X				

\* NAs in Study 1, 2 and 3 had already completed the training and/or taken on cervical screening.

### Fitting new role into established structures & systems

All the GP practices had a job description for the NA role, although this was not in place when the NA in Study 4 qualified. Study 3 also highlighted their work in aligning all the job descriptions in the nursing team to the competency framework in the NHS pay structure. The issue of pay for the NA role was brought up by Studies 2 and 3. It was recognised that the NAs would be taking on responsibilities currently being carried out by the PNs, and there would be similarities between the roles of PNs and NAs.

All practices described the role of NA as situated on a continuum between HCA and RN. However their exact remit varied amongst GP practices, and this was the view of two GP practices (Studies 1 and 4). For one GP practice (Study 5), due to primary

care experience of the postholder, the NA was said to be operating at a higher level in some ways when compared to their new practice nurses. In fact, some responsibilities such as childhood immunisation and cervical screening can be carried out by both NAs and RNs, and this was also highlighted by Study 4.

While Study 2 reiterated the big overlap between the HCA and NA roles, the difference in their involvement in clinical decision making was considered to be a key marker of differentiation by Study 3. This view was shared by Study 5 whose expectation was that the NA role would focus on practical treatment room duties, compared to the role of nurses. Study 1 described the duties of NAs as '.... the higher level of healthcare assistant work....coming from a different mindset because of the training' (M1). The above would explain to an extent the reason why the NAs continued to carry out primarily HCA tasks in all five GP practices. In fact, NA5 in Study 4 had never taken on any additional tasks after qualifying as a NA.

**Table 29: Tasks carried out by Nursing Associates at the time of interviews**

Tasks carried out by NAs	Study1	Study 2	Study 3	Study 4	Study 5
All HCA duties*	X	X	X	X	X
COVID clinics	X		X		X
Cervical screening	X	X	X		
B12 injections	X				X
Vaccinations - pneumococcal and shingles	X	X			
B12 injection	X				X
Tetanus					X
Baby imms		X			
Hormone injection such as Zoladex	X				
LTC part 2 reviews			X		
Complex dressings					X
Acute wounds					X
Vaginal swabs					X
Bariatric blood monitoring					X
Extended range of vaccination					X

\*included ECGs, phlebotomy, flu vaccination, blood pressures, simple dressing / wound care, first part of long-term conditions health check. HCAs in study 1 can already also do flu jabs, B12 and pneumococcal vaccine.

Table 29 shows the old and new tasks carried out by the NAs. These were the tasks described by the interviewees and is not an exhaustive list. In addition, the interviews were carried out over a period of time. Therefore the information was a snapshot and was not intended for direct comparison. Going forward, some duties

would be carried out with an element of overlap between RNs and NAs as highlighted (Studies 2, 3, and 4).

Except Study 4, all other four GP practices compared the NA role with the abolished SEN, highlighting the striking similarities in terms of length of training (two years) and their hands-on practical assistant role to RNs. All GP practices called for better clarity on the role remit of NA, and the current limited and restricted scope were raised by Studies 2 and 5.

Different actions (Table 30) had been taken or were planned by GP practices to communicate the new NA role to the wider team and to patients. Clinical and non-clinical members of the practice team had known the postholders in their previous capacity as HCAs for some time. Changing mindsets had proved a challenge and had not helped to construct a new identity for the NAs. As described by one NA, '*I struggle to get out of that healthcare assistant box... it is an ongoing thing.*' (NA6). Study 5 had trained other staff to backfill the HCA capacity left behind by the NA, in an attempt to encourage appropriate allocation of duties and tasks to receptionists, for example.

**Table 30: Activities to communicate the Nursing Associate role by GP practices**

Activities	Study1	Study 2	Study 3	Study 4	Study 5
Put the NA screen with nurses' screen but not HCAs	X			N/A	X
Notice / write up in corridor		X			
Promote the role on GP practice website (planned)			X		
A list of staff and remit to receptionist to help booking					X
Backfill HCA capacity					X

Study 5 highlighted some tension in the nursing team in trying to establish an identity for the NA role. Strong scepticism and a lack of support of the role were seen in the nursing team in Study 2, and it was likely that this had contributed to the slow progress in role development. One nursing team believed that as the NA gained new skills, this would help to '*make her stand out more from the HCA role*

(NT5-PN4)'. However, two nursing teams (Study 2 and 4) felt the role of NA was not needed in GP practices and this was probably linked to a lack of role clarity.

#### Proving value of new role to others

As described in the above section, GP practices had very little understanding of the NA role prior to the introduction, and as a result, how the expectations of the GP practices were met varied. Three practices (Studies 1, 3 and 5) had positive experiences and their confidence in the NA role had grown as a result. Indeed, this had enabled Study 5 to explore alternative ways of modelling its future workforce. Study 2 had expected there to be a much wider remit for the NA role. For Study 4, the departure of the NA was a disappointment and there was no return on investment. This had a knock-on impact in terms of considering future applications from other staff, and the practice intended putting in place a training contract to ensure future NAs would stay in the GP practice for a certain period of time.

From a service delivery perspective, four GP practices with NAs (Studies 1, 2, 3 and 5), had seen additional capacity and patient appointments. Specifically, studies 1, 3 and 5 referenced the freeing of RNs to focus on complex long-term conditions. Study 3 highlighted the release of GP time. Study 5 also described the impact as '*...keep services running.*' (M5). From a quality improvement perspective, positive changes included improved service quality as a result of the NA's enhanced knowledge (Study 1), extra skillset gained (Study 2) leading to better patient access and choice, and more time with patients (Study 2), continuity of care (Study 5) and resilience of the nursing team (Studies 3 and 5).

There were also benefits to the co-workers, in that NAs had been accessible and supportive. NAs in two of the GP practices had provided mentoring to phlebotomist (Study 1) and support to trainee NAs (Study 2). The potential of NAs in a supporting role was being recognised by the HCAs, but at the time of interviews, they were still looking primarily to the RNs for advice. In Study 5, the NA had been supporting the new practice nurses and mentoring the phlebotomist, while the relationship with the HCA team had been described as challenging at times.

While some patients noticed the change in uniform and/or commented on the different tasks, all four GP practices believed that the patients had little or no awareness of the new role. Two practices (Studies 3 and 5) also described the comparison made by patients with the SEN role.

## **5.8 Chapter conclusion**

This chapter examined the introduction of the NA role in five GP practices in the NE of England. To do that, 20 transcripts from interviews and focus groups were analysed using separate templates. These templates were developed using a priori themes from the Elaborated Institutionalisation Model (Kessler et al., 2017).

The findings of the case studies have been presented at two levels: case-based and cross-case synthesis. A mix of types of GP practices participated in this study, and all were medium or large size organisations. A brief description of each GP practice was provided in the case-based synthesis section. While the GP practices were made aware of the national initiative in different ways, the emergence stage was very similar. All GP practices established workforce and service needs, and had no issues to identify suitable people to undergo the training. There was a champion in all organisations, and they also shared many common barriers during the introduction of the NA role.

In terms of the legitimacy stage, all the NAs had largely continued to work in their previous role as HCAs, with small numbers of additional or enhanced duties. However, the NAs' newly gained knowledge and different ways of thinking were noticeable, and this had contributed to quality improvement. The six NAs completed their training between December 2020 to September 2021. Putting this into a real-world context in relation to the COVID lockdown and restrictions timeline, this period coincided with the second and third national lockdowns (December 2020 and January 2021), and the roll out of the vaccination programme throughout 2021. Findings confirmed that COVID had a negative impact on development, and this explains in part the slow development of the role. One notable finding across all case studies was the struggle to construct a new role identity for the newly qualified NAs.

A lack of role clarity and remit as observed by all GP practices had added to this vagueness and to an extent, hindered the opportunity to advance the role. Role legitimisation and professional identity will be further discussed in the next chapter.

Proving value to others at this early stage was mainly in the form of additional capacity and appointments. Except one GP practice, the expectations of GP practices were largely met / exceeded. There were also benefits to co-workers. Despite benefits in terms of enhanced care, patients' awareness and understanding of the NA role were very low or did not exist.

In summary, the policy intention for the new NA role to fill the skill gaps of HCAs and RNs was very much work in progress and had not been met at the time of interview. The overall findings show embedded actors who were aware of the potential of this role and wanted to seize the opportunities offered, and who took active steps to drive change. This resulted in implementation with varying degrees of success due to specific barriers that will be discussed more in the following chapter. Role identity and trust and confidence were shown to be key components to secure legitimising a new professional work role. In the medium to long term, the new role of NA could help to fill the skill gaps in GP practices, but this will require a clearer role remit, a much extended scope and strong professional identity.

The next chapter will discuss the key themes from the findings in the context of the conceptual framework.



## Chapter 6 Discussion

### 6.1 Introduction

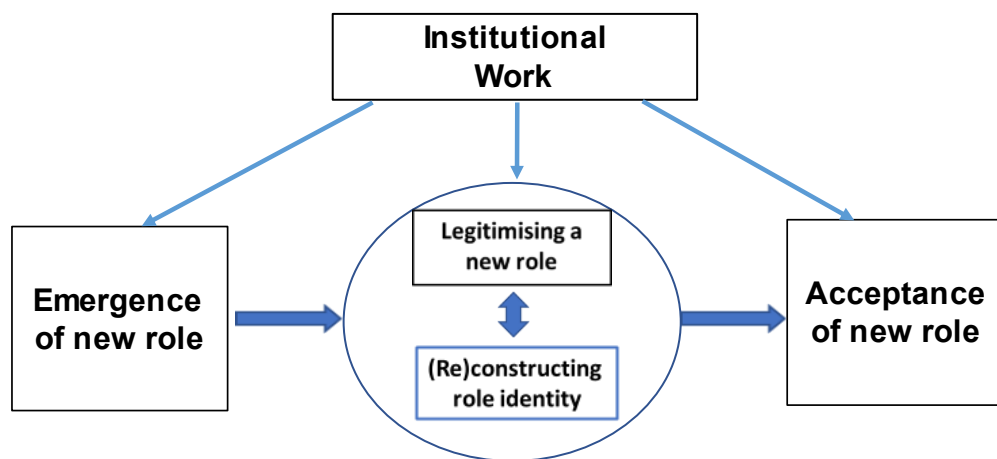
The introduction of the Nursing Associate (NA) role in England has three policy objectives: to provide a new route into nursing; to fill the skill gaps between healthcare assistants (HCAs) and registered nurses (RNs); and to retain a motivated workforce. The primary aim of this study is to investigate how the new NA role has been introduced and established in general practices in England. To that end, five qualitative case studies were carried out to understand common implementation barriers and identity impacts. Through the additional responsibilities of the NAs, this study has also provided an indication of early impacts on service delivery and if the role has achieved the policy intention to fill the skill gaps between RNs and HCAs.

The implementation of the NA role is of interest not only to the nursing profession but the wider NHS. From the nursing profession's perspective, NA is the newest 'regulated role' by The Nursing and Midwifery Council (NMC), and arguably some 75 years since the last regulated role, of State Enrolled Nurse (SEN), was introduced, in an age of markedly different healthcare delivery. Therefore, it is important to understand the early experience of role implementation, so as to inform and/or support the wider adoption of the role in England. For the healthcare sector, changing skill mix by introducing new non-medical clinical roles is identified as one proposal to address the challenges of workforce supply and healthcare demand (Francetic et al., 2022). Although there is some evidence to suggest changing skill mix in primary care can lead to appropriate, safe and satisfactory care for patients, at the same time, it has been suggested that skill-mix change may not always achieve the intended goals (Nelson et al., 2018). The findings from this study will contribute to this discussion and furnish evidence.

Drawing on the results from the case-based and cross-case analysis, this chapter will first discuss the findings in relation to the conceptual framework (Figure 20). To do that, it first brings in the evidence and knowledge from the literature review in relation to role introduction and changing skill-mix, and institutional theory. The

discussion will demonstrate where the findings contradict or support other research and theories as presented in the literature review. Through this process, the aim is to build and/or broaden the existing knowledge on implementation and legitimisation of new work roles, particularly in a healthcare setting. In addition, this will also allow a deeper analysis and understanding of the introduction of the new NA role in GP practices at a practice level.

**Figure 20: Conceptual Framework**



Section 6.2 on institutionalisation of the new role will be organised in three main subsections, using the three stages in the Elaborated Institutionalisation Model (EIM) for new work role by Kessler et al. (2017) as a guide. I have created headings in each subsection to reflect the key concepts identified from the literature review, so to provide a structure for the discussion. As explained in chapter 4, it was explicit during data coding that the NA role had not been 'taken for granted' at this early stage of development. Therefore the final stage in the institutionalisation model (acceptance) has been omitted from the analysis. However, some of the findings in relation to the emergence and legitimisation stages are relevant to the microprocesses in the acceptance stage of the model. Therefore, there is a total of three subsections to cover all the three stages in the EIM by Kessler et al. (2017) in this discussion. Institutional work is a cross cutting element, and it will be included in both emergence and legitimacy stages. Altogether, the findings have provided new

insights of introduction and legitimisation of the new work role, which is shown in a revised model in section 6.2.4.

This study has made a number of contributions to practice, and they will be discussed in section 6.3. There are also other potential contributions to institutional theory, and these areas are included in section 7.4 'Suggestion for further work'.

## **6.2 Institutionalisation of new work role**

### 6.2.1 Emergence

#### External factors

There are different schools of thoughts on how organisational change is initiated as well as its approaches. According to Meyer et al. (1990), there are two levels of change (firm/organisation and industry) and modes of change (first-order and second-order). First order change is incremental either within the organisation or at the industry level. Second-order change or discontinuous change associates with transformation of fundamental properties of a system. With this mind, one may argue that any introduction of a new work role falls into the category of second-order change. However, many of the new roles in the NHS are organically grown and evolve over a period of time, such as those included in the study by Kessler et al. (2017). The new regulated NA role was however developed for the nursing profession after limited piloting, and then rolled out across the whole of England. These differences in terms of how roles originated may impact on the approach taken by organisations to legitimise them.

Much of the established literature suggests that an external jolt is needed to destabilise established practices and initiate the institutional change process (Reay et al., 2006). In fact, much of the analysis of the hospital setting and in other industries has shown revolutionary or transformational change is driven by exogenous factors (Meyer et al., 1990). Putting this into the context of healthcare, these jolts can be manifested into legislative reform, workforce shortages or technology changes. As

can be seen in the literature in section 2.7.1, there is evidence of strategic or political drivers in all the new roles developed. On the other hand, some studies (Goretzki et al., 2013; Kessler et al., 2017; Reay et al., 2006) proposed that an external jolt is not required to introduce new work roles, and the embedded actors play a key instrumental role in the change process.

These divergent views are not necessary conflicting, but simply describe how change is initiated in first order and second order scenarios. This study demonstrates that a number of external jolts were indeed presented at the onset: staff and nursing shortages; the new GP contract with Additional Roles Reimbursement Scheme (ARRS) and the creation and regulation of the new NA role in England. This indicates that external jolt is present in second-order change and brings clarity to understanding the initiation of a new work role.

#### Motivations for change

The study by Gibson et al. (2023) found there are three common groups of motivating factors in skill-mix change in primary care: (1) better match with patient needs; (2) increase capacity and appointments; and (3) release GP time. Although the study involved only practice managers in relation to six specific new non-medical roles and NA was not one of them, the findings nevertheless provide a useful basis for comparison.

**Table 31: Motivations for change: code frequency for workforce and service**

Theme	Subthemes	Case Study 1	Case Study 2	Case Study 3	Case Study 4	Case Study 5	Total
<b>Service</b>		<b>4</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>13</b>
<b>Workforce</b>		<b>13</b>	<b>12</b>	<b>16</b>	<b>10</b>	<b>12</b>	<b>63</b>
	Bridging skill gap	2	1	2	1	1	7
	Knowledge of the role	2	3	3	3	3	14
	Nursing shortage	3	2	3	1	1	10
	GP shortage	0	1	0	0	0	1
	Workforce development	6	5	8	5	7	31

When the participants in this study were asked about the need for introducing the NA role in the GP practices, workforce issues were the overwhelming reason identified. This finding is similar to other empirical studies on new healthcare roles in literature reviewed in the last decade (Bungay et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Evans et al., 2020; Spilsbury et al., 2011). In particular, it also resembles the findings of the on-going NA research at King's College London, where two of the three most important objectives identified by Chief Nurses for introducing the role are workforce related: grow our own RN and provide HCA with new career opportunities (Kessler et al., 2020). Table 31 shows the frequency of the coding in this study for change reasons. The workforce reasons in this study cited by participants were primarily related to the nursing team, and nursing shortage, succession planning, retention, aging workforce, difficulty to attract younger people, and workforce development at both a general and individual levels were articulated. Although recruitment issues were identified by the participants in the Gibson et al. (2023) study, they were much lower in the ranking of the 12 factors / reasons. In fact, GP shortage and its knock-on impact was highlighted only by one GP practice in this study, and others did not appear to make the wider connection of this with the NA role. This is likely to be because of the distance between the NA role and the daily work of GPs, and therefore not considered as a way to release GP time. However, a broader skill-mix in the form of multidisciplinary working was discussed by two GP practices. When compared further to the findings in Gibson et al. (2023), no GP practices had expressed a preference for the Primary Care Network (PCN) to employ the new NA role.

Although increases in appointments and capacity was a consequence of introducing the NA role, this was not described by participants as the motive. In fact, workforce development in terms of both the NA postholders themselves and the wider HCA workforce and the nursing team were identified as the main reason for introducing the NA role into the GP practices. This objective can also be seen in other NA studies in hospital and social care settings, as a mechanism to retain experience (Kessler et al., 2022; Kessler et al., 2020). This is not an explicit finding in other empirical literature reviewed.

Although investment in staff development should be considered as part of wider workforce planning (Bungay et al., 2013; Imison et al., 2016), the planning behind the introduction of the NA role in GP practices varied from opportunistic to detailed 5-year strategy. This inconsistency illustrates the wide-ranging capabilities in primary care to underpin skill-mix changes, and that support to some GP practices or PCN will be beneficial. The relative lack of strategic planning may also be reflective of GP practices' appetite for change to embrace this innovation and adopt the NA role at this stage.

### Financial incentives

Payment systems can be an enabler and accelerate the pace of skill-mix change (Sibbald et al., 2004), and are often used to encourage uptake of new work roles (Drennan et al., 2019; Gibson et al., 2023; Spilsbury et al., 2011). The findings in this study support this view in other studies that financial incentives are not a key motivating factor to appoint non-medical roles (Gibson et al., 2023; Spilsbury et al., 2011). ARRS is available to all GP practices but only two out of five GP practices explicitly mentioned this. This is contrary to a significant uptake of NAs as expected by policymakers (Kessler, Harris, et al., 2021) and also a higher adoption rate of other non-medical clinicians (pharmacists and physician associates in this case) as a result in primary care settings (Gibson et al., 2023). The fact that only a small number of GP practices in the NE had taken the opportunity from the ARRS to put in place the NA role at the time of study suggests there are other more significant factors for GP practices in determining the type of role they wish to introduce. A smarter and more sensitive way of aligning financial resources will ensure incentives are rewarding efforts to expand the targeted staff group.

### Institutional work

There are four groups of actors in GP practices in relation to this study of introduction of NA role: NAs; GPs; RNs and NMs / PMs. The role of actors in organisational change is well researched and in particular, 'Institutional Entrepreneurs' are champions with an interest and access to resources to create and drive change. In this study, NAs in two of GP practices (Studies 4 and 5) had a

personal interest in the role and brought the idea into the GP practices. This was in contrast with other studies (Goretzki et al., 2013; Reay et al., 2006) where the initial idea of change was introduced by middle managers or those with authority. The finding of this study echoes the result in Kessler et al. (2017) where the development of a new role is reliant on a range of stakeholders including the postholders themselves. However institutional work of purposive actions aiming to create change (Lawrence et al., 2013) by manager actors with particular social skill (Fligstein, 1997) could also be seen. There were champions in all GP practices to promote the idea and encourage others to endorse and support change. In particular, the ones in Studies 1 (smallest GP practice) and 3 (largest GP practice) appeared to have taken a comparatively more leading and proactive role in the emergence stage. This would also suggest that the activity and the ability to influence by actors do not depend on the size of the organisations. There is also evidence that understanding and positive attitudes towards the new role as highlighted in other studies (Drennan et al., 2014; Drennan et al., 2019; Evans et al., 2020; Spilsbury et al., 2009) are key factors in introducing new roles. Kilpatrick et al. (2019) highlighted the ultimate decision on role implementation sits with professional hierarchy, and the findings of this study supports that, as all champions in this study were GPs and senior nurses.

Change champions need a wide range of skills and similar to the findings in Bungay et al. (2013), those in Study 3 particularly had highly developed technical skills in workforce needs analysis. When compared to others, this practice appeared to have a more organised approach in developing the NA role, and this perhaps illustrates the importance of moving from filling the gaps to wider transformation (Evans et al., 2020). There is also the role played by visible executive leadership as highlighted in Drennan et al. (2019), although it did not seem to be consistent across all GP practices in this study. It can be argued that the existing relationship of the champions with the postholders could mean they were the champions of the individuals but not necessary of the role. As for the GP actors, their involvement was mainly related to the approval of the proposals. Most of the barriers for change were external except time for supervision. This is an area where perhaps the champions could have done more in addressing the challenges.

Suchman (1995) pointed out that institutions / organisations are complex with multi-layered social structures. In addition, their dynamics are shaped by norms, beliefs and culture. While all GP practices identified a need for bringing in the new role, the roles and behaviours of the actors varied. This would seem to support the view by Scott (2013) that institutions can enable and empower, as well as control and restrain its actors. Evidence shows failure to pay attention to context can lead to organisational and/or operational challenges when implementing new roles (Nelson et al., 2019).

### 6.2.2 Legitimacy

There are three different ways to achieve a change in skill-mix, and by introducing the NA role, GP practices are seeking to adjust the ratio of senior to junior staff in the nursing team (Sibbald et al., 2004). Although an increasingly popular intervention, skill-mix change is associated with a range of organisational/operational complex issues (Nelson et al., 2018), and paying attention to the actual implementation process will help enhance the likelihood of achieving the desired outcome.

Using the classifications by Sibbald et al. (2004), the NA role is primarily an innovation, a new type of worker. However by creating this role in primary care, one may argue that it has indirectly enhanced the skills of the HCA workforce, allowed the practice nurses to delegate certain duties and tasks, and substitute the role of a junior practice nurse in the future. Current low levels of enthusiasm for NAs and the pace of change in GP practices does not appear to reflect the potential of the role. The findings in this study highlighted a number of challenges in the implementation process particularly around the ambiguity of the role. Together with a mismatch between training provision and practice needs, this has created a sizable gap which has hindered the advancement of the NA role in primary care, putting at risk future sustainability. Each of these areas will be further discussed in the remaining section.



### Purpose of the role

One of the policy intentions driving the new NA role is to fill the skill gap identified between HCAs and RNs. The study by Reay et al. (2006) showed that proactiveness and alertness of actors was needed to identify opportunities to increase visibility and advance a new work role. More will be discussed later through the lens of 'institutional work'. An assumption or hypothesis was that COVID would provide a burning platform for change, and enable the NA role to be exploited and expedited in GP practices. However, this study found this not to be the case and that the number of additional responsibilities or tasks taken on by the NAs was limited. The reasons for that are multifaceted and they will be examined in turn in this subsection.

A key criticism made by the participants was a lack of role clarity from the regulator NMC. This ambiguity manifested in perspectives of remit and scope, accountability, and professional boundaries and identity, and had a knock-on impact on determining the purpose and place of this new role in GP practices. Although it is clear that the NA aimed to fill the nursing skill gaps with an aspiration to release nurses' time, the GP practices appeared to struggle at times to decide what new responsibilities could be allocated to the NA role, and nurses were unsure where the accountability for some of these delegated tasks would lie. The higher skill set of HCAs in GP practices and a lack of robust workforce and service planning in some GP practices has further complicated the decision to introduce the NA role. Consequently, GP practices proceeded with great caution, and the pace of change and job contents of NAs were very much down to local interpretation. In turn, this has contributed to a slower than expected development of the NA role.

Some GP practices in this study articulated a treatment room nurse role for the NA. Some also envisaged that NA will replace practice nurses over time. However, the current professional scope of the practice and accountability framework does not allow NAs to carry out certain duties currently the remit of nurses. This leads to questions as to whether the policy purpose of the NA can be translated into practice reality.

## Scope and remit of the role

At the heart of this is an underlying misunderstanding of the role of NMC. The regulator sets out the competencies required at the time of registration, and the translation of those competencies into the education curriculum and clinical responsibilities lie with other bodies to deliver. This suggests that the GP practices were waiting for something that was never going to happen.

The importance of defining the scope of new work roles in role implementation has been emphasised and illustrated in many studies (Allen et al., 2013; Drennan et al., 2014; Drennan et al., 2019; Halse et al., 2018; Nelson et al., 2018; van der Biezen et al., 2017). Indeed, a lack of clarity has been highlighted again in a recent systemic review of skill-mix innovation across multiple countries as a barrier to skill-mix changes (Wisnar et al., 2022). This means the need for consideration during planning or implementing cannot be ignored, as getting this right can act as a critical facilitator. More specifically, role uncertainty and the associated negative impacts have also been raised throughout the current on-going evaluation of the NA role in other settings (Kessler, Harris, et al., 2021). In practice, a clear scope and remit will help with working arrangements and allocation of duties and responsibilities. Partly related to the ambiguity of the NA role as discussed above, at the time of this study, all the NAs continued to carry out all the HCAs' tasks with a small number of extended duties, and similar to NAs in other settings (Kessler, Steils, et al., 2021a). As a result, fitting the new role into the existing practices had become an operational challenge. As one participant described, '.... there's not enough nursing associate tasks to fill out full time per week...' Sibbald et al. (2004) highlighted that the professional boundaries by professional regulatory bodies can limit the opportunities for developing a role, and cited prescribing rights as an example. The findings of this study illustrate this issue and in particular, the inability of NAs to administer medications under the Patient Group Directive (PGD) was cited as a key barrier for change.

Human factors add to the complexity, in that relationships and levels of trusts between the champions and postholders of the new roles were highlighted as key determinants to recognise and advance the opportunities for development and

relevant to the success of skill-mix implementation (Farmer et al., 2011; Spilsbury et al., 2011; Wismar et al., 2022). However, there was a high level of trust in all five GP practices in this study, and this factor is unlikely to be sufficient reason to explain the difference in pace of change and barriers in the process.

Once a new role is developed as a Human Resource Management Innovation (HRMI), the meaning of this in daily practice needs to be translated and one way to do that is through job descriptions. Scott (2013) describes job descriptions for work roles as being under the normative pillar of an institution, which sets out the goals and objectives, expected standards and how things should be done. All the NAs had job descriptions which were adapted by GP practices from national templates and resources. While they were not reviewed as part of this study, it is reasonable to expect that they shared many similarities. Despite this, there was a difference in terms of the responsibilities or tasks that the NAs in the four GP practices had taken on. This is somewhat similar to findings in Francetic et al. (2022) where practitioners with the same title performed their role quite differently. This variation was partly due to the differences in how each practice interpreted the NMC frameworks and guidelines. In part, this also reflects an element of different ways of working in each GP practice, hence the role of HCAs and therefore the gap between RNs and the HCAs that needs to be filled. Moreover, it also suggests that other factors come into play in the implementation of the job description, and one of them is role identity.

### Role identity

In theory, the 'scripts' or job descriptions should help to define the behaviours of the NAs, and carrying out the role as described by Chreim et al. (2007), gives rise to professional identity. In practice, professional identity is also often associated by others with training and professional regulation as seen in studies (Evans et al., 2020; Spilsbury et al., 2011). While all the NAs recognised their new status and accountability as a registrant on the NMC and had a job description (JD), they nevertheless found it difficult to establish a new identity. As one NA put it, 'I do feel like though, overall, it's been very hard to shake the fact that I'm no longer a healthcare assistant with other members of staff..... and I do feel like I have

struggled to get out of the healthcare assistant box since I've qualified.' One explanation for this challenge is the intrinsic link and interaction between role and identity, as being two sides of the same coin (Chreim, 2007).

The lack of specific role content had clearly made it more difficult for the NAs to make the transition and move away from their previous HCA role and create a new identity. As shown in the study by Goretzki et al. (2013), the strong relationship between role and identity has meant the effort to legitimise a new work role needs to work 'glove in hand' with (re)construction of role identities. Moreover, the postholders not only need to accept the role but also to internalise it. This means a change in a professional role from HCA to NA will require a change in role identity as well as job title.

There are also other relevant factors which added to the complexity of establishing a role identity for the NAs at this early stage. Firstly, professional role identity is said to be highly resistant to change (Chreim et al., 2007). In a professional context, different job roles or titles such as doctor and nurse, give a clear indication of what others can predict and expect in terms of behaviour and standards. All the NAs were HCAs previously from the same GP practices, a well-established role. Four out of five GP practices also compared the NA role with SEN, another nursing role which had a strong identity. Against very established role identities and without a strong narrative for the new NA role, this explains in part the challenges to construct a clear identity. Some have argued that legitimising changes in professional identity also requires rhetorical strategies and moral reasons legitimising changes in practice (Goodrick & Reay, 2010). Others have argued that changing a new identity could be more incremental (Pratt et al., 2006) and time and space are needed to unfold the identity (Giddens, 1991). Other ways to facilitate the development of role identity is by purposeful linking of the intra-organisational level with the institutional environment (Goretzki et al., 2013). In this case, the development and (re)construction of NAs' role identities was made more difficult in the primary care environment as a whole, as there was no mechanism in place such as a peer network to help inspire, motivate and encourage NAs to internalise the new role at either PCN, Integrated Care Board (ICB) or regional levels.

Secondly, a limited role content (as discussed above) meant the NAs were not able to display distinctive professional behaviour. The research carried out by Pratt et al. (2006) showed the importance of the relationship between 'doing' and 'being' a professional, and that work and identity indeed reinforce each other. In primary care, HCAs are highly skilled and at the time of interviews, the restrictive list of new duties for the NAs had not allowed differentiation between the role of HCAs and NAs. Given the unevenness of the scope of the role amongst NAs meant it was difficult to construct a professional role identity. The 'doing' element was highlighted in Study 5 where certain tasks were associated with professional identity. As Sibbald et al. (2004) highlighted, managers also need to 'discontinue' the old way of working as part of changing the case-mix. There is also an internal element of 'being' a professional, and how the professionals look inward and view their role identity, and this determines how they interpret and act / behave in work situations (Pratt et al., 2006). This illustrates the value of a preceptorship programme for the newly qualified NAs, which was absent, as it would support personal and professional development. Moreover, this also highlights an inequality between NAs in primary care and NAs in a hospital setting, as 97% of NHS Trusts surveyed either had a programme in place for their NAs, or planned to introduce one (Kessler, Steils, et al., 2021b).

Finally, social validation of professional identity can be found to follow one of two ways (Pratt et al., 2006). One of these involves identifying specific role models by postholders. Considering the NA is a new role and particularly so in primary care, and that the way of working is different from hospitals and the numbers of qualified NA are extremely small, there are not yet role models in GP practices with which the NAs could identify. With the added complexity and ambiguity relating to the work role, this has made it even harder for the NAs to establish a professional identity.

Professional identity comes with regulation. A lack of regulation is a well-known barrier for integrating new work roles into primary care (Nelson et al., 2019), and there is a view that appropriate regulation can also help to maximise their contributions in primary care (Drennan et al., 2014). This study shows the regulation of NA has led to some tensions between the newly qualified NAs and HCAs, in that they had moved from being part of the HCA cadre and now aligned

with nurses. There were also some perceived privileges such as access to in-house training programmes for qualified clinicians, and this had added to friction. Therefore, one might argue that regulation had not facilitated integration in this case but instead, caused disruption. The findings of this study shows the regulated boundaries and the current scope of practice had restricted the opportunities to develop the NA role, supporting the view of Sibbald et al. (2004).

### Managing expectations

The different expectations by others also had a negative knock-on impact on the development of the role identity of NAs. According to Biddle (1986), work roles set out expectations of the behaviours of both post holders and other people. This also echoes the view expressed previously by Anglin et al. (2022). The role change of NAs from HCAs was not developed through repetitive actions or evolved over a period of time (Scott, 2013). Instead, this was a result of the introduction of an external institutional template (Goretzki et al., 2013). This meant that others' expectations would need to be shaped by other means. In another study of NA in social care setting (Kessler et al., 2022), the introduction of the role from 'above' has become a challenge for change, and to some extent, this is also the feeling of some stakeholders in GP practices. The findings showed stakeholders in all GP practices were unclear as to the NA's role remit and did not know what to expect, and looked for clarity from NMC as the regulator. In Study 3, the nurse manager described the need to use 'common sense' in navigating uncertainties. The nursing team in Study 2 had a sceptical attitude towards the real reason for bringing in the NA. The lack of understanding together with scepticism led to varying levels of expectation, which would have contributed to how the NA role was implemented and advanced in each GP practice.

The findings in Nelson et al. (2019) showed the practice staff's familiarity with similar existing roles could hinder understanding and validation of a new role. Similar findings were also present in this study. Many practice nurses and patients were comparing the new NA role to the abolished SEN role, and as discussed earlier, due to a lack of distinctive tasks assigned to the new NA role, many were trying to understand the differences between the HCA and NA roles. In Study 5, it was

reported that there were significant professional tensions and antagonism towards the newly qualified NA. These challenges on professional tensions and relationship echo the cautions and findings in other studies (Nelson et al., 2018; Nelson et al., 2019). In addition, there were also other aspects of stakeholders' expectations highlighted in this study. They included the uncertainty regarding professional accountability raised by the nurses in Study 2, and the expectation of a wider scope from some practice managers. The latter was similar to the finding in Nelson et al. (2019) where there was a gap between the GP practice's expectation and the abilities of the Physician Associate role to carry out certain tasks. They perhaps illustrate the importance for change leaders to actively manage stakeholders expectations and find time for meaningful communications and engagement before introducing new work roles, as emphasised by Nelson et al. (2019).

#### Training – practice gaps

Another element of stakeholder expectations in relation to the implementation of the NA role was education and training. Similar to other studies (Drennan et al., 2019; Greenhalgh et al., 2020; Halse et al., 2018; Kilpatrick et al., 2019), the points raised related to its importance and the resources required to develop the new role. This is confirmed by a systemic literature review (Wisnar et al., 2022) to show adequate training and education is pivotal to successful skill-mix implementations, as it links to skills and competencies and therefore professional role clarifications and understanding of the profession. The design and relevance of the 2-year training programme for NA in primary care was identified as a key barrier, although this could be partially related to a lack of role clarity as discussed above. Some participants expressed their concerns and questioned if it was 'fit for purpose' for a primary care setting. Moreover, additional task orientated training courses were needed for the newly qualified NA, before they could take on certain work. The participants described a shortage of training programmes available. While this lack of supply in general might be assigned to the situation re COVID, the point raised was about the shortage of programmes designed specifically for this group of new professionals. One option that should be explored is partnership working with other GP practices to commission bespoke training for NAs. This approach has been

shown working (Drennan et al., 2019) and PCNs and ICBs are well positioned to play a key role in making this happen.

A different interpretation of the GP practices' needs to secure training is their desire to legitimise the individuals in their new role. As discussed above, the postholders already had trust and effective relationships with their champions. Studies show the importance of training to reflect patient needs in creating new roles (Greenhalgh et al., 2020; Halse, 2018; Kennedy et al., 2015), so by creating a strong link between training and patient needs and the role, the champions were taking action to legitimise the individuals and their new roles.

Nursing shortages in general and particularly during the COVID period in GP practices, further hampered the capacity to support the local development of NAs. Training capacity and infrastructure is a particular challenge in skill-mix change in social care with smaller organisations and a dispersed provider model (Kessler et al., 2022), and a similar issue can be seen in GP practices. Participants described the challenges of trying to fit in supervisions with their daily workload, and managing the need to double-up with limited physical space. Together with a lack of suitable training, these barriers further impeded progress on the training and development of the NA role. Overall, the readiness to practise of NAs was being jeopardised.

Sibbald et al. (2004) highlighted that new titles for new work roles require radical revision of the individuals' training, skills and competencies. The findings in this study echo the view of Nelson et al. (2019) where education and training affect the feasibility of skill-mix change. More importantly, in this case they have to be tailored to a primary care setting. In addition, this study also shows the training itself needs to be relevant and customised to the new role. At the time of the study, from the perspective of both postholders and other stakeholders training was seen to be behind and had yet to catch up with the new title and expectations.

### Institutional work

Using insitutional work as a analytical lens enables an understanding of the skill-mix change process from the perspective of human actions. This approach has allowed



the type of work carried out by actors to create, maintain or disrupt institutions to be identified and in turn, enriched the analysis of this study. Compared to the list of categories, types and definitions of institutional work (Giezen, 2018) in section 3.4.2, this study shows much of the work by actors at this stage of role implementation is related to activities under 'creating strategies' (Table 32).

**Table 32: Institutional Work – Creating Strategies, Types and Definitions (Source: Giezen, 2018)**

Type	Definition
Advocacy	The mobilisation of political and regulatory support through direct and deliberate techniques of social suasion
Defining	The construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field
Vesting	The creation of rule structures that confer property rights
Constructing Identities	Defining the relationship between an actor and the field in which that actor operates
Changing normative associations	Re-making the connections between sets of practices and the moral and cultural foundations for those practices
Constructing normative networks	Constructing of interorganisational connections through which practices become normatively sanctioned and which form the relevant peer group with respect to compliance, monitoring and evaluation
Mimicry	Associating new practices with existing sets of taken-for-granted practices technologies and rules in order to ease adoption
Theorising	The development and specification of abstract categories and the elaboration of chains of cause and effect
Educating	The educating of actors in skills and knowledge necessary to support the new institution

Specifically, six dominant types are Defining, Vesting, Constructing Identities, Mimicry, Theorising and Educating. These activities by GP practices are primarily internally focused at the organisational level, indicating a gap at system level in either PCN and/or across ICBs to further develop the role and the postholders' identities. A focus on 'Constructing Normative Networks' as a next step will help to legitimise the role. The following paragraphs examine the actions associated with the six types of actions.

Despite the embedded position and strong influence of the champions as senior clinicians and executives in their respective GP practices, the regulatory ambiguity of the NA role had at times held them back from identifying opportunities to advance

the NA role. However, some practices took some actions in attempts to define the new role. For example, all the NAs were given a different uniform. In one practice, the patient booking arrangements were changed and NA clinics were moved across to the nurses' screen to give new status and draw a professional boundary with the HCAs. In Study 5 the NA had access to internal training sessions available to RNs only, and this can be seen as creating a new rule to grant a particular right as part of 'vesting'. In all the GP practices, NAs had taken on or would be taking on cervical screening, and another new area of childhood immunisation. NAs are able to carry out these tasks due to their regulated status and setting up of these NA clinics were clear actions aimed at creating identity for the new role. This supports the findings in Goretzki et al. (2013) where professional identities can be managed and (re-) constructed from the 'outside' by other actors. One may argue that the title of 'nursing associate' has borrowed the established taken-for-granted nursing status to ease adoption, a strategy to normalise and legitimise the new identity (Goodrick & Reay, 2010). At a practice level, allocation of certain duties/tasks traditionally only carried out by nurses, such as childhood immunisation, is a way of mimicry. In one practice, the nurse manager managed issues of professional tension with the HCAs, in an effort to educate team members with new knowledge of the NA role. Most of the practices attributed an improvement in quality with additional capacity and better continuity of care to the introduction of the new NA role. Over a period of time, this could enable diffusion to other GP practices in PCN, resulting in the adoption across primary care in the NE region (Greenwood et al., 2002).

One area of action missing is 'Constructing Normative networks'. Despite being part of a PCN, all GP practices were, generally speaking, operating in isolation in implementation of the NA role. This reflects that PCNs were at an early development stage in terms of workforce planning, and a poor connection to a systemic narrative. As shown in Goretzki et al. (2013), there is real value in linking the intra and extra levels of activities to maximise the impact of (re)-construction of an identity. This also supports a wider role for ICB to support the PCNs in workforce planning and skill-mix changes. There are also other areas of work that ICBs can take on to mobilise political and regulatory support, such as a national communication campaigns and influencing the NMC to further develop their quality assurance programme for NA programmes.

### 6.2.3 Acceptance

Kessler et al. (2017) described three microprocesses in order to enable a new role to be accepted: establishing a distinctive contribution; ensuring the role is trusted; and creating a dependence on the role. Although there were inconsistencies across the GP practices, the NA role did provide visible benefits and made a positive impact on service delivery, by increasing capacity. Demonstrating impact and added value will be the key factors to determine the pace and scale of future roll out of the NA role in GP practices. Indeed, the need to demonstrate impact was also highlighted in another study of three new roles in primary care (Nelson et al., 2019). Due to role ambiguity and a relatively higher skillset of HCAs, the findings in this study showed some GP practices were not fully convinced of the additional benefits of the new NA role, when compared to organisational efforts and investment. To positively influence their decisions to adopt will rely on a distinctive contribution associated with the role (Kessler et al., 2017) and evidence of an improvement in care quality (Kessler, Steils, et al., 2021b).

There was also evidence of trust from some of the participants that the new role would meet the service and workforce needs. Moreover, the postholders of the NA roles were trusted by some members of the GP practices at the emergence stage. In fact without this confidence and trust, these individuals would not have been supported to undertake the programme in the first place. The trustees (NAs) and the trustors (champions) can be seen as working together to gain and build trust from the wider teams as a dynamic and ongoing process: define; prioritise; plan; action; evaluate and adjust (Hurley, 2012). For example, the NAs and champions were working actively together to respond to the situational barriers such as educational barriers and professional tensions. It is particularly evident that situational factors such as integrity and capability of the postholders were highly influential in gaining that trust, as the GPs, Managers and Nurses spoke highly of the individuals concerned. This finding also indicates that building confidence is a cross cutting theme underpinning all the micro-processes in the model. Without that, specific nursing tasks traditionally associated with a 'qualified / regulated' professional status would not be transferred or shared by the nursing team. Due to the different nature of the new role examined in this study, the findings indicate a need for the GP

practices and nursing profession to trust the NA role before legitimisation of the role can occur. A similar situation can be seen in Spilsbury et al. (2011) where the strong resistance by staff of the Assistant Practitioner role had led to adverse impact on the transition process. From this perspective, contrary to Kessler et al. (2017) institutionalisation model, creating trust in the new role is part of the emergence stage rather than at the end of the process to institutionalise a new role.

At the time of this study, the NA role had yet to be further developed and legitimised, and therefore, no dependency had been created.

#### 6.2.4 Summary

This section has discussed the research findings in relation to conceptual framework and literature reviewed. The discussion was structured using the final templates, which were based on the institutionalisation model for new work role (Kessler et al., 2017).

The findings of this empirical study show a number of external jolts were delivered at the onset of introduction of the NA role, including staff and nursing shortages. Compared to existing literature, this would suggest that they are required in second-order change whereas they are not necessary in first-order change. This perspective provides new insight and enhances the understanding of initiation of a new work role. Although financial incentives can be an enabler for change, the findings from this study did not seem to support that in this case. This is not to discredit the value of such initiatives, but to propose that a smarter way to align the incentive and support is likely to produce better results in terms of expansion of the targeted non-medical role.

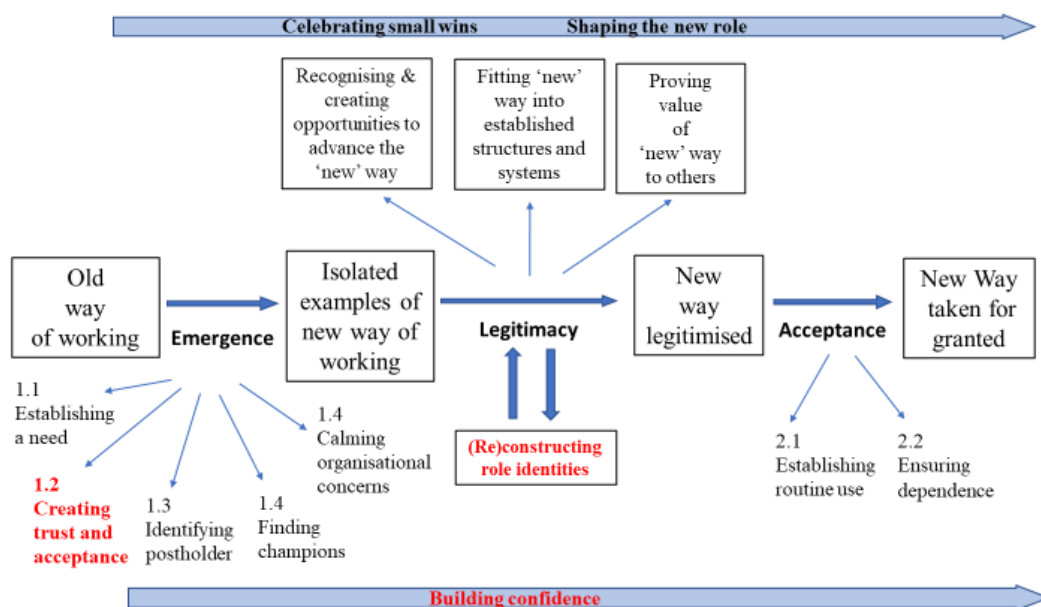
Workforce issues were given as the main motivation for change, and others reported by GP practices were similar to those in Gibson et al. (2023), such as increase in capacity / appointment and release of GP time.

Institutions / organisations are complex structures, and implementing a new role requires dynamic and responsive organisational processes. Purposive actions by

actors could be seen in GP practices, and there were champions in all of them to promote the idea and encourage others to endorse and support change. While there were some differences in relation to the organisational determinants, they did not appear to have correlated to the outputs of their implementation process or the actions of their actors. Overall, the implementation of the NA role in the five GP practices highlights a number of challenges. Key themes captured are: (1) purpose and scope of the new role; (2) role identity and professional tensions; (3) managing expectations of stakeholders; (4) training-practice gaps; (5) future of the new role involving the demonstration of added value and additional impact.

Findings in this study also show trust in the role in principle is needed in the emergence role, or the process will struggle to move forward to legitimacy. Building confidence is important across all stages of implementation. As a result of utilising the EIM for new work role by Kessler et al. (2017) in this study, it has been advanced as a tool to support future implementation in the healthcare setting and beyond. Figure 21 shows the modified institutionalisation model and the changes made are in 'red'. 'Creating trust' has been moved from acceptance to emergence stage, and there is an ongoing activity to build confidence across all stages. Finally (re)constructing identities has to go hand in hand with role legitimising.

**Figure 21: Modified Institutionalisation model for new work role**



Despite the role ambiguity, some GP practices were positive about the potential. However, the extent of buy-in from the majority of the nursing team overall was neither consistent nor high. There was no clear narrative for the NA role and the professional identity had yet to be developed. At this stage, the role is yet to be widely accepted and/or established in GP practices. Despite the policy intention, the study concludes that at this stage the NA role is not yet able to fill the skills gap between RNs and HCAs.

### **6.3 Contributions to practice**

#### 6.3.1 Empirical evidence

This study has made empirical contributions. This study has contributed to under-researched areas and helped to fill evidence gaps: new work roles in healthcare and primary care. It has also added to the limited evidence on implementation of NA role and professional identity. I will now outline the specifics in each of these three areas.

Firstly, Kessler et al. (2017) has highlighted the limited numbers of studies on establishment of new work roles in healthcare. Although a handful of studies continue to emerge regarding healthcare roles in the NHS such as the recent one by Kessler et al. (2017), it is the case that as with previous ones, these were mainly in a hospital setting and were bottom-up initiatives. Moreover, the lack of evidence for primary care has been highlighted recently and the situation has been described as patchy (Nelson et al., 2018; Spooner et al., 2022). This study on the new NA role has added to the limited portfolio of evidence in healthcare settings as well as in primary care.

The NA is a new professional nursing role. At the time of writing this thesis, there are only an interim report and some associated papers available related to on-going research of the introduction of the NA role. This study is also one of the few that have been carried out involving qualified NAs in service settings. To date, there has

been no published research or papers looking at the implementation process of NA in GP practices or its impacts. To my knowledge, this study is the first of its kind to research the NA role in general practice, providing some in-depth insights into how the NA role has been implemented in English primary care.

Finally, although this study did not set out initially to explore professional identity, it emerged as a concept from the literature review and was then brought up by participants as a discussion topic from the interviews. There is limited evidence on legitimisation of profession role identity (Goodrick & Reay, 2010), and the findings of the study will contribute to this evidence.

### 6.3.2 Professional and health policy

At a policy level, this study offers key transferrable learning for primary care stakeholders in other parts of England, such as policy makers, service commissioners, clinicians, higher education institutions, PCNs and GP practices, who may be involved in the implementation and/or further roll out of NAs.

The findings in this study have indicated development opportunities in a number of areas. Each of them will be discussed below together with key recommendations.

#### Regulator

NMC is the regulator for nursing and midwifery professions in the UK. Its core function is to regulate and as part of this, a range of standards are developed in relation to training and education and supervision, as well as the knowledge and skills standards that NAs have to meet. Amongst these is the 'standards of proficiency for registered nursing associates' which includes at annex B: procedures to be undertaken by the nursing associate. Together, they aim to provide clarity for the NA role and allow education institutions to develop and deliver appropriate programmes.

The different ways of working in primary care was emphasised by the participants on many occasions. Overall, HCAs in GP practices are already working at a much

higher level than may be generally understood, and so the view amongst the GP practices was that the training programme for the NAs does not meet the skills gap needs of primary care. Given that the role of NA has been introduced to fill the skill gaps between RNs and HCAs, it will be important to reflect on what the RNs and HCAs are already able to take on, and have taken on.

The 'standards of proficiency for registered nursing associates' is a competency framework and it is the responsibility of the Higher Education Institutions (HEIs) to translate them into an education curriculum. As the NMC provides validation to the training providers, it has a responsibility to ensure the programme is meeting the needs of the learners from different parts of the systems, and that the learners have equitable experiences and access to clinical placements. There is an opportunity for the NMC to strengthen its current quality assurance of HEIs.

**Recommendation 1:** NMC should review the current quality assurance system to ensure the NA training programmes provided by the validated HEIs are meeting the needs of different settings in health and social care.

#### Education - commissioning

At the time of writing this thesis, Health Education England (HEE) is the commissioner of the training for NAs. Together with NHS Digital and NHS England, it will become the new NHS England (NHSE) as from April 2023. For the purpose of this section, recommendations for HEE will be for NHSE. At the moment, the 2-year NA programme provides generic training for all settings. Due to the diversity of the settings, both in terms of their service needs and the skillsets of the applicants, it is inevitable that the programme is not meeting the expectations of different employer organisations.

The 'Standard Framework for Nursing and Midwifery Education' issued by NMC acts as the structure for education institutions and their practice learning partners running NMC approved programmes. Working within the flexibility and standards provided, HEE should ensure the 2-year training programme for NA is fit for purpose for those working in GP practices. At the moment, most of the learners on the NA training programme are from hospital settings. The participants of this study



also commented adversely on the appropriateness of the contents. Together they would indicate the need to ensure the modules are better tailored for those working in GP practices. This would be consistent with national policy of delivering care closer to home, using primary care capabilities. HEE should review its current commissioning of NA programmes from HEIs and enhance its quality assurance process, to ensure the training is meeting the needs of GP practices. There is also an opportunity for the ICBs to work with and support HEE in this process.

The challenges in identifying suitable training for NAs after they have completed the 2-year were raised by GP practices. This is to allow the NAs to take on additional responsibilities. At the time of the study, there was limited training available specifically for NAs. Although this may be related to the lack of role clarity, nevertheless, this indicates a gap in the provider market. There are two suggestions to address this issue. Firstly HEE should develop the provider market for training tailored for NAs. This will ensure the availability of suitable providers and enable timely access of appropriate training by the NAs. In turn, service needs can be met and the NA role can be maximised. Secondly the training for the core / common tasks can potentially be incorporated into the existing curriculum of the 2-year programme as additional modules, or provided immediately following on at the end. In particular, cervical screening and childhood immunisation were described as common needs. Participants talked about a practice-ready NA and the latter approach will equip individuals with the necessary skills to function as soon as they are qualified.

**Recommendation 2:** HEE should review the curriculum design of the NA programme with the HEIs to ensure it is meeting the needs of primary care. As part of this, there is opportunity to strengthen the current quality assurance of HEIs to allow ongoing monitoring.

**Recommendation 3:** HEE should develop the current provider market for subject-specific training tailored for NAs.

## Communication

Systemic review of UK and European skill-mix implementations show formalisation of communication are strong enablers for professional role clarification (Wismar et al., 2022). In addition, Wismar et al. (2022) also highlighted that perceived impact of the interventions (new role in this case) are key influencing factors, and could be facilitators or barriers in skill-mix implementations. For the introduction of the NA role across the whole of England, they are crucial. It is clear from the findings that other NHS professions and public and patients are not aware of or familiar with the new NA role and its purpose. The first cohort of NAs from primary care settings qualified just before the COVID pandemic, and as expected, focus and priority have been on other elements of service delivery. As the UK recovers from the pandemic, this is now a good time to consider a nationwide media campaign including success stories and myth busters. This type of communication will help to construct an identity for the new profession, raise the role profile and inject confidence. In turn, this will support the pace and scope of local development and benefit patient care.

**Recommendation 4:** NHS England and NMC to consider a nationwide media campaign and work with ICBs to raise public and professional awareness of the new NA role.

### 6.3.3 Clinical practice at organisational level

Successful implementation of skill-mix changes requires actions at the level of policy-making as well as organisation (Wismar et al., 2022). At a practice level, this study provides (or is it 'has provided'?) useful and much needed knowledge to support the implementation of a wide range of skill-mix change in the wider health and social care settings.

This study shows introducing a new role is a complex process with planned and unintentional consequences. It also requires significant investment both in terms of workforce, time and money. With the increasing focus on diversifying skill-mix in GP practices, organisations need to underpin this with robust workforce planning before its implementation. In particular, the purpose and place of new roles and how

they align to the service objective need to be clear. There is evidence from this study that those practices with a clear workforce and service plan are more able to advance the role development despite other constraints. Using the modified EIM as a guide could facilitate the implementation of the NA and other professional roles in GP practices.

This study identified a number of challenges in expanding the skillsets in the practice clinical teams and bringing in the new NA role. In particular, role definition and identity, profession tensions and the gaps between training (supply) and practice (needs) were the major ones. Change leaders have an important role. Each of them will be covered below with recommendation/s.

### Role definition and role identity

The study findings showed the role of NA appeared to the GP practices as ambiguous and vague. This view was expressed by all GP practices and all types of participants included the NAs themselves. GP practices described their need to interpret these standards using their common sense, and it was evident that this had caused challenges in implementing the role. This subjectivity and inconsistency in the interpretation of the standards had led to different role contents in some cases and hindered the pace of change. The call for more clarity of the NA role was made repeatedly by all the GP practices.

At a practice level, the findings also showed the importance of de-construction of the NA's previous identity of HCA, and creation of the new identity as NAs. To do that, there should be a common JD and a distinctive list of responsibilities for the new NA role, as a minimum across each ICB. This common understanding and interpretation of the NA role will help to create a new identity for the NAs and manage expectations of stakeholders and patients. It will also help to inform resource allocation and commissioning of education and training programmes and priorities.

One area that would exponentially develop of the NA role is the ability to administer medications via PGD. Although NA is regulated by NMC, currently it is not on the list of registered healthcare professionals who can administer medication under a

PGD. To do that would require changes to current regulations. ICBs should work with NHSE to explore this further and influence the relevant stakeholders.

**Recommendation 5:** ICBs should lead on the development of a generic JD for the NAs. Where appropriate, ICBs should work with their respective NHSE regional team to adopt the same template and contents.

**Recommendation 6:** ICBs should work with PCNs to define the scope of professional practice of NAs and promote consistency across their ICBs in the first instance, and across the region subsequently.

**Recommendation 7:** ICBs should work with NHSE to explore the possibility of adding NAs onto authorised registered healthcare professional list to administer medications under a PGD.

Role transition for the newly qualified NAs is a key challenge. There is big overlap of duties between HCAs and NAs at the moment. In addition to other factors, this situation has contributed to the difficulty of establishing the NA as a new separate role, both from the perspective of the postholders and the wider team. GP practices should identify distinctive responsibilities for the NA, underpinning by workforce planning. By the same token, service delivery requirements permitting, GP practices should enable NAs to cease HCA tasks. This will help to deconstruct their old identity as HCA. ICBs have a key role in supporting the PCNs and GP practices to make this happen.

**Recommendation 8:** GP practices should eliminate / reduce the overlap between the NA and HCA roles as soon as possible. Distinctive responsibilities for the NA role should be identified to help to construct new identity.

**Recommendation 9:** ICBs should support PCNs to carry out workforce planning to identify skill gaps in the nursing team, which would inform the development of the NA role.

## Education and Training

Due to factors outside the control of GP practices, GP practices were not able to access required training for their NAs. Working with the ICBs and HEE, PCNs should consider commissioning this training directly from education providers in the interim, while a strategic and long-term solution is developed. This approach will also ensure the training is tailored to service needs, meeting local and professional standards.

**Recommendation 10:** PCNs should consider commissioning modular training to support the ongoing professional development of NAs, with the support of ICBs and HEE.

One of the challenges found by participants was the organisation and arrangement for clinical placements. It is the responsibility of the employer organisation to identify suitable clinical placements, contact the respective organisations and negotiate access. This often involved setting up an honorary contract for the trainee NAs. For small independent organisations like GP practices, this is extremely challenging from the perspective of capacity and contacts. One participant reported she had almost decided to abandon the training completely because of the associated stress.

One participant reported that there is now a placement co-ordinator (unverified) at the university to help with arrangements. Considering the size of the North East (NE) and the numbers of GP practices involved, if this arrangement is now in place, it will be important to ensure this resource is sufficient to meet the need of the GP practices.

**Recommendation 11:** The providing university should review the placement co-ordinator facility to ensure the support is sufficient and is addressing the needs of GP practices.

In addition, the establishment of PCN offers an opportunity to further enhance the support to GP practices. At the moment even for the larger GP practice partnership /

company, there is often no dedicated resource to support learners or newly qualified NAs. Evidence shows dedicated roles at system level to support TNAs in social care have made positive impacts (Kessler et al., 2022), and the same approach should be considered in primary care. With the expanding skill-mix and an increased formal working arrangement between groups of GP practices, ICBs or PCNs should consider creation of a co-ordinator role to oversee the training activities of the NA role. There is also an opportunity to broaden the scope of this new role to include other responsibilities related to wider changing skill-mix in primary care multidisciplinary clinical teams.

**Recommendation 12:** ICBs / PCNs should consider creation of a training / practice co-ordinator role to oversee and support training and implementation of NA role.

The aim of preceptorship is to support newly registered professionals. Although it is voluntary, amongst other objectives, it will help the NAs to grow in confidence and create and strengthen their identities, as the role develops and embeds into the health and care workforce.

All the NAs interviewed had not had a preceptorship programme, and this should be put in place. As discussed above, the establishment of PCNs and ICBs provide a real opportunity to support a range of workforce related development and activity at practice level. For single-handed or smaller practices, this kind of support and working as a group would be beneficial and advantageous. In addition, this way of working would allow development of practice staff themselves and help to foster a learning environment for the NAs and the wider practice teams. A role such as practice link nurse or placement co-ordinator should be considered.

**Recommendation 13:** GP practices should ensure preceptorship is in place for newly qualified NAs. A PCN or ICB model role in supporting GP practices to implement should be considered.

In particular at this early stage of development, a peer network for the NAs will provide peer support and allow sharing of good practice across GP practices. A structured and facilitated peer learning network should be put in place. Due to the relatively small numbers of NAs in GP practices, ideally the network should be

developed at region or ICB level in this instance, depending on the size of the geographical footprint. As time goes on and when the numbers of NAs increase, the network could be transferred to a PCN level. A national peer network at the moment will also help to share good practices and learning in different parts of England.

**Recommendation 14:** NHSE and/or ICB should put in place a NA peer network.

**Recommendation 15:** NHSE should lead on the development of a national peer network for NAs in primary care.

#### Change management

Research studies (including this one) show skill-mix change involves complex organisational and operational issues and challenges. The ability to recognise and address them will enable smoother transition of those individuals into primary care and assist in retention (Nelson et al., 2019). As part of the wider support to GP practices from ICBs, change management training should be made available to primary care clinicians and leaders to access as needed. This will also assist the introduction of other non-medical clinical roles in primary care.

**Recommendation 16:** ICBs should make available training for change management and workforce planning to primary care clinicians and leaders.

#### **6.4 Limitations of the research**

There has been limited published evidence directly related to implementation of nursing work roles. At the start of this study, there was no published reports on implementation of the role of NA in any settings in the NHS. While there have been studies in NHS and other sectors in the UK and abroad related to the introduction and/or legitimisation of new work roles, they were mainly extended roles but not a new regulated professional role. Where appropriate and relevant, the evidence has been drawn on to use as the underpinning theories for this study.

As a piece of student research, this study has several limitations in relation to access and design. Firstly, it has not been possible to recruit a GP practice from all the seven clinical commissioning group areas as intended. Due to the impact of COVID on the NHS, only certain GP practices had the capacity and felt they were able to put themselves forward to take part in this study. This had implications on the sampling strategy overall, and had also meant that some parts of the NE were not included in this study. While all the key groups of actors in each GP practice were interviewed, the overall number of participants was relatively small. A wider coverage and more participants would have added weight to the findings. Further case studies may offer additional confirmation of findings. Moreover, GP practices elsewhere may have different experiences and success in introducing the NA role, which may restrict the transferability of the findings of this study to other parts of England.

Looking from the perspective of design and methods, this study focused on practice staff only and the patients' perspectives were not included. Semi-structured interviews and focus groups were used in this study to collect the data. A mixed method approach and use of other source of evidence would increase the robustness of the findings. Moreover, the real world and other contextual conditions are key to case study research. The interview questions were adopted from another national study examining the introduction of NA in other settings. As a result, this had restricted the areas to be explored and data collected specifically in relation to role legitimisation and the wider organisational context. That said, taking these design cues from national study lends some validity to the interview tools developed for this study. The a priori themes used for the Template Analysis were based on work conducted by Reay et al. (2006) and Kessler et al. (2017), which were also rooted in healthcare. It is recognised that the microprocesses underpinning the institutionalisation of a new role has not been widely tested in other employment context / industries.

As a researcher-practitioner and someone working in the NHS in the NE region, this unique position has inherent advantages but also potential bias in relation to the process, particularly the interpretation and analysis of the findings.



## **6.5 Chapter conclusion**

This study has contributed to under-researched areas: new work roles in healthcare and primary care. It has also added to the evidence of skill-mix change and implementation science, as well as professional identity in role change.

NA is a new professional nursing role, and this study is believed to be the first that has been carried out on role implementation in GP practices. Therefore, despite some potential limitations, it has significant value to policy and practice development both at national, regional, and local level. The insights of this comparable study across five different sites can inform future planning and implementation of NAs and other non-medical roles in primary care. A total of 16 recommendations have been made for regulator, NHSE / commissioners, HEIs, ICBs and PCNs.

## **Chapter 7 Conclusion**

Through a case study methodology, this research has explored the introduction of the Nursing Associate role in GP practices in the North East (NE) of England. The findings have enabled a better understanding of how, why, and to what extent this new role has been implemented. As a new role in the nursing profession, the first registrants only qualified in January 2019. There is therefore limited knowledge and published evidence available in relation to its implementation process. In particular, the numbers of NAs in the GP practices are very low in comparison to those in hospital settings.

I believe this study is the first of its kind to research the NA role in general practice. Therefore, despite some potential limitations, the insights of this comparable study across five different sites can inform future planning and implementation of NAs and other non-medical roles in primary care and beyond. The study has also contributed to under-researched areas and helped to fill evidence gaps: new work roles in healthcare and primary care. In addition, this study had highlighted key organisational factors and barriers that are applicable when considering skill-mix changes in a healthcare and non-healthcare settings. This study also adds to the limited evidence on legitimisation of profession role identity (Goodrick & Reay, 2010).

As well as empirical contributions, this study has also made practical contributions at profession, policy and organisation levels. There are a total of 16 recommendations which are summarised in the following section. This section follows by plans to disseminate the findings and suggestions for future research. The final sections of this chapter contain personal reflections and final remarks.

### **7.1 Summary of recommendations**

This study identified opportunities for policy and practice development as outlined in the previous chapter. A total of 16 recommendations have been made and a summary is provided in Figure 22 below.

**Figure 22: 16 recommendations**

**Recommendation 1:** NMC should review the current quality assurance system to ensure the NA training programmes provided by the validated HEIs are meeting the needs of different settings in health and social care.

**Recommendation 2:** HEE should review the curriculum design of the NA programme with the HEIs to ensure it is meeting the needs of primary care. As part of this, there is opportunity to strengthen the current quality assurance of HEIs to allow ongoing monitoring.

**Recommendation 3:** HEE should develop the current provider market for subject-specific training tailored for NAs.

**Recommendation 4:** NHS England and NMC to consider a nationwide media campaign and work with ICBs to raise public and professional awareness of the new NA role.

**Recommendation 5:** ICBs should lead on the development of a generic JD for the NAs. Where appropriate, ICBs should work with their respective NHSE regional team to adopt the same template and contents.

**Recommendation 6:** ICBs should work with PCNs to define the scope of professional practice of NAs and promote consistency across their ICBs in the first instance, and across the region subsequently.

**Recommendation 7:** ICBs should work with NHSE to explore the possibility of adding NAs onto authorised registered healthcare professional list to administer medications under a PGD.

**Recommendation 8:** GP practices should eliminate / reduce the overlap between the NA and HCA roles as soon as possible. Distinctive responsibilities for the NA role should be identified to help to construct new identity.

**Recommendation 9:** ICBs should support PCNs to carry out workforce planning to identify skill gaps in the nursing team, which would inform the development of the NA role.

**Recommendation 10:** PCNs should consider commissioning modular training to support the ongoing professional development of NAs, with the support of ICBs and HEE.

**Recommendation 11:** The providing university should review the placement co-ordinator facility to ensure the support is sufficient and is addressing the needs of GP practices.

**Recommendation 12:** ICBs / PCNs should consider creation of a training / practice co-ordinator role to oversee and support training and implementation of NA role.

**Recommendation 13:** GP practices should ensure preceptorship is in place for newly qualified NAs. A PCN or ICB model role in supporting GP practices to implement should be considered.

**Recommendation 14:** NHSE and/or ICB should put in place a NA peer network.

**Recommendation 15:** NHSE should lead on the development of a national peer network for NAs in primary care.

**Recommendation 16:** ICBs should make available training for change management and workforce planning to primary care clinicians and leaders.

## **7.2 Plans for dissemination of findings**

The findings of this research will be provided to the funder as a requirement. The report and/or its findings and recommendations will also be shared with a range of stakeholders at both local, regional and national levels for professional and ethical reasons.

I received a grant from the RCN Foundation Professional Bursary Scheme towards the cost of the DBA programme. A report will be provided as a requirement on completion of the programme after concluding the Viva.

The NHS staff in the five GP practices have generously given up their time and participated in this study. A summary of the report will be provided to each of the practices and a full report made available on request.

There is an active clinical research community in the NE region. In June 2022, I was invited to a research event on primary care and shared the progress of this study. The intention is that the findings of this research will be shared with the clinical research community at the next annual meeting in summer 2023. There are also ICB research and evidence locality meetings in the NHS. I am planning to contact the North East Commissioning Support Unit (which provides the administration support) in due course, and request an opportunity to present findings. I am planning to apply and present at the next annual Post Graduate Researcher Conference at Northumbria University. I have also submitted an extended abstract to the Northern Advanced Research Training Initiative (NARTI) Annual Conference in June 2023 for single-blind peer review. If accepted, it will be turned into a full paper presentation for wider sharing.

The findings of this study will be of interest to the wider NHS particularly ICBs and Primary Care Networks, and the new NHS England (which will include Health Education England as from April 2023) as commissioner of the NA programmes provided by the HEIs. I have already made contact with the Executive Director of Innovation and Executive Chief Nurse at the North East North Cumbria ICB, and will be presenting this study's findings at the next ICB workforce planning event.

The ICB covers the whole of NE region and all the GP practices that participated in this study. A summary report will also be sent to a range of national and regional stakeholders including the Chief Nursing Officer (England), Chief Nurse for Health Education England (HEE), Head of Nursing of HEE North East and Yorkshire (or equivalent in the new NHS England after restructuring), ICB Chief Nurses in England. I will make myself available to speak to other regions and to share findings as necessary.

On completion of the DBA programme, I will be submitting findings for publication in relevant peer reviewed nursing, healthcare and Human Resources journals including Nursing Times, Health Service Journal and Human Resource Management Journal.

Finally, I am keen to build on my experience and continue to develop my skills. I will be interested to work in collaboration with other researchers to progress the suggestions for future research outlined in section 7.4 below, should the opportunities arise.

### **7.3 Personal reflection of the research process**

Both Polit and Beck (2014) and King & Brooks (2017) stressed the role of reflexivity as a part of the research process. Reflection in relation to the methodology has been included within the thesis. This section contains my personal reflections of the research journey, taking in personal development, choice of research area, challenges and the role as a practitioner-researcher.

The topic of NA was chosen because of my desire to make a significant contribution to the nursing profession in a very important area. At a personal level, I also want to leave a legacy as this is likely to be my last postgraduate academic degree programme. The introduction of NA could be argued as 'the' single most significant development in the nursing profession in recent years, and there is unlikely to be another new regulated role for many years to come. I had hoped to receive more formal support from relevant organisations in undertaking this research, but

regrettably that has not been the case. However, I am pleased to have received strong and continuing encouragement from my colleagues.

COVID has added additional complexity and challenges to the research process. With the immense operational pressure in the NHS, including in primary care, the recruitment by GP practices during and post pandemic was not easy. I had the advantage of being a clinician working in the NHS, otherwise I have no doubt that this research journey would have proved even more convoluted and harder to navigate. I am well aware of the pros and cons and potential bias of being a practitioner-researcher in the same system being researched. However, I believe overall this is a positive position to be in, and has enabled me to understand and interpret the findings better, and the evidence of this lies in what I trust are high quality and meaningful recommendations for policy and practice.

This is the first time I have carried out an end-to-end research study, and the DBA programme has contributed greatly to my professional development. However, it has been a steep learning curve in some areas. For example, some of the research skills such as using NVivo, have to be self-identified and self-taught, and this has been challenging at times. The DBA programme has also enhanced my personal resilience, trying to balance the pressures of a full-time job during COVID against the need to make progress on the research and thesis. Overall, I have thoroughly enjoyed the experience, finding it both stretching and rewarding. The DBA programme has not just equipped me with the transferrable knowledge to my daily working practice, but also life skills that have enriched me personally.

Looking back at the design of the study, I stand by my choice of methodology and methods and adoption of case study and Template Analysis. However, I am aware of other lenses such as change management theories which would offer interesting ways of looking at different angles of the issues. However, change management has a much wider scope and I consider a focused theory, concentrating on introduction of new roles and their implementation, does provide a more specific analysis of the research problem.

## 7.4 Suggestion for further work

Based on findings and constraints of this study (discussed above in section 6.4), there are areas that could be addressed in future development from the perspectives of methodology and methods and theory.

Firstly, further research could adopt a more explicitly evaluative framework. One option is use of Realist Evaluation (Pawson & Tilley, 1997). This would employ the institutionalisation theory used in this research, as a candidate programme theory to examine the contexts, mechanisms, and outcomes of the new roles. Focusing skill-mix innovations and role implementation in specific clinical areas (e.g. long-term conditions, health prevention) and linking it to outcomes (e.g. quality, access to services) could also help explore specific influencing factors on implementation and enhance understanding of enablers and barriers to change. Such inquiry would deepen the understanding of the relationships between each GP practice, actors' actions and interventions, and the status of their respective role implementation. This is particularly relevant in primary care settings as GP practices are independent organisations working within a complex NHS system.

Although both this study and the one by Kessler et al. (2017) with the EIM were focused on role implementation, Kessler used an inductive and exploratory approach whilst I have adopted a deductive approach. Utilising an inductive approach for example, might generate other interesting perspectives. A longitudinal study with different data collection points and retrospective and real time data could provide a more extensive understanding of implementation predictors and outcomes (Trullen et al., 2020). This study was carried out during the initial stage of implementation of the NA role and early development of PCNs and ICBs. A later study would allow the progress of the role development in GP practices to be re-assessed, and might conclude with different findings.

In spite of the adverse impact of COVID and recovery work, this study recruited GP practices from five of the possible seven CCGs. That said, it is not clear whether the pandemic influenced the type or size of GP practices which participated. Having a wider variety of GP practice characteristics may reveal other relevant results in

relation to role implementation and legitimisation which were not present in the GP practices studied. Therefore, the theory developed in this study may be further tested with GP practices with different sizes (number of employees), and decision-making structure / business models. A mixed method study could potentially further enhance the data quality in two main ways. Firstly by improving the allowing triangulation of different types of data, constructs could be identified, measured, and validated (Yin, 2018). Secondly, a quantitative method would allow reaching out to more GP practices in the region and beyond, and a result, could strengthen the study's external validity and reliability (Yin, 2018).

There are also a number of areas for potential development in the conceptual areas. Firstly, this research could be informed through the lens of change management theory. This could allow closer examination of other aspects of role implementation such as organisation processes and resources. Trullen et al. (2020) carried out a literature review of HRM implementation and highlighted five conceptual frameworks where they were anchored on. The NA study falls into practice-based approaches, and others four could be used to examine different aspects of introduction of the NA role. For example power perspectives, how the values and motivations of the champions could drive the adoption of the new role. Contextual approaches could be used to examine the impact of different levels of contextual factors on implementation processes, and a structural views approach could help to better understand the impact of decision-making systems on the effectiveness of the implementation. The fourth area is how motions are connected to and influence legitimacy and resistance behaviours. By employing institutional theory, this study uncovers issues relating to professional identity and illustrates the importance of this in role legitimisation. Identity is not an area of primary investigation of this study and further work could be carried out to allow a fuller understanding. A focus study on institutional work could add to the current knowledge of what the actors in GP practices do to implement skill-mix change, particularly types of work relating to creating strategies.

Lastly, my study and the work conducted by Reay et al. (2006) and Kessler et al. (2017) are all rooted in healthcare. In addition, my study has focused on a regulated nursing role, and also proposed modified perspectives in understanding



legitimation of new work role in transformational change, including an adapted institutionalisation model (Figure 25). This proposed model could offer advancement in institutional theory and would benefit from further testing, to explore if the microprocesses are sensitive to other employment context, such as legal and accountancy. This is because quite often, these sectors have individuals progressing from non-regulated to regulated role.

## **7.5 Final remarks**

As well as advancing my own personal academic development, I believe this research will make a significant contribution to practice and theory. I believe this study is the first to research the implementation of the Nursing Associate role in GP practices, and as a piece of work originating in the north-east of England, it has additional significance. Moreover, this study has contributed to under-researched areas: new work roles in healthcare and primary care. Potentially this study also contributes to institutional theory including development of a modified institutionalisation model for new work roles to guide future implementation in healthcare and other settings. For all these reasons, I believe that this research will make a tangible difference.

Nursing Associate is a new registrant role and one that I believe to be 'the' most important development in the nursing profession in several decades. Some three and a half years ago, I set out to investigate how this new role was being implemented in GP practices. The research that I have pursued has been by no means plain sailing, and was carried out while the NHS was facing the biggest challenge in its history – to overcome an epidemic that shut down the world. I have stayed the course, as has the NHS to which I have dedicated my working life and to which I am immensely proud to belong. It has been my intention that this work should provide a sound foundation not only on which to build future research, but also future healthcare reform.

## Appendix A: Overview of analysis of the 18 literatures

	Factors that are supportive of or conducive to the successful employment of NAs	Moran A et al (2011)	Bungay H et al (2013)	Stewart-Lord Adele et al (2011)	Allen K et al (2013)	Drennan VM et al (2014)	Imison C et al (2016)	Laurent M et al (2017)	Halse J et al (2018)	Kessler I & Vandana N (2019)	Spilsbury K et al (2009)	Kilpatrick K (2019)	Kennedy C (2015)	Griffin M (2006)	Vas S (2010)	Drennan VM et al (2019)	Greenhalgh S & Yeowell G (2020)	Evans C et al (2020)	Morris Leah et al (2011)	Total		
Planning	Robust workforce planning		X				X	X	X	X			X					X	X	7	13	
	Service needs	X	X				X		X	X	X				X	X					6	
Role	Well defined scope	X			X	X		X	X												3	11
	Role standardisation	X						X								X					3	
	Education programme mirrors patient need	X							X				X	X			X				4	
	Allow time for role realisation																	X			1	
Change Management	Strong leadership		X						X							X		X			3	35
	Use change management methodology		X				X		X												2	
	Time & money & capacity are adequate	X					X		X		X					X					4	
	Provision of a clinical educator (Training capability)	X				X	X		X							X	X				5	
	Receptive culture for change	X		X			X									X		X	X		4	
	Strong communication		X			X	X				X					X		X	X		6	
	Attitudes of others and understanding of the role		X	X	X	X		X			X	X	X	X		X		X	X		10	
Political / professional bodies support	X							X												1		
Local context	Local context - Practice model, team work, collaboration, experience of HCAs - link to service needs					X		X											X		3	5
	Professional support staff relationships	X				X															1	
	Hierarchy of seniority/profession	X														X					1	
Impact	Evidence of effectiveness		X			X					X										2	2
	ACP																					
	FCP																					
	PA																					

## Appendix B: Working template of literature review

	Change Management		Reay et al (2006)	Goodrick E & Reay T (2009)	Kessler et al (2017)	Halse J et al (2018)	Imison C et al (2016)	Moran A et al (2011)	Evans C et al (2020)	Derckx E & Wensing M (2017)	Spilsbury K et al (2009)	Spilsbury K et al (2011)	Bungay H et al (2013)	Greenhalgh S & Yeowell G (2020)	Morris Leah et al (2011)	Drennan VM et al (2019)	Drennan VM et al (2014)	Allen K et al (2013)	Kilpatrick K (2019)	Farmer et al (2011)	Aldossary A (2013)	Zida A (2017)	Fligstein N (1997)	Goretzki L (2013)	Patriotta et al (2006)	Perkman et al (2008)	Akintola A (2017)	Altshuler S (2009)	Xu (2012)			
Wider context	x	Time & capacity needed				X	X				X					X																
	x	Create a receptive culture for change.					X	X	X							X																
		Political								X													X		X							
	x	Adopt a systematic approach to workforce development and change				X	X		X	X			X			X	X															
		Local context - Practice model, team work, collaboration, experience of HCAs - link to service needs								X						X		X										X				
Emergence		1.2: Establishing needs			x	X	X		X		X						X															
		1.2: Identifying post holders			x	X	X	X										X														
	x	1.3: Finding champions (leadership)			x	X							X			X																
	x	1.4: Calming organisational concerns			x		X				X		X																			
		1.5: Support transformation with a strong change management strategy				X	X			X				X																		
	x	1.6 Develop and invest in a training capability	X			X	X	X	X	X				X		X	X	X					X									
		Evidence of success															X	X														
Legitimacy		Clear boundaries															X	X														
		2.1 recognising and creating opportunities to advance 'the new way';	x																						X							
		2.2 Fitting new way into established structures/ systems	x		X																					X						
		2.3 Proving value of new ways to others	x		X																				X							
		2.4 Dependent on the qualified practitioner herself / himself						X		X	X		X				X					X										
		2.5 Acceptance of service users																					X									
		2.6 Use of rhetoric strategies in accomplishing the institutionalization of changes to professional role identity		X																												
		2.7 Local knowledge																								X						
		2.8 Identity re-construction																							X							
		2.9 The person's Cultural assimilation																							X							
		2.9 Delegitimise the old role																							X							
	2.10 Interlinking the intra-organisational level with an (external) institutional				x																			X								
	2.11 Possession of superior knowledge																										X					
Acceptance		3.1: establishing a distinctive contribution			x			X			X																					
		3.2: ensuring the role is trusted - delegation			x			X										X														
		3.3: creating a dependence on the role			x																											
Sustainability		Build sustainability for new and extended roles					X						X																			
Contextual	x	Evaluate change					X																									
		Ensure robust triage mechanisms					X																									
		Additional elements not in Reay or Kessler																														
		Physician Assistant																														
		FCP																														
		ACP																														
		Nursing																														
		Non NHS																														

## Appendix C: Reorganisation and the mapping of features against the Elaborated Institutionalisation Model

		Countries	England	England	England	England	England	England	Canada	Scotland	Germany	Italy	S Africa	USA	China	
		Primary care	X				X		X							
			Healthcare	Healthcare	Healthcare	Healthcare	Healthcare	Healthcare	Healthcare	Healthcare	Manufacturing	automotive	Construction	Education	Third sector	Total
			Evans C et al (2020)	Spilsbury K et al (2011)	Bungay H et al (2013)	Drennan VM et al (2019)	Drennan VM et al (2014)	Allen K et al (2013)	Kilpatrick K (2019)	Farmer et al (2011)	Goretzki L (2013)	Patriotta et al (2006)	Akintola A (2017)	Altshuler S (2009)	Xu (2012)	
Wider context - political and organisational factors	x	Time & capacity needed				X			X			X				3
	x	Create a receptive culture for change.	X			X				X						3
		External drivers / jolts	X	X	X	X	X	X	X		X	X	X	X	X	11
	x	Adopt a systematic approach to workforce development and change	X		X	X						X				4
	Local context - Practice model, team work, collaboration, experience of HCAs - link to service needs					X						X			2	
Emergence		External drivers / jolts	X	X	X	X	X	X	X		X	X	X	X	X	11
		1.2: Aligning with explicit needs	X	X	X	X	X	X	X	X	X	X	X	X	X	13
		1.2: Identifying post holders	X	X		X	X	X	X	X	X	X	X		X	11
	x	1.3: Finding champions (leadership)	X	X	X	X	X				X				X	7
		Embedded agents			X						X		X			4
	x	1.4: Calming organisational concerns	X	X	X	X	X									5
		Evidence of success			X	X	X			X						3
		Clear boundaries / clarity		X	X	X	X	X		X	X					7
		Support transformation with a strong change management strategy	X	X	X	X										4
	x	Comms (related to 1.4)	X	X	X	X	X	X	X	X						7
		Develop and invest in a training capability	X	X		X	X	X	X	X		X				7
		Community / institution building - belonging			X	X				X		X			X	4
	Legitimacy		Financial incentive		X	X	X				X					
		2.1 recognising and creating opportunities to advance 'the new way';	X	X	X	X	X			X	X	X	X	X		10
		2.2 Fitting new way into established structures/ systems	X			X			X		X	X				6
		2.3 Proving value of new ways to others	X	X	X	X	X	X	X	X	X	X	X	X		10
		Accountability						X	X							4
		Dependent on the qualified practitioner	X	X		X		X								5
		Local knowledge			X						X	X				2
		Possession of superior knowledge								X	X	X	X	X		2
		The person's Cultural assimilation								X	X	X			X	3
		Identity re-construction	X	X					X		X	X		X		6
		Delegitimise the old role		X							X	X				3
		Interlinking the intra-organisational level with an (external) institutional environment			X					X		X			X	4
		Acceptance of service users	X			X	X			X	X		X	X		7
	Comms								X				X		1	
	Team working								X						1	
Acceptance		3.1: establishing a distinctive contribution					X	X		X		X	X			5
		3.2: ensuring the role is trusted - delegation		X				X				X				0
		3.3: creating a dependence on the role														0
		Mutual understanding of the role	X													1
		Political	X									X				2

ACP  
Physician Assistant  
Nursing  
Non NHS

## **Appendix D: Invitation email to CCG Directors of Nursing**

Dear colleagues,

I would be most grateful if you could forward this invitation to take part in research, on the new nursing associate role in primary care, to GP practices in your CCG area. All GP practices with qualified Nursing Associates (NAs) will be invited to participate.

As you know, the introduction of Nursing Associates (NAs) intends to increase the number of nurses through widening progression routes into nursing; address the skill gap between healthcare assistants (HCAs) and registered nurses (RNs); and retain and motivate the nursing workforce. The first cohort of trainees in the northeast started their training in 2017, and many more are currently being trained. To date, little is known about the actual impact of NAs working in hospitals or out of hospital settings in England on patient care and service quality, and there has been no published research or formal evaluation on this. It is not known whether the policy intentions have been met.

As part of my Professional Doctorate Degree Programme at the University of Northumbria, I will be carrying out a research on NAs. The study will examine to what extent and in what ways the introduction of Nursing Associate has filled the skill gap between HCAs and RNs in GP practices in the northeast, and what impact this has made to service delivery as a result. It is hoped that the findings of my research will provide that much needed evidence to inform the ongoing uptake and/or development of the role of Nursing Associate in GP practices in the northeast and beyond.

More information on the research is provided in the attached Information Sheet. GP practices can email me their expressions of interests to take part in this study to [annietopping@nhs.net](mailto:annietopping@nhs.net)

Many thanks for your support.

Kind regards



Annie Topping  
Executive Director of Nursing and Quality,  
Northumberland CCG.

## Evaluating the introduction of Nursing Associates in General Practice in the northeast of England

### Participant Information Sheet (GP Practice)

You\* are being invited to take part in this research study. Before you decide, it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.

*\*In this document, any reference to 'you' or 'I' means the GP practice and 'we' means the sponsor organisation (Northumbria University).*

#### **What is the Purpose of the Study**

The introduction of Nursing Associates (NAs) intends to increase the number of nurses through widening progression routes into nursing; address the skill gap between healthcare assistants (HCAs) and registered nurses (RNs); and retain and motivate the nursing workforce.

The first cohort of trainees in the northeast qualified in 2019, and many more are currently in training. To date, little is known about the actual impact of NAs working in hospitals or out of hospital settings in England on patient care and service quality, and there has been no published research or formal evaluation on this. It is not known whether the policy intentions have been met.

This study will be examining the extent and the ways the introduction of NA has filled the skill gap between HCAs and RNs in General Practice in the northeast of England. The findings will provide that much needed evidence to inform the ongoing uptake and development of the role of NA in GP Practices in the northeast of England and beyond.

This study will be using multi-case studies as a research method, and each GP practice will be a case study site. Data will be collected from interviews and focus groups with Nursing Associates, GPs, Practice Managers and Registered Nurses, and management reports / information on nursing skill mix and other patient activities and services.

#### **Why have I been invited?**

Based on the information provided by Health Education England, there have been 4 intakes of 26 trainee NAs in GP practices across the 7 clinical commissioning groups in the northeast of England between April 2017 and March 2019. The training is 2-years long so the working assumption is that most or all of them would have qualified

by March 2021. All GP practices with qualified NA/s at 31 March 2021 are invited to participate in this study.

This invitation is forwarded to you by your CCG because it believes that currently your GP practice has employed one or more qualified NA/s.

### **Do I have to take part?**

No. It is up to you whether you would like to take part in the study, and the information in this document aims to help you to make that decision.

If you do decide to take part, you can stop being involved in the study whenever you choose, without having to say why. You are completely free to decide whether or not to take part, or to take part and then leave the study before completion. We will keep information/data about you that we already have.

### **What will happen if I take part?**

#### a. Preparation

In the first instance, you should send an expression of interest to the researcher at [annietopping@nhs.net](mailto:annietopping@nhs.net). The researcher will arrange a planning meeting with the Practice Manager and/or one of the GP Partners to discuss any further queries you may have, and the logistical arrangements for becoming a case study site. You will be asked to sign an organisational consent form.

#### b. Interviews & Focus groups

Interviews and focus groups will take place at the GP Practice to avoid the need for participants to travel. You will be asked to identify some suitable/convenient dates and times, as well as the participants in the different groups – Nursing Associate, GP, Practice Manager and Practice Nurse. This list of participants with their contact details will be used by the researcher to send out invitations to attend interviews and focus groups. A Participation Information Sheet and a consent form will be sent out to each participant in advance, and consent forms will be obtained before 1:1 and focus group interviews.

One to one interviews will take no more than 45 minutes and focus group discussions will be 90 minutes or less.

#### c. Management and skill mix information

The GP Practice will be asked to identify relevant management reports / information on nursing skill mix and other patient activities and services, and share with the researcher. This information will be used to provide the context and help assessment of the impact on patient services.

### **What are the possible disadvantages of taking part?**

The study involves one to one and group interviews, and it is not envisaged that there will be any potential adverse effects on the participants.

The interviews will be carried out in GP practices during working hours Mondays to Fridays, and will be incorporated in between existing workloads. This could cause inconvenience and increase the burden for participants. The researcher will work with you to identify appropriate time to carry out interviews, and that there will be no disruptions to patients and clinical activities.

### **What are the possible benefits of taking part?**

By taking part in the study, you will be able to help to provide much needed evidence to inform the development of the new Nursing Associate role in the region and beyond. There are only a small number of Nursing Associates in GP practices nationally and locally in the northeast of England, so your participation will be invaluable.

### **Will my taking part in this study be kept confidential and anonymous?**

Yes. It is recognised that GP practices are small organisations with relatively small numbers of employees, so there is a high possibility that participants will be indirectly identifiable when their place of work and job title / role are linked together. Therefore, all geographical details of practices will be removed in the reporting of the findings and quotes will be anonymised.

Your name will not be written on any of the data we collect; the written information you provide will have an ID number, not your name. Your name will not be written on the recorded interviews, or on the typed up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. The consent form you have signed will be stored separately from your other data. The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

As a Registered Nurse, the researcher is required to act in accordance to the Code of Professional Conduct published by the Nursing and Midwifery Council. A number of standards in the Code are relevant to the research activity, particularly (5) Respect people's right to privacy and confidentiality. The researcher will be adhering to this requirement at all times.

### **How will my data be stored, and how long will it be stored for?**

All paper data, including consent forms will be kept in locked storage. Consent forms will be scanned within 48 hours and then stored in the University's secure U drive, and the hard copies will then be destroyed appropriately as confidential waste. All electronic data; including the recordings from your interview, will be stored on the



University U drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (2018).

In accordance with the University's Research Records Retention Schedule (principle of storage limitation), the data will be retained in an appropriate format for a period of 7 years. This retention period will also be compliant with the Department of Health's Records Management Code of Practice for Health and Social Care 2016. At end of the retention period, the research data will be destroyed.

### **What categories of personal data will be collected and processed in this study?**

The names and job titles of the participants (NHS staff), and their place of work i.e. name of GP practice will be collected and processed in this study. Pseudonymisation of data will be carried out to ensure the confidentiality of personal data, and the names and other identifiers (i.e. job title and place of work / name of GP practice) of participants will be replaced with a reference number. Reference numbers will be used in the written transcripts of 1:1 interview and focus group discussions.

It is not envisaged that there will be personal data in the management and nursing skill mix information, but if there are, they will be replaced by reference numbers.

### **What is the legal basis for processing personal data?**

This is a university research project and the legal basis under GDPR is Article 6(1) (e)... "processing is necessary for the performance of a task carried out in the public interest".

### **Who are the recipients or categories of recipients of personal data, if any?**

The audio recording of interviews and focus groups will be transcribed by an external organisation in the UK. The researcher is the principle investigator and she will be the only person that has access to the pseudonymisation log.

### **What will happen to the results of the study and could personal data collected be used in future research?**

The general findings might be reported in a professional or peer reviewed journal or presented at a research conference, however the data will be anonymized and you or the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organisations that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below.

At the end of the study we will save some of the data in case we need to check it and/or for future research. We will make sure no-one can work out who you are from the reports we write.

### **Who is Organising and Funding the Study?**

Northumbria University is the organiser of this study.

The researcher has received as a small study grant from the Royal College of Nursing Foundation Professional Bursary Scheme.

### **Who has reviewed this study?**

The research project, submission reference 24705 has been approved in Northumbria University's Ethics Online system. It has been reviewed in order to safeguard your interests, and have granted approval to conduct the study.

Ethical approval has also been obtained from the Human Research Authority (IRAS project ID 283034) in October 2020.

### **What are my rights as a participant in this study?**

The GDPR provides the following rights to you as a participant:

1. The right to be informed
2. The right of access
3. The right to rectification
4. The right to erasure
5. The right to restrict processing
6. The right to data portability
7. The right to object
8. Rights in relation to automated decision making and profiling.

If you wish to access a copy of information comprised in your personal data (to do so individuals should submit a [Subject Access Request](#))

If you are dissatisfied with the University's processing of personal data, you have the right to complain to the Information Commissioner's Office. For more information see [the ICO website](#).

### **Others**

The Sponsor (Northumbria University) is ultimately responsible for the safe conduct of the study and the well-being of participants. Any unforeseen circumstances will be reported to the Sponsor's representative (Research Policy Manager, Research and Innovation Services) and dealt with appropriately.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions on 07843 302592. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's supervisor (please see below email address). As study Sponsor, Northumbria University has insurance to cover this research study, which includes compensation cover in the event that any claims arise from participation in the study.

**Contact for further information:**

**Researcher email: [annietopping@nhs.net](mailto:annietopping@nhs.net)  
Supervisor email: [hannah.hesselgreaves@northumbria.ac.uk](mailto:hannah.hesselgreaves@northumbria.ac.uk)**

**Name and contact details of the Records and Information Officer at  
Northumbria University: Duncan James ([dp.officer@northumbria.ac.uk](mailto:dp.officer@northumbria.ac.uk)).**

***[www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notice/](http://www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notice/)***

## Appendix F: Consent form - GP practices

IRAS ID: 283034

Case Study Site Number: TO INSERT

Name of GP Practice / Case Study Site: TO INSERT

### CONSENT FORM – GP Practice

Title of Project: Evaluating the introduction of Nursing Associates in General Practice in the northeast of England

Name of Researcher: Annie Topping

- |  |                               |
|--|-------------------------------|
|  | Please<br>tick/initial<br>box |
| 1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/>      |
| 2. I understand that the participation of the GP Practice is voluntary and that we are free to withdraw at any time without giving any reason.   | <input type="checkbox"/>      |
| 3. I agree to take part in the above study.  | <input type="checkbox"/>      |
| 4. I consent to the retention of this data under the condition that any subsequent use also be restricted to research projects that have gained ethical approval from Northumbria University.                        | <input type="checkbox"/>      |

_____	_____	_____
Name of person signed on behalf of the GP Practice (BLOCK LETTER)	Date	Position

_____	_____	_____
Name of person taking consent (BLOCK LETTER)	Date	Signature

## **Appendix G: Sample of the agenda for on-boarding meeting**

### **On boarding meeting (30 min)**

1. Welcome and thankyou
2. Purpose of this meeting
  - to seek consent
  - to discuss arrangements for interviews and focus groups
  - to discuss any queries the practice may have
3. Interview / focus group
  - GP practice will be asked to identify the participants
  - This list of participants with their contact details will be used to organise interviews and focus groups, and a Participation Information Sheet (NHS staff) and a consent form will be sent out to participants in advance.
  - Consent forms will be obtained from the participants in these GP practices by the researcher before one to one or focus group interviews
4. What next / Actions

## Evaluating the introduction of Nursing Associates in General Practice in the northeast of England

### Participant Information Sheet (NHS Staff)

You are being invited to take part in this research study. Before you decide, it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.

*In this document, 'we' means the sponsor organisation (Northumbria University).*

#### **What is the Purpose of the Study**

The introduction of Nursing Associates (NAs) intends to increase the number of nurses through widening progression routes into nursing; address the skill gap between healthcare assistants (HCAs) and registered nurses (RNs); and retain and motivate the nursing workforce.

The first cohort of trainees in the northeast qualified in 2019, and many more are currently in training. To date, little is known about the actual impact of NAs working in hospitals or out of hospital settings in England on patient care and service quality, and there has been no published research or formal evaluation on this. It is not known whether the policy intentions have been met.

This study will be examining the extent and the ways the introduction of NA has filled the skill gap between HCAs and RNs in General Practice in the northeast of England. The findings will provide that much needed evidence to inform the ongoing uptake and development of the role of NA in GP Practices in the northeast of England and beyond.

This study will be using multi-case studies as a research method, and each GP practice will be a case study site. Data will be collected from interviews and focus groups with Nursing Associates, GPs, Practice Managers and Registered Nurses, and management reports / information on nursing skill mix and other patient activities and services.

#### **Why have I been invited?**

All GP practices in the northeast of England with qualified NA/s at 31 March 2021 are invited to participate in this study, and your GP practice is one of them. Your GP practice has agreed to take part in this study, and identified you as a potential participant.

### **Do I have to take part?**

No. It is up to you whether you would like to take part in the study, and the information in this document aims to help you to make that decision.

If you do decide to take part, you can stop being involved in the study whenever you choose, without having to say why. You are completely free to decide whether or not to take part, or to take part and then leave the study before completion. We will keep information/data about you that we already have.

### **What will happen if I take part?**

Depending on your job role and numbers of people in your participant group, you will be having either a 1:1 interview or focus group discussion with the researcher. All interviews and focus groups will be taking place locally at your GP practice and no travelling is required. One to one interview will take no more than 45 minutes and focus group discussions will be 90 minutes or less.

You will be asked to sign a consent form in advance of the 1:1 or focus group interviews.

### **What are the possible disadvantages of taking part?**

The study involves one to one and group interviews, and it is not envisaged that there will be any potential adverse effects on the participants.

The interviews will be carried out in GP practices during working hours Mondays to Fridays, and will be incorporated in between existing workloads. This could cause inconvenience and increase the burden for participants. The researcher will work with you to identify appropriate time to carry out interviews, and that there will no disruptions to patients and clinical activities.

### **What are the possible benefits of taking part?**

By taking part in the study, you will be able to help to provide much needed evidence to inform the development of the new Nursing Associate role in the region and beyond. There are only a small number of Nursing Associates in GP practices nationally and locally in the northeast of England, so your participation will be invaluable.

### **Will my taking part in this study be kept confidential and anonymous?**

Yes. It is recognised that GP practices are small organisations with relatively small numbers of employee, so there is a high possibility that participants will be indirectly identifiable when their place of work and job title / role are linked together. Therefore, all geographical details of practices will be removed in the reporting of the findings and quotes will be anonymised.

Your name, job title and place of work i.e. name of GP practice will be collected and processed in this study. Pseudonymisation of data will be carried out to ensure the confidentiality of personal data, and your name and other identifiers (i.e. job title and place of work / name of GP practice) will be replaced with a reference number. Reference number will be used in the written transcripts of 1:1 interview and focus group discussions.

Your name will not be written on any of the data we collect; the written information you provide will have an ID number, not your name. Your name will not be written on the recorded interviews, or on the typed up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. The consent form you have signed will be stored separately from your other data. The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

As a Registered Nurse, the researcher is required to act in accordance to the Code of Professional Conduct published by the Nursing and Midwifery Council. A number of standards in the Code are relevant to the research activity, particularly (5) Respect people's right to privacy and confidentiality. The researcher will be adhering to this requirement at all times.

#### **Who are the recipients or categories of recipients of personal data, if any?**

The audio recording of interviews and focus groups will be transcribed by an external organisation in the UK. The researcher is the principle investigator and she will be the only person that has access to the pseudonymisation log.

#### **How will my data be stored, and how long will it be stored for?**

All paper data, including consent forms will be kept in locked storage. Consent forms will be scanned within 48 hours and then stored in the University's secure U drive, and the hard copies will then be destroyed appropriately as confidential waste. All electronic data; including the recordings from your interview, will be stored on the University U drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (2018).

In accordance with the University's Research Records Retention Schedule (principle of storage limitation), the data will be retained in an appropriate format for a period of 7 years. This retention period will also be compliant with the Department of Health's Records Management Code of Practice for Health and Social Care 2016. At end of the retention period, the research data will be destroyed.



### **What will happen to the results of the study and could personal data collected be used in future research?**

The general findings might be reported in a professional or peer reviewed journal or presented at a research conference, however the data will be anonymized and you or the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organisations that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below.

At the end of the study we will save some of the data in case we need to check it and/or for future research. We will make sure no-one can work out who you are from the reports we write.

### **Who is Organising and Funding the Study?**

Northumbria University is the organiser of this study.

The researcher has received as a small study grant from the Royal College of Nursing Foundation Professional Bursary Scheme.

### **Who has reviewed this study?**

The research project, submission reference 24705 has been approved in Northumbria University's Ethics Online system. It has been reviewed in order to safeguard your interests, and have granted approval to conduct the study.

Ethical approval has also been obtained from the Human Research Authority (IRAS project ID 283034) in October 2020.

### **What are my rights as a participant in this study?**

The GDPR provides the following rights to you as a participant:

1. The right to be informed
2. The right of access
3. The right to rectification
4. The right to erasure
5. The right to restrict processing
6. The right to data portability
7. The right to object
8. Rights in relation to automated decision making and profiling.

If you wish to access a copy of information comprised in your personal data (to do so individuals should submit a [Subject Access Request](#))

If you are dissatisfied with the University's processing of personal data, you have the right to complain to the Information Commissioner's Office. For more information see [the ICO website](#).

### **Others**

The Sponsor (Northumbria University) is ultimately responsible for the safe conduct of the study and the well-being of participants. Any unforeseen circumstances will be reported to the Sponsor's representative (Research Policy Manager, Research and Innovation Services) and dealt with appropriately.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions on 07843 302592. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's supervisor (please see below email address). As study Sponsor, Northumbria University has insurance to cover this research study, which includes compensation cover in the event that any claims arise from participation in the study.

#### **Contact for further information:**

**Researcher email: [annietopping@nhs.net](mailto:annietopping@nhs.net)**

**Supervisor email: [hannah.hesselgreaves@northumbria.ac.uk](mailto:hannah.hesselgreaves@northumbria.ac.uk)**

**Name and contact details of the Records and Information Officer at Northumbria University: Duncan James ([dp.officer@northumbria.ac.uk](mailto:dp.officer@northumbria.ac.uk)).**

***[www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/](http://www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/)***

**m**

## Appendix I: Consent form - NHS staff

IRAS ID: 283034

Case Study Site Number: TO INSERT

Participant Identification Number for this study: TO INSERT

### CONSENT FORM – NHS Staff

Title of Project: Evaluating the introduction of Nursing Associates in General Practice in the northeast of England

Name of Researcher: Annie Topping

Please tick/initial  
box

I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and this will not affect my employment/job.

I am willing to be interviewed / participate in the focus group discussion.

I am willing for my comments to be tape-recorded.

I am aware that my name and details will be kept confidential and will not appear in any printed document.

I agree to take part in the above study.

I consent to the retention of this data under the condition that any subsequent use also be restricted to research projects that have gained ethical approval from Northumbria University.

\_\_\_\_\_  
Name of Participant  
(BLOCK LETTER)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person  
taking consent  
(BLOCK LETTER)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## **Appendix J: Interview Schedules (Combined)**

### **A. Nursing Associate**

#### Background

1. What job did you hold before becoming an NA (give job title e.g. HCA)?
2. When did you complete your NA training (Date)?
3. When did you become an NA (Date)?
4. What clinical area do you currently work in (be sure to capture clinical specialism or activity e.g. Well man/women clinic, imms clinic, Long term conditions clinic etc)?
5. Were you working in the same clinical area before you became an NA?
6. Have you changed clinical area since becoming an NA (if so probe nature of change- where from-why)?
7. What made you want to become an NA (probe on their aspirations at the time they chose to become an Trainee NA- for example, did they want to be TNA so they could become nurse, or become an NA as a role of value/interest in its own right; probe on how important registered status was to becoming an NA.)

#### Current NA role

8. What days/hours do you work?
9. How are you counted in the staff numbers (as a registered or unregistered member of staff)?
10. Typically how many NAs will there be on any given day? (If applicable)
11. Describe what your typical day looks like (probe by exploring the tasks typically undertaken).
12. Has your NA role changed since you qualified? For example in terms of your tasks and responsibilities, broadened? Narrowed? How? Why?
13. How is your NA role different to that of HCAs in the GP practice?
14. How is your NA role different to that of registered nurses in the GP practice?
15. What do you most/least enjoy about your current role as an NA?

#### Management of the role

16. Who do you report to (who is your line manager)?
17. Do you have a separate mentor (if yes, who-job title)
18. As an NA have you had a personal development review yet (probe: if yes when was the review(s); who did the review and how useful did you find it)
19. Did you have a preceptorship following completion of your NA training (if yes probe on when, how long was the preceptorship, what did cover and were nurses and NA covered by same preceptorship scheme or did NAs have their own.)
20. Have you received any other training since becoming an NA? If yes, probe on the nature of the training; did they ask for it; were they ask to do it.

## Stakeholder engagement

### a. GPs:

21. How did GPs view and respond to you when you first qualified and joined the ward/team?
22. Have GPs' responses to you changed? How do they view you and your role now?

### a. Practice Manager

23. How did the PM view and respond to you when you first qualified and joined the ward/team?
24. Has the PM's responses to you changed? How does he/she view you and your role now?

### a. Registered Nurses:

25. How did registered nurses view and respond to you when you first qualified and then joined the nursing team?
26. Have responses to you changed? How do they view now (probe on tensions and challenges faced in dealing with nurse)?
27. Do nurse appropriately delegate tasks to you? If not, why not?
28. Who is accountable or the performance of these delegated tasks?

### a. Patients:

29. How do patients view and relate to you?
30. Do they realise who you are - an NA?
31. Do you introduce yourself to patients as an NA?
32. Do they ever ask (unprompted) about your role? (Probe what patient asks about)
33. Do you related differently now to patient then when you were an HCA? (If appropriate)

## Others

34. Any other comment you would like to make on any aspect of the NA role?

## B) Practice Manager

### Background

1. Some details on the GP practice: Registered population; numbers of GP (partners and salaried); turnover; overall workforce size; size of nursing workforce.
2. How many qualified NAs do you have in your GP practice?
3. In which clinical areas are they located (be sure to capture clinical specialism or activity e.g. Well man/women clinic, imms clinic, Long term conditions clinic etc).
4. How many TNAs are there currently in the GP practice? Are these in new clinical areas or the same ones as already have qualified NAs?
5. Does your GP practice have any assistant practitioners? If so, roughly how many?
6. Is your organisation still employing and training assistant practitioners?

### Emergence of the NA programme in the GP practice

7. Tell me the specific reasons for the introduction of the NA role at the GP practice? (Explicitly ask respondents about the relative importance of the following a reason for introducing the NA role in to the GP practice: addressing nurse shortages; providing career opportunities for HCAs; developing a new bridging role; dealing to financial/cost pressures; service delivery needs; and other possible reasons).
8. Was there any initial debate on and resistance from within the GP practice to the introduction the NA role? If so, give details; nature of debate/reasons for resistance.
9. Was a business case made for the introduction of the NA role into your GP practice?
10. Who is the organisation lead for the NA programme? (title of lead's job)
11. Do you have a dedicated post in your organisation to support the NA programme? If yes, provide details of job title.

### Preparation

12. How many were there on your GP practice's initial cohort of TNAs? (If applicable)
13. Is there a job description(s) for the NA role in your organisation?
14. Was the introduction of the NA preceded by any review of staff mix at nursing team / GP practice level?
15. How many of your original cohort of TNAs completed the programme and qualified?
16. Of those TNAs who completed the programme and qualified, how many are still working in your GP practice? Where the GP practice has lost qualified NAs, ask where they have gone (e.g. on to nurse training; to other organisations as NAs).
17. Is there an NA preceptorship programme?
18. Do NAs administer medication? If so, give details on form of medication administered.

### The NA role in action

19. How well has the NA role settled down?
20. What, if any, challenges and problems have been faced in embedding the NA role? Probe on how any difficulties have been dealt with.
21. How are NAs counted on the staff numbers?
22. Has there been any resistance to the NA role anywhere in the GP practice or amongst any particular group? If so, give details - press on resistance from nurses, HCAs and/or APs.
23. How is the NA role different to the nurse role?
24. How is the NA role different to the HCA role?
25. How is the NA role different to the AP role?
26. Have any concerns/issues arisen in relation to the delegation of and accountability for tasks at the NA-nurse interface?

### Impact

27. Is your organisation evaluating the impact of the NA role? If so, probe for detail on the nature of the evaluation and any findings to date.
28. Has the NA role impacted on the nature and quality of service delivery? Any examples of impact?
29. Has the NA role impacted on the GP practice (work and team) in any way?
30. Has the NA role impacted on the nurse and HCA roles in any way?
31. How does the NA role feed into the GP practice's workforce planning?
32. Has the GP practice's expectation for the NA role been met? If not, why not?
33. Have there been unintended consequences of introducing the NA role into your GP practice? If yes provide details.
34. Do you have any ongoing concerns about the role?
35. Has the GP practice's initial experience of the NA role affected its approach to and management of future cohorts of TNAs? If yes, give details included any changes to policies and procedures.
36. What is the future for the NA role in your GP practice? (More NAs; shifting/broadening range of tasks performed by the NA?)

## C) Registered Nurse / Nursing Team

### Background

1. Job title
2. Years working in the primary care and this GP practice
3. Clinical area & level of responsibility (be sure to capture clinical specialism or activity e.g. running the LTC clinics, nurse prescriber etc)
4. What involvement have you had and do you have with NAs? (Probe on whether they have been a TNA/NA mentor; whether they regularly work with NAs on duty; if work with NA when did this first start?)

### General views on the NA Role

5. Why do you think the NA role was introduced into your GP practice? (Probe on use of NA to address nurse shortages, cost pressures, service needs and on the value of the NA role in its right.)
6. Do you personally feel there is a need for an NA role and if so why?
7. Were you consulted or involved in any way on the introduction of the NA role?
8. How much did you know about the NA role before (T)NAs started to appear in your GP practice?
9. Are you now clear about the nature of the NA role?
10. If so, how would you describe/characterise the NA role in term of what it contributes to the nursing team?
11. Have your views on the NA role changed since you became aware of it, in any way (if so how and why)?
12. Do you personally have any concern about the NA role? If so, elaborate.

### The NA role in action

13. Did you work with the NA(s) in your GP practice before they qualified as an NA (say when they were HCAs)?
14. Have you or the nursing team or GP practice faced any challenges in taking on an NA(s)? If so, elaborate on the nature of these challenges and whether/how they have been addressed.
15. What tasks does the NA perform in your GP practice?
16. Are there any uncertainties or tensions about the tasks the NA might perform in your GP practice? If so, provide details.
17. Are you happy to delegate tasks to NAs? If so, what kind of tasks do you delegate?
18. Where does accountability for the performance of these delegated tasks lie?
19. Does the registered status of the NA affect your willingness to delegate tasks to NAs?
20. Are you confident in the capabilities of the NA you work with? If not, elaborate why.
21. How is the NA role different to the nurse role?
22. How is the NA role different to the HCA role?
23. How is the NA role different to assistant practitioner role? (If applicable)



### Impact

24. In general, how has the NA role impacted on the nature and quality of care delivery?
25. Can you provide an example of how the NA role has impacted (positively or negatively) on care delivery?
26. How if at all, has the NA role impacted on the way your team works?
27. How if at all, has the NA role impacted on the nature and quality of your working life?
28. Are there still challenges you and your team face in developing and using the NA role? If so, provide details.
29. Would you welcome more NAs in your team, or is the current number about right?

### Others

30. Any other comment you would like to make on any aspect of the NA role?

## C) GPs

### Background

1. Position (partner, salaried GP)
2. Years working in the primary care and this GP practice
3. Clinical area (be sure to capture clinical specialism or activity e.g. MSK, Safeguarding lead etc)
4. What involvement have you had and do you have with NAs? (Probe on whether they regularly work with NAs on duty; if work with NA when did this first start.)

### General views on the NA Role

5. Why do you think the NA role was introduced into your GP practice? (Probe on use of NA to address nurse shortages, cost pressures, service needs and on the value of the NA role in its right.)
6. Do you personally feel there is a need for an NA role and if so why?
7. Were you consulted or involved in any way on the introduction of the NA role?
8. How much did you know about the NA role before (T)NAs started to appear in your GP practice?
9. Are you now clear about the nature of the NA role?
10. If so, how would you describe/characterise the NA role in term of what it contributes to the GP practice?
11. Have your views on the NA role changed since you became aware of it, in any way (if so how and why)?
12. Do you personally have any concern about the NA role? If so, elaborate.

### The NA role in action

13. Did you work with the NA(s) in your GP practice before they qualified as an NA (say when they were HCAs)?
14. Have you or the GP practice faced any challenges in taking on an NA(s)? If so, elaborate on the nature of these challenges and whether/how they have been addressed.
15. What tasks does the NA perform in your GP practice?
16. Are there any uncertainties or tensions about the tasks the NA might perform in your GP practice? If so, provide details.
17. Are you happy to assign tasks to NAs? If so, what kind of tasks do you assign?
18. Where does accountability for the performance of these delegated tasks lie? (the nurse or NA)?
19. Does the registered status of the NA affect your willingness to assign tasks to NAs?
20. Are you confident in the capabilities of the NA you work with? If not, elaborate why.
21. How is the NA role different to the nurse role?
22. How is the NA role different to the HCA role?
23. (If appropriate) how is the NA role different to assistant practitioner role?

### Impact

24. In general how has the NA role impacted on the nature and quality of care delivery?
25. Can you provide an example of how the NA role has impacted (positively or negatively) on care delivery?
26. How if at all, has the NA role impacted on the way your GP practice works?
27. How if at all, has the NA role impacted on the nature and quality of your working life?
28. Are there still challenges you and the GP practice face in developing and using the NA role? If so, provide details.
29. Would you welcome more NAs in your GP practice, or is the current number about right?

### Others

30. Any other comment you would like to make on any aspect of the NA role?

The above questions are adopted from the research ‘Examining the Introduction of the Nursing Associate Role in Health and Social Care’ which is being carried out by the NIHR Health & Social Care Workforce Research Unit at King's College London.

## **Appendix K: Data management plan**

# **EVALUATING THE INTRODUCTION OF NURSING ASSOCIATES IN GENERAL PRACTICE IN THE NORTHEAST OF ENGLAND**

*A Data Management Plan created using DMPonline*

**Creator:** Annie Topping

**Affiliation:** University of Northumbria

**Funder:** RCN Foundation Professional Bursary Scheme

**Template:** DCC Template

**ORCID iD:** 0000-0002-5258-3290

**Grant number:** RCN 2192340

### **Project abstract:**

In 2015, the government announced the introduction of the Nursing Associate (NA) role in England. This was in response to 'The shape of caring' review published by Health Education England early that year. Amongst other objectives, it is intended that this new role will fill the skill gaps between the healthcare assistants (HCAs) and the registered nurses (RNs), and enable the RNs to focus on more complex clinical duties. It is the researcher's experience that GP Practices in the northeast are reluctant to put forward HCAs onto this training programme, as they are unsure of the added value of NAs. To date, there has been no published research evaluating the introduction of Nursing Associates in any front line services. This study will be examining the extent and the ways the introduction of NA has filled the skill gap between HCAs and RNs in General Practice in the northeast of England. The findings of this research will provide that much needed evidence to inform the ongoing uptake and development of the role of NA in General Practice, and the wider practice nursing teams. Case study approach will be used in this research. All practices in the northeast of England with registered NAs on the 31/3/2021 will be invited to become case study sites. Interviews and focus groups per test site will be undertaken to include Nursing Associates, Registered Nurses, GPs and Practice Managers. There will also be collection of information on nursing skill mix and activities, and other practice level management information to help assessment of impact on patient services. This research forms part of the 3-year part-time Professional Doctorate programme from 2019 to 2022, and the data collection phase will begin in January 2021 (subject to ethical approval).

**Last modified:** 19-07-2020

# **EVALUATING THE INTRODUCTION OF NURSING ASSOCIATES IN GENERAL PRACTICE IN THE NORTHEAST OF ENGLAND**

## **DATA COLLECTION**

### **What data will you collect or create?**

Work package 1:

The case studies will use a combination of in-depth semi-structured interviews and standardised measures to answer questions about the impact of NAs upon skill mix. There will be four interviews (one to one and group) per case study site/GP practice to include NAs, Practice Manager, GPs and Registered Nurses (RNs). The NIHR Health and Social Care Workforce Research unit (HSCWRU) is currently undertaking an evaluation of the NA role in the mental health and acute hospital settings. While the scope of their study is much broader, this evaluation will also be examining whether or not the introduction of NA has filled the skill gaps between HCAs and RN. The researcher has received permission from the lead researcher of HSCWRU to adopt or adapt the questions in case study interview schedule where appropriate and used them in this research.

Work package 2:

In each case study site, information on nursing skill mix and activities and other relevant management reports will be analysed to identify the way and extent of NAs have filled the skill gaps in GP practices.

### **How will the data be collected or created?**

#### Collection

Based on the breakdown provided by Health Education England, there have been 4 intakes of 26 trainee NAs in GP practices across the 7 clinical commissioning groups (CCGs) in the northeast of England since the introduction of this role. The training is 2-years long so the working assumption is that most or all of them would have qualified by March 2021. All their employing GP practices will be invited to become case study sites, and Directors of Nursing at the 7 CCGs will be approached to assist with recruitment of GP practices to become case study sites in their area.

Participants will be recruited in three cohorts/groups based primarily on the intake dates, and interviews and focus groups will take place at least 6 months after the NAs have qualified. This will allow a period of time for this role to embed into the nursing team, and the working assumption is that this will allow the other participant groups (Registered Nurse, Practice Managers and GPs) more able to appraise the extent and ways the introduction of this new role has filled the skill gap between healthcare assistants and Registered Nurses in GP Practices. One to one and group interviews with NAs, Registered Nurses (RNs), GPs and practice managers (PMs) will be undertaken in the respective GP Practice case study site.

There will also be collection and analysis of information on nursing skill mix and activities, and other practice level management information to help assessment of impact on patient services as a result. This information will be supplied by the case study sites.

#### Creation

Qualitative 1:1 and focus group interviews will be digitally recorded and transcribed anonymously. Once transcribed and checked for accuracy, the digital recording will be deleted. Transcription data will be held on a secured and password protected University system.

Information on nursing skill mix and activities, and other practice level management information from each case study site will be transferred to Microsoft word and Excel for analysis during the data collection phase (20 months duration - subject to timing of IRAS approval) and stored within a password secured university server.

All data will be obtained and held in accordance with GDPR guidelines outlined in The Data Protection Act (2018) and as per the University of Northumbria Research Data management policy: <https://northumbria-cdn.azureedge.net/-/media/corporate-website/new-sitecoregallery/research/research-data-management/research-data-management-policy---version-11--01,-d-,05,-d-,2019.pdf?modified=20190502080554&la=en&hash=FC96BE9A1054394109182D39D5EA112785191099>

Research records will be named according to University of Northumbria records management policy: <https://northumbria-cdn.azureedge.net/-/media/corporate-website/documents/pdfs/about-us-corporate/legal-services-team/guide-to-electronic-file-naming.pdf?modified=20170221102316>

## **DOCUMENTATION AND METADATA**

### **What documentation and metadata will accompany the data?**

Research data alongside files generated from analysis (Word / Excel / NVivo) will be stored for 7 years from the completion date of the study at the University of Northumbria as per section 10 of the Records Retention Schedule within a secured and password protected server.

A list of Clinical Commissioning Groups in the northeast of England together with the numbers of GP practices in each area participated in the study will be provided.

Qualitative data will include a report of the thematic analysis, indexes in transcripts, the formulation of codes, themes and sub themes.

Quantitative data extracted from the workforce and management information of each case study, alongside with analysis, will be presented in an Excel.

## **ETHICS AND LEGAL COMPLIANCE**

### **How will you manage any ethical issues?**

Written invitations to GP practices to participate in this study will be sent to Clinical Commissioning Groups to forward to the relevant GP Practices. All GP Practices with qualified NAs in the 7 Clinical Commissioning Groups in the northeast of England @31 March 2021 will be invited to become a case study site. GP practices will be asked to contact the researcher if they are happy to participate in the research.

All the participants will be NHS staff working in GP Practices in the northeast of England, and no patients will be involved in this study and no patient records will be reviewed. Participants in each case study sites will be identified by the respective GP practice / case study site. The researcher will not require access to identifiable personal information to invite participants.

Study information including the participant information sheet and consent form will be sent to the potential participant in advance of the interviews and focus group, in order to ensure there is sufficient time to make a decision to participate. The participants will be given at least 10 working days' notice before the interviews or focus groups take place. This will provide the participants time to decide if they want to take part or not, and questions they wish to be answered before the interviews or focus groups take place. The researcher will be working to a 4 weeks' notice in practice so to avoid any disruption to clinical activities. No issues related to mental capacity are envisaged as only NHS staff are included in this study. Consent forms including permission to preserve and store data will be obtained from the participants before focus group or one to one interviews.

Participants will only be involved in one to one and group interviews, and it is not envisaged that there will be any potential adverse effects, pain, discomfort, intrusion, or changes to lifestyle to participants. The interviews will be carried out in GP practices during working hours Mondays to Fridays, and will be incorporated in between existing workload. This could cause inconvenience and increase burden to participants. The researcher will work with the GP practices and the participants to identify appropriate time to carry out interviews, and that there will no disruptions to patient and clinical activities.

The researcher recognises that there is a potential for the participants to feel upset in interviews for whatever reasons. If this happens, the interviews will be stopped immediately and rearranged if appropriate. All participants will be informed that they are free to leave the study at any time without having to give a reason, without any impact to their jobs. The researcher who will carry out the interview is a Registered Nurse and is experienced in dealing with distressed and upset patients and service users. The participants may also have concerns of breach of confidentiality and the details of discussions are attributed to the individuals. As part of the consenting process, clarifications and assurance will be given to allay any anxiety.

Pseudonymisation of data will be carried out to ensure the confidentiality of personal data, and the names and other identifiers (i.e. job title and place of work / name of GP practice) of participants will be replaced with a reference number. This pseudonymisation log will be password protected and stored electronically in the personal secured space in the University's secure 'U' drive server. Reference numbers will be used in the written transcripts of 1:1 interview and focus group discussions. This research is to be carried out using case study approach. It is recognised that GP practice is a small organisation with relatively small numbers of employee, so there is a high possibility that the participant will be indirectly identifiable when their place of work and job title / role are linked together. Therefore, all geographical details of practices will be removed in the reporting of the findings and quotes will be anonymised. It is not envisaged that there will personal data in the management and nursing skill mix information, and if so, they will be replaced by reference numbers. All personal data (name and post of the participants, and employing GP practices) will be destroyed as soon the viva has taken place and the DBA programme has completed. No personal data will be included in publication, and quotes from participants in interviews will be anonymised if included in the thesis.

As a Registered Nurse, the researcher is required to act in accordance to the Code of Professional Conduct published by the Nursing and Midwifery Council. A number of standards in the Code are relevant to the research activity, particularly (5) Respect people's right to privacy and confidentiality. The researcher will be adhering to this requirement at all times.

The Caldicott Principles will be adhered to. No patients will be involved in this study and no patient records will be reviewed. All research data will be obtained and held in accordance with GDPR guidelines outlined in The Data Protection Act (2018) and as per the University of Northumbria Research Data management policy. Recorded interviews and written materials and notes of meetings will be destroyed as soon as the study has been written up and the viva has taken place. As a NHS staff, the Department of Health's Records Management Code of Practice for Health and Social Care 2016 will also be applied. In line with the appendix 3 of the Code, the research dataset will not be retained for more than 20 years (in this case 7 years as per university policy) and at the end of the retention period, the dataset will be reviewed and considered to be transferred to a Place of Deposit.

The researcher is aware of the policy development of NA in her capacity as the Director of Nursing at Northumberland Clinical Commissioning Group (CCG), and has been involved in the introduction of this role in the northeast as part of the national roll out. However the researcher does not work in GP Practices in the region. The employing organisation of the researcher (CCG) does not employ Nursing Associates, and the researcher does not work with this staff group directly in her daily work. The focus of the research is on the impact of this role in clinical practice, and therefore, the researcher does not consider that there will be any conflict of interests with her role as a healthcare professional, and the integrity of the research may be or perceived to be compromised.

#### **How will you manage copyright and Intellectual Property Rights (IPR) issues?**

Data generated will be owned by the University of Northumbria. There is no intention to license the data for reuse. Any results generated will remain the intellectual property of Northumbria University. There is no second or third party data generated within this study.

The researcher has received a small education grant from RCN Foundation Professional Bursary Scheme. As part of the terms and conditions, a report will be provided at the end of the DBA programme on the benefits of the course to patient care, which may be published on the RCN Foundation website. The researcher may also be asked to present the findings at an RCN Foundation event. The bursary from the RCN Foundation will be acknowledged in all publications, presentations and posters arising from this funded activity.

The researcher will be the data guardian and the University of Northumbria will be the data controller. There will be no license or restrictions other than when the research is published. This research will not lead to the development of a new product/process or the generation of intellectual property, and no patenting issues are expected.

#### **STORAGE AND BACKUP**

##### **How will the data be stored and backed up during the research?**

The laptop used by the researcher to carry out the research study and access the University's server is provided by the NHS, and is maintained by the Northeast Commissioning Support Unit with up to date firewall protection and other necessary security.

Audio recordings will be destroyed once written transcription is completed within 21 working days. Hard copies of the consent form will be initially stored in a locked cabinet allocated to the researcher in the CCG office. They will then be scanned within 48 hours and then stored in the University's secured One-drive server, and the hard copies will then be destroyed appropriately as confidential waste. Electronic files with confidential or personal data will be password protected/encrypted

All research data and associated files such as interview recordings and transcripts and data analysis will be stored within the University of Northumbria secured Microsoft one-drive server which enables real time back-up of all data files. Recovery of user profiles is possible through the restore feature.

A back-up will also be made following each contact with downloaded data / data analysis files onto the secure university 'U' drive server. Support is provided for both one drive and university services by 24 hr IT support team.

University of Northumbria has sufficient data storage available to meet the needs of this study and on-going storage requirements.

##### **How will you manage access and security?**

Access to all storage drives and online data collection is password protected and limited to the researcher as the chief investigator only.

Hard copies of the consent form will be initially stored in a locked cabinet allocated to the researcher in the office of NHS Northumberland Clinical Commissioning Group (employer). They will then be scanned within 48 hours and then stored in the University's secured One-drive server, and the hard copies will then be destroyed appropriately as confidential waste.

#### **SELECTION AND PRESERVATION**

### **Which data are of long-term value and should be retained, shared, and/or preserved?**

All research data and analysis will be managed in accordance with GDPR guidelines outlined in The Data Protection Act (2018) and as per the University of Northumbria Research Data management policy v11 May 2019 section 10. This includes recording, storage and retention of research data. The ethical risk level for this study is classified as high as it involves NHS staff, and in accordance with the University's Research Records Retention Schedule (principle of storage limitation), the data will be retained in an appropriate format for a period of at least 7 years.

As a NHS staff, the Department of Health's Records Management Code of Practice for Health and Social Care 2016 will be applied. Appendix 3 of the Code contains the detailed retention schedules and specifies that research dataset should not be retained for more than 20 years. In this case, the University's 7-year retention period will meet its requirement. At end of the retention period, the research data will be destroyed / transferred to a Place of Deposit.

Audio recordings will be destroyed once written transcription and checking are completed. The transcripts of the interviews and focus groups and the analysis will include participant reference numbers only, and will be stored in the researcher's personal secured space on Northumbria University's U drive for 7 years.

Hard copies of the consent form will be initially stored in a locked cabinet allocated to the researcher in the CCG office. They will then be scanned within 48 hours and then stored in the University's secure U drive, and the hard copies will then be destroyed appropriately as confidential waste.

The data will be stored in the University's secure U drive. There will be no additional cost for this data to be archived. There is no anticipated cessation to the IT infrastructure that the University provides.

### **What is the long-term preservation plan for the dataset?**

All personal data (name and post of the participants, and employing GP practices) will be destroyed as soon the viva has taken place and the DBA programme has completed.

## **DATA SHARING**

### **How will you share the data?**

The researcher is considering to use an external organisation in UK to transcribe the 1:1 and focus group interviews. Otherwise, there will be no sharing of data. Should this be the case, the Records and Information manager of the University of Northumbria will be consulted with regard to the transfer of anonymous audio recordings outside of the organisation, and Northumbria University Ethics Committee will also be informed. The researcher will also submit an amendment to Health Research Authority (HRA) via IRAS detailing the transfer of anonymous data.

The data will be analysed in the UK by the researcher and stored as password encrypted documents on the University's secure server. There is no plan to export data outside the UK.

Long-term sharing will be managed by the guidelines of the University of Northumbria.

### **Are any restrictions on data sharing required?**

Consents will be obtained from all participants and the possibility of sharing the data for transcription purposes will be clearly stated.

There are no other restrictions on data sharing.

## **RESPONSIBILITIES AND RESOURCES**

### **Who will be responsible for data management?**

The researcher will be the guardian of the generated data, including the implementation and adherence to this data management plan (DMP), data capture, metadata, quality, storage and initial archive. The DMP will be reviewed on a regular basis and revised/updated accordingly.

The University of Northumbria will maintain the storage of the data archive on One drive, 'U' drive server and future data sharing.



**What resources will you require to deliver your plan?**

All resources are currently available and supported by the University of Northumbria IT services to meet the requirements of this data management plan.

## Appendix L: Research protocol - Extracted from the Health Research Authority Qualitative Protocol Development Tool

### STUDY PROTOCOL

Evaluating the introduction of Nursing Associates in General Practice in the northeast of England

#### 1 BACKGROUND

Nursing Associate (NA) is a new role in the nursing team in England and the first cohort of trainees only graduated in January 2019. The development of the NA role is in response to 'The Shape of Caring' Review, (raising the bar) published by Health Education England in March 2015. It intends to create a significant shift within the nursing and care workforce and in turn, supports delivery of high quality care over the next few decades. The NAs offer a higher skillset and it is hoped that they will bridge the gap between healthcare assistants (HCAs) and Registered Nurses (RNs). As well as providing a clear career progression for HCAs, it is also hoped that this development will lead to an increased supply of nurses, creating capacity to allow nurses to develop more advanced skills.

Against the backdrop of shortage of RNs and an increasing numbers of unregistered support workers<sup>1</sup>, the role of NA has the potential to make a significant contribution to care<sup>2</sup> and one would have expected it to have received a warm welcome by the nursing profession and families/carers. However this has not proved to be the case and it is evident that there is a high degree of scepticism and many concerns over its introduction.

The first issue is its 'ill-defined role'. The Royal College of Nursing (RCN) cautioned that this would lead to NAs being asked to carry on duties outside the remit of a support role, and as a result, adversely impact on patient care.<sup>3</sup> Questions were also raised as to whether the role of NA differed sufficiently from the role of 'abolished' enrolled nurse and the existing nursing practitioner.<sup>4</sup>

The real and main concern is that the introduction of NAs would dilute expertise on the front line and pose a substantial risk to patient safety, and there are strong opinions<sup>5 6 7 8 9 10</sup> expressed. There is no evidence as to what may happen to replace nurses with NAs,<sup>11</sup> and some critics have suggested that the introduction of the NA role is a means of cutting the costs of healthcare delivery. Nursing experts have warned against the substitution of nurses

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<sup>1</sup> Professor Elizabeth Rosser, Nursing associate: a new role to enhance care (Nursing in Practice 13th June, 2016) <<https://www.nursinginpractice.com/article/nursing-associate-new-role-enhance-care>> accessed 29 May 2019

<sup>2</sup> Sam Foster, 'Introducing the nursing associate role' (2016) 25(5) Br J Nurs 233

<sup>3</sup> Rebecca Gilroy, 'RCN concerned nursing associate role remains ambiguous' (2018) Independent Nurse <<http://www.independentnurse.co.uk/news/rcn-concerned-nursing-associate-role-remains-ambiguous/176176/>> accessed 29 May 2019

<sup>4</sup> Petra Kendall-Raynor, 'Is the nursing associate role an innovation or a step backwards?' (2016) 30(20) Nursing Standard 12

<sup>5</sup> Nadine Falconer, 'Nursing Associates' (2016) 31(9) Nursing Standard 32

<sup>6</sup> Jennifer Trueland, 'Why the nursing associate role is dividing opinion' (2018) 33(6) Nursing Standard 44

<sup>7</sup> Longhurst Chris, 'Concern remains over nursing associate role' (2017) 31(27) Nursing Standard 10

<sup>8</sup> Kendall-Raynor n4

<sup>9</sup> Foster n(2)

<sup>10</sup> Jo Stephenson, 'NHS eyeing nursing associates to plug nurse gaps, leaked report suggests' Nursing Times (2019) Nursing Times <<https://www.nursingtimes.net/news/workforce/nhs-eyeing-nursing-associates-to-plug-nurse-gaps-leaked-report-suggests-04-12-2019/>> accessed 14 December 2019

<sup>11</sup> University of Southampton chair of health services research Peter Griffiths as quoted in Longhurst Chris, 'Concern remains over nursing associate role' (2017) 31(27) Nursing Standard 10

with less qualified staff,<sup>12</sup> and an eminent academic<sup>13</sup> believes that the role poses a substantial risk to patient safety and has called for evaluation of the effect on patient outcomes and patient safety. Others have proposed that the role of NA requires robust quality assurance for the safety and effectiveness of clinical practice.<sup>14</sup>

Indeed there is growing global evidence gathered by high profile academics including the current RCN President Professor Anne Marie Rafferty<sup>15</sup> to show more nurses with the right skills and support are needed in order to reduce patient mortality and improve nurses' wellbeing.<sup>16</sup> These findings showed hospitals with a greater proportion of professional nurses in their bedside workforce is associated with better outcomes for patients and nurses. Aiken L H et al<sup>17</sup> reviewed the surgical mortality data of 243 hospitals in 6 EU countries (included NHS Hospitals in England) and found that deaths were significantly lower in hospitals with fewer patients per RN and patient satisfaction rates were also higher in hospitals with good RN ratios. The research also showed that substituting one RN for one nursing support worker is associated with a 21% increase in chance of death, and poor staffing level also leads to lower patient satisfaction levels. The above echoed the conclusions of another retrospective longitudinal study<sup>18</sup> on nurse staffing and hospital mortality, and highlights the adverse consequences of compensating RNs with lower skill staff. Although there has been no similar study on staffing skill-mix and patient outcomes in an out of hospital setting including primary care, the findings of these two pieces of research have nevertheless reinforced the belief of some that the role of NAs is a negative development and detrimental to patient care.

On the other hand, some have welcomed and are positive about this development, particularly the nursing profession.<sup>19</sup> There is recognition that the NA role is intended to complement the existing registered nursing workforce<sup>20 21</sup> and widen access to the nursing profession.<sup>22 23</sup> This will also help to address the current needs and pressures of the NHS as a consequence of staff shortages. With more complex patients to be cared for in the primary and community setting, there is a need for the RN to become an autonomous practitioner with advanced nursing skills, and the introduction of NA can facilitate this.<sup>24</sup> Clearly there are different views on this new development, and evidence is needed to confirm and challenge these diverse opinions.

In early 2017, HEE commissioned an evaluation of the introduction of NAs, covering the 2-year pilot of the programme in 35 pilot sites. The phase 1 report was published in July 2018 and the year 2 (final report) issued in October 2019. Both reports were primarily focused on evaluating the training and development of the first cohort of trainees over the 2-year programme. The study showed there was 'limited understanding and acceptance' of

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<sup>12</sup> Shaun Lintern, 'Leaked NHS document reveals government plan to use cheaper staff to fill nurse vacancies' Independent (London 3 Dec 2019) <<https://www.independent.co.uk/news/health/nhs-nurses-leaked-documents-staffing-care-a9230101.html>> accessed 4 Dec 2019

<sup>13</sup> Alison Leary, Professor of healthcare and workforce modelling at London South Bank University and Peter Griffiths .

<sup>14</sup> Alan Gasper, 'The nursing associate: a welcome new member of the NHS family?' (2017) 26(5) Br J Nurs 294

<sup>15</sup> RCN President

<sup>16</sup> Royal College Nursing Bulletin, 'Research proves we need safe staffing' ( 23 July 2019) <<https://www.rcn.org.uk/magazines/bulletin/2019/august/qa-research-behind-safe-staffing-aug-2019>> accessed 14 January 2020

<sup>17</sup> LH Aiken LH, D Sloane, P Griffiths, et al, 'Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care' (2017) 26 BMJ Qual Saf p559

<sup>18</sup> P Griffiths, A Maruotti, A Saucedo Recio, et al. Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study BMJ Qual Saf 2019; 28:609–617

<sup>19</sup> Gasper n14

<sup>20</sup> Elizabeth Rosser, 'Nursing associate: our chance to influence' (2016) 25(6) British Journal of Nursing 336

<sup>21</sup> Danny Mortimer, How the new nursing associate role will break new ground (NHS Confederation 17 April 2019) <<https://www.nhsconfed.org/blog/2019/04/how-the-new-nursing-associate-role-will-break-new-ground>> accessed 29 May 2019

<sup>22</sup> Zoe Morgan, 'Nursing Associates' (2017) 31 (20) Nursing standard 28

<sup>23</sup> Ruth Williams, 'Nursing Associates' (2017) 24(8) Nursing Management 11

<sup>24</sup> Rosser n(1)

this controversial new role among the nursing profession.<sup>25</sup> Findings also showed that while the trainees felt they had brought additional capacity to their workplace, some of them were still being viewed as HCAs. It was reported that trainees were making a greater contribution to service delivery and to patient care, and they were able to assist nurses with a greater range of care giving responsibilities. As a result, this had freed up nurses to focus on more on complex tasks and is leading to faster and more responsive care.

The researcher is aware that the NIHR Health & Social Care Workforce Research Unit (HSCWRU)<sup>26</sup> has been commissioned to undertake a new evaluation of the NA role which builds on the work undertaken by Traverse. This will examine the extent to which it has achieved the policy aims of providing a new route into nursing and of reducing the skills gap between healthcare assistants and registered nurses.<sup>27</sup> Based on the discussion with its lead researcher, the researcher understands that no GP practices have been recruited and the focus of this evaluation is on the mental health and acute hospital settings only. This study is due to be completed in 2023 although it is currently being put on hold due to Covid-19. To date, little is known about the actual impact of NAs working in hospitals or out of hospital settings in England on patient care and service quality, and there has been no published research or formal evaluation on this.

Case study approach will be used in this research. All practices in the northeast of England with registered NAs on the 31/3/2021 will be invited to become case study sites. Interviews and focus groups per test site will be undertaken to include Nursing Associates, Registered Nurses, GPs and Practice Managers. There will also be collection of information on nursing skill mix and activities, and other practice level management information to help assessment of impact on patient services.

## 2 RATIONALE

The introduction of Nursing Associates has 3 policy intentions: (1) to provide a new route into nursing; (2) to fill the skill gaps between health and care assistants (HCAs) and registered nurses (RNs); (3) to retain a motivated workforce. The research aims to investigate intention 2. The key research question of this study is:

To what extent and what way does the introduction of nursing associates in General Practices in the northeast of England fill the skill gaps between HCAs and RNs?

The evaluation of the 35 pilot sites by Traverse showed that the trainee NAs felt they had brought additional capacity to their workplace, and were able to assist nurses with a greater range of care giving responsibilities. As a result, this had freed up nurses to focus on more on complex tasks and is leading to faster and more responsive care. None of the Clinical Commissioning Groups or GP practices from the northeast was a Nursing Associate test site, so they were not included in this piece of work.

To date, little is known about the actual impact of qualified NAs working in hospitals or out of hospital settings in England on patient care and service quality, and there has been no published research or formal evaluation on this. The researcher believes that the findings of this research will provide that much needed evidence to inform the ongoing development of the role of NA in General Practice in the northeast of England and beyond.

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<sup>25</sup> Jo Stephenson, 'Evaluation of associate pilot sites reveals 'positives' and 'challenges' from first wave' (2018) Nursing Times <<https://www.nursingtimes.net/news/education/nursing-associate-evaluation-reveals-positives-and-challenges/7025523.article>> accessed 26 May 2019

<sup>26</sup> HSCWRU) is a research partnership between King's College London and the Institute for Fiscal Studies

<sup>27</sup> King's College London, 'Examining the Introduction of the Nursing Associate Role in Health and Social Care' <<https://www.kcl.ac.uk/scwru/res/roles/nursing-associates>> accessed 24 September 2019

The study will be examining the extent and the ways the introduction of NA has filled the skill gap between HCAs and RNs in General Practice in the northeast of England.

### 3 THEORETICAL FRAMEWORK

Based on the researcher's assumptions about the source and nature of knowledge, ontologically speaking, the researcher would consider herself as a pragmatist with no firm commitment to any particular theory, method or ideology. Pragmatism originates from the work of Charles Sanders Pierce, William James, George Herbert Mead and John Dewey,<sup>28 29</sup> and is situations and actions orientated. One the most important features of pragmatism is that it rejects the distinction between realism and anti-realism. For pragmatists, there is no such a thing as reality, and it is ever changing based on our actions. Therefore attempts to find a lasting, external reality are set to fail and Dewey called this a "spectator theory" of knowledge. The researcher's philosophical standing as a pragmatist is perhaps a reflection of her background in the NHS and patient care, where the focus is on actions, consequences and problem solving, and truth is what works at the time. Her daily work concerns with evidence and consistency of service quality, and this had provided the underpinning for the research methodology and methods.

Tashakkori & Teddlie<sup>30</sup> describes pragmatism is a paradigm that 'focuses instead on 'what works' as the truth regarding the research questions under investigation'. In embracing pragmatism as the underpinning research philosophy, this means a combination of objective and subjective ontological positions will be adopted to carry out the research. This way, it will allow the topic to be evaluated from both viewpoints. The research will be a mixed methods study using both inductive and deductive approaches. Qualitative and quantitative methodology will be employed in drawing assumptions during the research, as well as using different methods to collect and analyse data. More details on the methodology are provided in the following sections.

The Nursing Associate role is in its early stage of development and the numbers of practices in the northeast of England with qualified NAs are comparatively very small. Case study approach has been adopted because it allows an in depth focus on a case (in this case a GP practice) while retaining a holistic real world perspective.<sup>31</sup> There is a variety of philosophical stance in relation to case study. In choosing a methodological position, careful consideration of the different case study approaches has been taken by the researcher to determine the design that best addresses the aim of the study, and that aligns with her worldview. Robert Yin is one of three prominent methodologists in case study research, and he describes his approach to case study as using a 'realist perspective'<sup>32</sup> and focuses on maintaining objectivity in the methodological processes within the design. Precision (how credible the sample is), process, and practicality are considered to be the core attributes of Yin's approach to case study.<sup>33</sup> These characteristics together with Yin's logical approach in research design<sup>34</sup> and his emphasis on validity and reliability are indeed in tune with the researcher's own personal values.

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<sup>28</sup> John Creswell, *Research Design, qualitative, quantitative, and mixed methods approaches* (4th Edition) 2014

<sup>29</sup> Michael Crotty, *The Foundations of Social Research* (1998, reprinted 2015) Sage Publications Ltd p10

<sup>30</sup> A Tashakkori & C Teddlie, *Handbook of Mixed Methods in Social & Behavioral Research*. (Thousand Oak: Sage 2003) p713

<sup>31</sup> Robert K Yin, *Case Study Research and Applications* (6th edition, Sage 2018) page 5

<sup>32</sup> Yin (n31) page 16

<sup>33</sup> Harrison Helena et al, 'Case Study Research: Foundations and Methodological Orientations' (2017)

<<http://www.qualitative-research.net/index.php/fqs/article/view/2655/4079>> accessed 13/4/2020

<sup>34</sup> Yin (n21) page 26

## **4 RESEARCH QUESTION/AIM(S)**

### **4.1 Objectives**

The introduction of Nursing Associates has 3 policy intentions: (1) to provide a new route into nursing; (2) to fill the skill gaps between health and care assistants (HCAs) and registered nurses (RNs); (3) to retain a motivated workforce. The research aims to investigate intention 2. The key research question is:

To what extent and what way does the introduction of nursing associates in General Practices in the northeast of England fill the skill gaps between HCAs and RNs?

The secondary questions are:

1. How is the Nursing Associate role used in General Practices?
2. Whether or not the NA role has encouraged a re-profiling of practice nursing teams or deployment, in terms of the allocation of tasks and responsibilities.
3. What are the tasks and responsibilities that are delegated from the Registered Nurses to Nursing Associates?
4. What is the impact of the new way of working on the Practice Nurses themselves and service delivery?

### **4.2 Outcome**

One of the policy intentions for the introduction of NAs is to fill the skill gaps between health and care assistants (HCAs) and registered nurses (RNs). The primary outcome measure of this study is the range of responsibility and tasks delegated and transferred to Nursing Associates from the Registered Nurses in GP practices.

They are:

- 1) Re-profiling of the practice nursing team in the GP practice as a result of the introduction of Nursing Associates.
- 2) Different way of service delivery (if any).
- 3) The way how Registered Nurses are working differently.

## **5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYSIS**

Case study approach will be used in this research and GP practices will be recruited as case study sites. Face to face interviews and focus group discussions per test site (GP practice) will be undertaken by the researcher at the GP practice.

One to one interviews will be carried out with Nursing Associates and Practice Managers. Focus group discussions will be carried out with Registered Nurses and GPs. An interview schedule with semi structure questions will be used to guide the discussions. All interviews and focus group discussions will be audio recorded with consent, and then transcribed within 21 working days. The names and other identifiers (i.e. job title and place of work / name of GP practice) of participants will be replaced with a reference number. Reference numbers will be used in the written transcripts of 1:1 interview and focus group discussions.

Data analysis will be carried out using Microsoft Word and Excel, and computer assisted tools e.g. NVivo. Reference numbers will be used in this process.

There will also be collection and analysis of information on nursing skill mix and activities, and other practice level management information to help assessment of impact on patient services as a result. It is not envisaged that there will personal data in the management and nursing skill mix information, and if so, they will be replaced by reference numbers.

## **6 STUDY SETTING**

This is a multi-site case study. GP practices will be recruited as case study sites. All one to one and group interviews with participants will take place in the respective GP Practice case study site. This will help to minimise any disruption to clinical activities.

## **7 SAMPLE AND RECRUITMENT**

### **7.1 Eligibility Criteria**

#### **7.1.1 Inclusion criteria**

All GP practices in the northeast that have employed qualified Nursing Associates on the 31/3/2021 will be invited to take part in this study.

#### **7.1.2 Exclusion criteria**

General Practices in the seven CCGs in the northeast of England with no qualified Nursing Associates on the 31 March 2021 will be excluded in the research study.

### **7.2 Sampling**

#### **7.2.1 Size of sample**

Based on the information from Health Education England, there could be a total of 26 qualified Nursing Associates (NAs) by March 2021:

<b>CCG</b>	<b>Numbers of NAs</b>
County Durham	7
Newcastle Gateshead	6
North Tyneside	1
Northumberland	6
South Tyneside	1
Sunderland	1
Tees Valley	4
Total	26

All GP practices employing these 26 NAs will be invited to take part in this research. Due to information governance restriction, it is not possible to establish the total numbers of GP practices at this stage.

### **7.2.2 Sampling technique**

All the participants will be NHS staff working in GP Practices in the northeast of England. A purposive sampling technique will be adopted, and written invitations to participate will be sent to Clinical Commissioning Groups to forward to the relevant GP Practices (those with registered NAs at 31/3/2021). The researcher is well aware of the search nationally and locally for evidence to underpin the implementation of the new role of Nursing Associate in the NHS. As a clinician working in one of the Clinical Commissioning Groups in the northeast, the researcher is confident that through the support of her colleagues, GP Practices will be encouraged to take part in this research and access issues could be overcome.

## **7.3 Recruitment**

### **7.3.1 Sample identification**

An invitation letter/email together with a Participant Information Sheet (GP practice) will be emailed out to the Directors of Nursing of the 7 CCGs in the northeast of England for forwarding to the relevant GP practices in their area. Practices are asked to send their expressions of interest directly to the researcher and a database will be kept for purposive sampling, ensuring at least one GP practice in each CCG area and a mix of urban and rural communities. The researcher will then contact the Practice Manager and/or the senior Partner of the selected GP practices to discuss any queries they may have, and arrangements for interviews and focus groups. GP practices/ case study sites will be asked to identify the participants. This list of participants with their contact details will be used to organise interviews and focus groups, and a Participation Information Sheet (NHS staff) and a consent form will be sent out to participants in advance.

The 'UK Information Pack' will be used for setting up participating NHS organisations (GP practices). The pack will include:

- Covering email using standard template format
- Localised Organisation Information Document
- Schedule of Events (SoECAT)
- Relevant supporting documents

### **7.3.2 Consent**

The participants in this research will only be NHS staff. No patients will be involved in this study and no patient records will be reviewed. No issues related to mental capacity are envisaged.

This list of participants with their contact details will be used to organise interviews and focus groups, and a Participation Information Sheet (NHS staff) and a consent form will be sent out to participants in advance. Consent forms will be obtained from the participants in these GP practices by the researcher before one to one or focus group interviews.



## **8 ETHICAL AND REGULATORY CONSIDERATIONS**

### **8.1 Assessment and management of risk**

The study involves one to one and group interviews of NHS staff only, and it is not envisaged that there will be any potential adverse effects, pain, discomfort, intrusion, or changes to lifestyle to participants. I can confirm that there are no physical risks associated with this project and so no risk assessments are required.

The interviews will be carried out in GP practices during working hours Mondays to Fridays, and will be incorporated in between existing workload. This could cause inconvenience and increase burden to participants. The researcher will work with the GP practices and the participants to identify appropriate time to carry out interviews, and that there will no disruptions to patient and clinical activities.

The researcher recognises that there is a potential for the participants to feel upset in interviews for whatever reasons. If this happens, the interviews will be stopped immediately and rearranged if appropriate. All participants will be informed that they are free to leave the study at any time without having to give a reason, without any impact to their jobs. The researcher who will carry out the interview is a Registered Nurse and is experienced in dealing with distressed and upset patients and service users. The participants may also have concerns of breach of confidentiality and the details of discussions are attributed to the individuals. As part of the consenting process, clarifications and assurance will be given to allay any anxiety.

The researcher is the Director of Nursing of a CCG and has adult and children safeguarding in her remit. Enhanced DBS clearance is in place and the latest certificate was issued in April 2020. If the participant discloses any information / issues related to safeguarding, this will be handled appropriately and referred to the relevant safeguarding team.

Only nursing skill mix data and practice level management information will be collected to help assessment of impact on patient services, and no patient identifiable information will be gathered or analysed in this research.

### **8.2 Research Ethics Committee (REC) and other Regulatory review & reports**

Following independent peer review of the research proposal (ref: 24705), ethical approval has been granted by University of Northumbria at Newcastle (study sponsor) on the 28 July 2020. The university will be notified of any changes to the research design, and any incidents which have an adverse effect in participants, researcher or study outcomes.

In addition, the application to HRA together with the associated documentation has been reviewed by the study sponsor as part of Northumbria's IRAS Internal Approval process.

After approval is provided by the NHS Health Research Authority:

- Substantial amendments that require further review by the REC will not be implemented until that review is in place and other mechanisms are in place to implement at site.
- All correspondence with the REC will be retained.
- Chief Investigator will produce the annual reports as required.
- The Chief Investigator will notify the REC of the end of the study.
- An annual progress report (APR) will be submitted to the REC within 30 days of the anniversary date on which the favourable opinion was given, and annually until the study is declared ended.

- If the study is ended prematurely, the Chief Investigator will notify the REC, including the reasons for the premature termination.
- Within one year after the end of the study, the Chief Investigator will submit a final report with the results, including any publications/abstracts, to the REC.

## **Regulatory Review & Compliance**

Patients are not participants of this study.

For any amendment to the study, the Chief Investigator or designee, in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator or designee will work with sites so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as [amended](#).

## **Amendments**

If the sponsor wishes to make a substantial amendment to the REC application or the supporting documents, the sponsor will submit a valid notice of amendment to the REC for consideration. It is the sponsor's responsibility to decide whether an amendment is substantial or non-substantial for the purposes of submission to the REC. Amendments will also be notified to the participating sites (GP Practices), so they can decide if they wish to remain in the study.

The researcher will be responsible to amend the protocol under the guidance of the Chief Investigator / supervisor. The Chief Investigator and the study sponsor will decide whether an amendment is substantial or non-substantial, and notify REC of the substantial changes in writing if necessary.

All protocol will be version control to track amendment history and changes.

### **8.3 Peer review**

The research proposal had gone through an independent peer review by the University of Northumbria at Newcastle as part of the internal ethical approval process in July 2020.

### **8.4 Patient & Public Involvement**

No aspects of the research process have actively involved, or will involve, patients, service users, and/or their carers, or members of the public.

### **8.5 Protocol compliance**

Accidental protocol deviations can happen at any time, and they will be adequately documented on the relevant forms and reported to the Chief Investigator and Sponsor immediately. The Sponsor will be informed of any changes to the study design through the 'Ethics Amendment Form, and any incidents which have an adverse effect on the participants, researcher or study outcomes will be reported by the researcher through the 'Ethical Incident Form'.

### **8.6 Data protection and confidentiality**

The researcher will comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles. The researcher will be responsible for the use, security and management of all data generated by the study. Only NHS staff are included in this study.

### Confidentiality

As a Registered Nurse, the researcher is required to act in accordance to the Code of Professional Conduct published by the Nursing and Midwifery Council. A number of standards in the Code are relevant to the research activity, particularly (5) Respect people's right to privacy and confidentiality. The researcher will be adhering to this requirement at all times.

The Caldicott Principles will be adhered to. No patients will be involved in this study and no patient records will be reviewed. Recorded interviews and written materials and notes of meetings will be destroyed as soon as the study has been written up and the viva has taken place.

### Personal data

Pseudonymisation of data will be carried out to ensure the confidentiality of personal data, and the names and other identifiers (i.e. job title and place of work / name of GP practice) of participants will be replaced with a reference number. This pseudonymisation log will be password protected and stored electronically in the secure central U drive of University of Northumbria. Reference numbers will be used in the written transcripts of 1:1 interview and focus group discussions.

This research is to be carried out using case study approach. It is recognised that GP practices are small organisations with relatively small numbers of employee, so there is a high possibility that the participant will be indirectly identifiable when their place of work and job title / role are linked together. Therefore, all geographical details of practices will be removed in the reporting of the findings and quotes will be anonymised.

It is not envisaged that there will personal data in the management and nursing skill mix information, and if so, they will be replaced by reference numbers.

All personal data (name and post of the participants, and employing GP practices) will be destroyed as soon the viva has taken place (usually 3 months after submission date of 30 Sept 2022) and the DBA programme has completed.

### Processing

This is an educational research and only the researcher has access to the participants' personal data during the study.

The data will be analysed in the UK by the researcher and stored as password encrypted documents on the central secure server of University of Northumbria. There is no plan to export data outside the UK.

### Storage

All research data and associated files such as interview recordings and transcripts and data analysis will be stored electronically in the secure U drive of University of Northumbria's,

which enables real time back-up of all data files. Recovery of user profiles is possible through the restore feature.

Audio recordings will be destroyed once written transcription is completed within 21 working days. Hard copies of the consent form will be initially stored in a locked cabinet allocated to the researcher in the CCG office. They will then be scanned within 48 hours and then stored in the University's secure central server, and the hard copies will then be destroyed appropriately as confidential waste. Electronic files with confidential or personal data will also be password protected/encrypted.

University of Northumbria has sufficient data storage available to meet the needs of this study and on-going storage requirements. Research data alongside files generated from analysis (Word / Excel / NVivo) will be stored for 7 years from the completion date of the study at the University of Northumbria as per section 10 of the Records Retention Schedule.

## **8.7 Indemnity**

This is a student research and the liability is to be covered by Northumbria University insurance as the sponsor. Please see the 'Northumbria University Internal Approval Form' included in the appendix.

All necessary indemnity or insurance arrangements will be in place before the research begins.

The arrangements for insurance are to cover:

- insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research
- insurance and/or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research
- insurance and/or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research

The researcher with a substantive NHS employment contract has designed the research, and NHS indemnity scheme will also apply.

## **8.8 Access to the final study dataset**

Only the researcher will have access to the final full dataset.

At the end of the study, some of the data will be saved in case the researcher need to check it and/or for future research. This has been made clear to the participants in the Participant Information Sheet to accompany the consent form.

## **9 DISSEMINATION POLICY**

### **9.1 Dissemination policy**

Feedback of research results to research participants will be available at intervals where work package datasets have been analysed completely and are closed. Periodic reports on study progress will be prepared for the Annual Progression Review Panels in February 2021 and February 2022.

The research will be written up as a thesis and submitted to the University of Northumbria at Newcastle as the Sponsor. A summary of the research and findings will be shared with Health

Education England and the Northeast and North Cumbria Integrated Care System workforce group. The researcher also intends to secure publication in one or more peer review management journals and nursing / professional journals. No personal data will be included in publication. Quotes from participants in interviews will be anonymised if included in the thesis. Offers will be made to GP practices / case study sites and the participants to receive a summary of the findings from the study

As part of the terms and conditions of grant agreement, a report on the study and its impact on patient care will be provided to the RCN Foundation.

## **9.2 Authorship eligibility guidelines and any intended use of professional writers**

The researcher will be the sole author of the final study report / thesis under the supervision of the Chief Investigator. There will be a viva at the end of the DBA programme and further amendments may be made.

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## 11. APPENDICES

### 11.1 Appendix 1- Required documentation

Appendix	Name	Attachment
A	Organisation Information Document	 Organisation_Information_Document_Nor



B	Participant Information Sheet (GP practice / case study site)	 PIS - GP practice.docx
C	Participant Information Sheet (NHS staff / participants)	 PIS - NHS staff.docx
D	Consent form (GP practice/case study site)	 Consent form - GP practice.docx
E	Consent form (NHS staff / participants)	 Consent form - NHS staff.docx
F	Combined schedules / interview questions	 Combined Schedule.docx
G	Data management plan	 Data Management Plan.docx

## 11.2 Appendix 2 – Schedule of Procedures

Intervention	No for each participant	Duration	Who will carry out the intervention
Seek consent with each GP practice / case study site.	1	30 min	The researcher will contact the Practice Manager and/or the senior Partner of the selected GP practices to seek consent and discuss arrangements for interviews and focus groups.
Seek consent with each participants in advance of the 1:1 and focus group interviews.	1	10 min	The researcher will send an email/letter to introduce the study and establish interest and obtain the consent in the participant's work place (GP practice) before the interviews and focus group discussions.

1:1 interview with qualified Nursing Associate/s in each case study site	1	45 min	The researcher will carry out this intervention in the participant's work place (GP Practice).
1:1 interview with the Practice manager in each case study site	1	45 min	The researcher will carry out this intervention in the participant's work place (GP Practice).
Focus group interview with Registered Nurses in each case study site	1	90 min	The researcher will carry out this intervention in the participants' work place (GP Practice).
Focus group interview with GPs in each case study site.	1	90 min	The researcher will carry out this intervention in the participants' work place (GP Practice).

### 13.3 Appendix 3 – Amendment History

<b>Amendment No.</b>	<b>Protocol version no.</b>	<b>Date issued</b>	<b>Author(s) of changes</b>	<b>Details of changes made</b>

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