

Exploring cross-organisation delegation between District Nursing and registered Nursing Associates in Residential Care Homes: Evaluation of Pilot

Enhanced Roles within Social Care
Programme – Care City

June 2026

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REGISTERED MANAGER – EBURY COURT CARE HOME

“What began as a pilot has become simply the way we work, and we would not have it any other way. Our fabulous RNA working closely with our wonderful colleagues from the district nursing service enables our residents to lead better and healthier lives as they receive timely, expert clinical care from someone they know and trust. Conditions are caught early before they escalate, and the distress that once accompanied visits from unfamiliar clinical staff is a thing of the past. This is a fantastic example of the huge benefits for residents when health and social care work together.

This is not an experiment. It is a model that works, that is already delivering every day for our residents, and every care home in the country should have access to this. In our view the case for rolling this out nationally is overwhelming.”

INTEGRATED COMMUNITY SERVICE MANAGER – NELFT

“When initially approached for this pilot, cross-organisational delegation of this kind was new territory for our team and created both anxiety and excitement in line with service transformation and an enhanced patient experience. This has now become embedded in practice, and is simply part of how together, these clinicians deliver safe and effective patient care.

Having a Registered Nursing Associate embedded at Ebury Court – someone the community nursing team have supported to develop clinical skills and competencies, and with whom they have established trust and rapport – who knows the residents well, understands their needs, and can be trusted to practise safely and escalate concerns appropriately, has made a huge difference to all involved. Patients at Ebury Court receive a more responsive, effective and consistent approach to care than could be achieved solely via the community nursing team, enabling more senior clinicians to focus their expertise where it is needed most.

This is what good community nursing looks like when the right partnerships are in place, and we are in no doubt that this model should be replicated more widely to enhance the patient pathway.”

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Executive Summary

This report evaluates **a pilot of cross-organisation clinical delegation between a District Nursing (DN) team and a Registered Nursing Associate (RNA)** employed by Ebury Court, a non-nursing residential care home in North East London. Running from September 2024, the pilot tested a model in which the RNA was formally delegated clinical interventions by the NELFT District Nursing team via an agreed governance framework.

It is important to situate this pilot within the current policy landscape. There is growing national interest in delegating care tasks to non-registered care staff in residential settings. This pilot is concerned with something distinct: the additionality that comes from delegating to a Registered Nursing Associate, a qualified healthcare professional operating within the NMC Code, with formal accountability for their own practice. The RNA's registration creates a new and distinct clinical capability within the home, and this evaluation is specifically interested in what that registered status makes possible: in the range and complexity of tasks that can be safely delegated, in the quality of clinical judgement brought to bear, and in the nature of the relationship with the DN team it enables.

Over the course of the pilot, tasks were formally delegated to the RNA across nine residents, covering wound care, pressure ulcer management, catheter care, B12 administration, and palliative support. A well-functioning governance and supervision framework was established, with weekly handovers, regular direct observation, and prompt communication between the RNA and DN team. Competencies were signed off prior to delegation in line with NELFT policy, and the model has operated safely throughout.

The benefits the pilot has produced are wide-ranging. Residents, many of whom live with dementia, receive faster, more consistent, and more person-centred care from someone they know and trust. The significance of this cannot be overstated: Ebury Court's management team note that for residents with dementia, clinical interventions from unfamiliar professionals have historically been difficult, distressing, and sometimes unsuccessful. The RNA's embedded presence changes this fundamentally. Beyond direct care, he has strengthened the clinical capability of the wider care home team through day-to-day knowledge-sharing, and has contributed to a model of prevention and early intervention that has supported low rates of ambulance callouts and emergency admissions throughout the pilot period. The DN team, meanwhile, has been able to redirect capacity towards more complex community cases.

The indicative cost avoidance to NELFT is estimated at approximately £12,164 over the seven-month pilot, equating to around £20,852 annualised. These figures reflect what would otherwise have been spent on band 4 DN staff time and should be read as

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indicative rather than as net savings, as they do not account for supervision, training and coordination costs borne by the DN team.

What began as a structured pilot has become business as usual. Both Ebury Court and the DN team have confirmed that cross-organisation delegation will continue within the governance and supervision framework tested during the pilot: a clear expression of the confidence all parties have developed in the model. The pilot provides a strong and replicable blueprint for embedding Registered Nursing Associates in residential care settings as a sustainable component of community health delivery, and all partners are agreed that it merits wider adoption.

1. Introduction

This report evaluates a pilot of cross-organisation clinical delegation between a District Nursing (DN) team and a Registered Nursing Associate (RNA) employed by a residential care home. The pilot was conducted at Ebury Court, a non-nursing residential care home in North East London, in partnership with the NELFT District Nursing service. It tested a model in which the RNA, already an established member of the Ebury Court care team, was formally delegated clinical interventions by the DN team via an agreed governance framework. The programme was developed under the Enhanced Roles within Social Care initiative, led by Care City, with the dual aim of increasing District Nursing capacity and improving the quality, continuity, and responsiveness of clinical care for residents.

It is important to be clear about what distinguishes this pilot from other current policy developments in this space. There is growing national interest in the delegation of care tasks to non-registered care staff in residential settings, and a number of policy and regulatory frameworks are being developed to support this. This pilot is concerned with something quite different: the additionality that comes from delegating to a Registered Nursing Associate: a qualified healthcare professional operating within the NMC Code, with formal accountability for their own practice. Ebury Court is a non-nursing home; it does not employ registered nurses. The RNA's registration therefore creates a new and distinct clinical capability within the home that goes beyond what can be achieved through delegation to non-registered care staff, however well-supported. This evaluation is specifically interested in what that additional clinical registration makes possible: in the depth and range of tasks that can be safely delegated, in the quality of clinical judgement brought to bear, and in the relationship with the DN team that registered status enables.

The RNA's role at Ebury Court operates across three distinct but complementary functions: a caring role as part of the Ebury Court residential team; a nursing associate role supporting the DN team through formally delegated clinical interventions; and a separately contracted nursing associate role with the local GP practice, for which he is

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directly employed by the practice for approximately eight hours per week. This evaluation focuses specifically on the DN delegation aspect of his role. The GP-employed sessions are outside the scope of this pilot and are not included in the findings, though they form part of the broader context of his work at Ebury Court.

2. Methodology

The evaluation draws on three sources of evidence.

Qualitative interviews. Semi-structured interviews were conducted with the RNA, four members of Ebury Court staff across a range of roles, individuals who have received care from the RNA, and two members of the District Nursing team. These were used to capture perceptions of how the model operated in practice, how well the RNA integrated into both teams, and the impact on clinical care.

Quantitative and administrative data. Programme documentation was reviewed, including records of delegated tasks (Appendix A), competencies achieved, training opportunities, supervision sessions, and health service use data (specifically GP visits, DN visits, ambulance callouts, and hospital admissions – Appendix B). It should be noted that some sections of the training and supervision records were unavailable, raising the possibility of under-recording; the documented level of support may not fully reflect the reality of what was provided.

Direct written feedback from Ebury Court's management team. Following circulation of a draft report, the Managing Director, Registered Manager, and RNA at Ebury Court provided written commentary on the pilot's impact and the accuracy of the findings. This feedback has been incorporated into the report and is attributed where quoted directly.

It should be noted that the RNA was already an established and experienced care worker within Ebury Court before qualifying, so his integration into the care home team was not a starting point for this evaluation. The key focus of integration for this pilot was his working relationship with the District Nursing team, as this is where the delegation model operates. The pilot ran from September 2024; given that delegation is ongoing, the evaluation period extends to the time interviews were conducted in July 2025.

Finally, the findings are based on the specific experience at Ebury Court and may not be generalisable to other settings without further study.

Table 1 below presents the logic model for the pilot and Table 2 the programme's outputs and outcomes, highlighting both the areas that have been evidenced and those still requiring evaluation.

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Table 1: Logic model for the cross-organisation delegation pilot

Inputs	Activities	Outputs	Outcomes (short-term)	Outcomes (long-term)	Impacts
Qualified NA in role with specific competencies signed off	Additional competencies signed off	Number (and nature) of tasks delegated to, and completed by, NA that would otherwise be completed by DN	Increased early identification of signs/symptoms and preventative action	Increased trust between DN team and Ebury Court team	Residents receive more person-centred care with health tasks delivered by those who know them best (particularly relevant for those living with dementia).
Agreed delegation governance framework	DN team delegate tasks to NA (via RiO)	DN delegation of interventions in line with achieved competencies only.	Increased DN and NA satisfaction with delegation and supervision models and processes (including communication)	Decreased health service use by residents through prevention/proactive care	Residents receive more preventative, proactive and timely care.
Agreed supervision model	NA delivers tasks as delegated, reports outcomes via RiO for every delegated intervention, and handover through fortnightly visits	Number (and nature) of signed off competencies	Delegation and supervision models and processes followed as described	Improved quality of life (QoL), continuity of care and care satisfaction for residents	NAs and DNs work as 'one team' to deliver care to residents
Technology (RiO and Laptop)		Number of supervision sessions	Reduced DN attendance at care home and cost savings	Improved resident, friend and family satisfaction with care and support	Improved care is delivered to residents with reduced pressure on DN teams
Identified nursing intervention needs of home residents	Clinical supervision conducted as agreed in relation to delegated activities	Number (and nature) of early signs/symptoms identified by NA and preventative action taken	Reduced resident non-compliance and distress in relation to health tasks	Increased skills, knowledge and experience for wider care home team through NA skills and knowledge sharing	NA is an established and sustainable role
	Delegation and supervision models iterated as required throughout pilot	Number (and nature) of early signs/symptoms identified by wider care team and preventative action taken	Increased, and expedited, preventative input from health care professionals to NA	Increased staff (home and DN) satisfaction with role	
	Patient assessment and regular review by DN		Ensuring care plan is up to date and suitable/patient-centred.		

Inputs	Activities	Outputs	Outcomes (short-term)	Outcomes (long-term)	Impacts
	Regular communication between NA and DN team	Volume of communication between NA and DN	Increase in care home staff seeking support/advice from NA	Increased DN capacity for more complex work	
	NA uses skills and knowledge to identify signs/symptoms of deterioration early and take preventative action	Number (and nature) of advice sought from NA by wider care home team	Reduction in resident health service use (primary, secondary, acute)	Increased NA competencies in response to resident need	
	NA supports and advises wider care home team	Number of resident interactions with health services (primary, secondary, acute)	Improved resident and family satisfaction with, and experience of, care		
	Increasing local understanding of role and arrangements in place				

Table 2: Outputs and outcomes – evidence status

Outputs & Outcomes	Evidence (Yes/No)
Outputs	
Number (and nature) of tasks delegated to, and completed by, NA that would otherwise be completed by DN	Yes
Number (and nature) of signed off competencies	Yes
Number of supervision sessions	Yes
Number (and nature) of early signs/symptoms identified by RNA and preventative action taken	Yes
Number (and nature) of early signs/symptoms identified by wider care team and preventative action taken	No
Volume of communication between RNA and DN	Yes
Number (and nature) of advice sought from RNA by wider care home team	Yes

Outputs & Outcomes	Evidence (Yes/No)
Number of resident interactions with health services (primary, secondary, acute)	Yes
Outcomes (short-term)	
Increased early identification of signs/symptoms and preventative action	Yes
Increased DN and RNA satisfaction with delegation and supervision models and processes (including communication)	Yes
Delegation and supervision models and processes followed as described	Yes
Reduced DN attendance at care home and cost savings	Yes
Reduced number of incidents of a resident becoming distressed (or refusing the task) when health tasks are being delivered	Yes
Increased, and expedited, preventative input from health care professionals to RNA	Yes
Increase in care home staff seeking support/advice from RNA	Yes
Reduction in resident health service use (primary, secondary, acute)	Yes (anecdotal)
Improved resident and family satisfaction with, and experience of, care	Yes
Outcomes (long-term)	
Increased trust between DN team and Ebury Court team	Yes
Decreased health service use by residents through prevention/proactive care	Yes
Improved quality of life (QoL), continuity of care and care satisfaction for residents	Yes
Improved resident, friend and family satisfaction with care and support	Yes
Increased skills, knowledge and experience for wider care home team through RNA skills and knowledge sharing	Yes
Increased staff (home and DN) satisfaction with role	Yes
Increased DN capacity for more complex work	Yes
Increased NA competencies in response to resident need	Yes



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3. Key Findings

This section presents the findings from the pilot across four areas: how the delegation model operated in practice; how the RNA integrated into both teams and the relationships that developed; the RNA's own reflections on his expanded role and future sustainability; and the outcomes and benefits the model has produced for residents, staff, and the wider health system.

3.1 How the model operated

Delegation and supervision framework

The DN team described a well-established process for delegation, with weekly catch-ups and handovers to ensure clinical tasks remain appropriate and current. The RNA's delegated responsibilities include simple wound care, management of pressure ulcers, administration of B12 injections, and elements of palliative support. The DN team retains responsibility for more complex interventions such as compression bandaging, advanced wound management, and end-of-life medication administration.

Consistent with NELFT policy, relevant RNA competencies were signed off by the DN team prior to any delegation. The RNA holds these signed-off competencies as evidence. District Nurses have observed the RNA's practice and noted his competence in a wide range of clinical tasks. They described seeing him carry out wound dressings, catheter flushes, and repositioning for pressure relief, as well as demonstrating these skills to other members of the care home team.

To maintain safety and confidence in delegation, supervision is both formal and informal. Weekly handovers between the RNA and the DN team, usually held every Friday via Teams, provide an opportunity for discussion and review, while monthly visits allow direct observation and case review. In keeping with NELFT policy, clinical supervisions took place 4–6 weekly. The District Nurses reported that the RNA communicates promptly about any concerns, often emailing or calling outside of the scheduled meetings when issues arise. This frequent contact is seen as a key factor in maintaining safe delegation and mutual confidence.

Range of formally delegated clinical tasks

The DN records show that tasks have been formally delegated to the RNA across nine residents. These include:

- Wound care (weekly)
- Pressure ulcer care (twice weekly)
- Palliative support (monthly)

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- B12 administration (every three months)
- Catheter care PRN and 12-weekly for routine changes

The DN team also reported that regular joint reviews enable timely updates to care plans and wound management charts, ensuring delegated work remains clinically appropriate and responsive to residents' changing needs.

Beyond formally delegated tasks, the RNA carries out a wide range of additional clinical responsibilities during his Ebury Court-employed time, including blood pressure checks, ECGs, diabetes monitoring, wound dressings, and liaison with mental health specialists. He has also supported disability checks and vision and hearing assessments. Note: some of these activities relate to his separately contracted GP sessions (see Section 1) and are outside the scope of this evaluation.

Communication between teams

The DN team has adapted its visiting patterns based on the RNA's presence. One colleague recalled that when the DN team arrived on a day he was off, the first question they asked was *"Is he here today?"* This small detail reflects how he has become a reliable point of continuity between the two organisations.

Building confidence and sustainability

The DN team acknowledged that delegation initially felt unfamiliar and required time to build mutual trust. Over time, regular contact, transparent communication, and direct observation of the RNA's work helped establish confidence in the process. The collaboration is now described as both safe and effective, with strong professional respect on both sides.

Looking ahead, the team identified opportunities to extend this model, provided the same structures for supervision and communication remain in place. They suggested that ensuring the RNA has adequate time with the DN team ahead of starting their post would support the trust-building needed for the relationship to succeed. They also noted that additional training, for example in compression bandaging, could further expand the scope of delegation, and that embedding skilled nursing associates in care homes could help reduce safeguarding concerns by improving clinical oversight.

3.2 Integration and relationships

The RNA was already an established and experienced member of staff at Ebury Court before qualifying, which meant his integration into the care home team was not a challenge in itself. The focus of integration for this pilot was his working relationship with the District Nursing team. Colleagues consistently described the transition as smooth. A care coordinator said he had become *"the glue between us and the District*

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Nurses,” explaining that his presence makes collaboration between the two teams easier.

The overall relationship between Ebury Court and the DN team has matured into a well-functioning, collaborative model. The structured delegation process, regular handovers, and clear communication channels have allowed safe and effective clinical work to take place within the care home.

Knowledge-sharing with the wider care home team

The DN team supported the RNA to undertake training that would enable him to provide learning to care workers at Ebury Court, focused on tasks appropriate for residential care staff. The RNA cascaded this through a small number of formal training sessions, but mostly through ongoing ad hoc support on the job as the need arose.

Interviews make clear that Ebury Court staff are learning through daily practice. A senior staff member described how the RNA has helped them spot and respond to early warning signs: *“He always explains things, like with infections or sepsis, so we can understand and act quicker. I’ve improved my knowledge a lot from working with him.”* The sharing of expertise has contributed to improved standards of day-to-day care and a stronger link between the DN team and residential staff.

3.3 Nursing Associate reflections

Since qualifying as a Registered Nursing Associate, his role at Ebury Court has expanded considerably. His registration has enabled a more holistic and clinically informed approach to resident care, with earlier identification of health needs, more proactive interventions, and closer collaboration with the district nursing and primary care teams.

He spoke with pride about how much he has learned and how far his clinical practice has developed, from wound dressings and pressure ulcer care to ECGs, diabetes monitoring, and palliative support, and described how this has stretched him in positive ways. He also contributes to staff education and clinical governance, leading sessions on infection prevention and the early signs of sepsis, supporting staff in assessing pain using validated tools, and overseeing the annual medication competency audit.

Sustainability and career progression

At the same time, the RNA was candid about uncertainty when thinking about the future. He shared: *“Maybe it’s a very successful program in front of everyone, but I don’t know what my future is. Nobody can say what’s going to happen next.”* This is not expressed negatively, but as a practical question about whether the role will continue to be supported and whether there is a clear pathway for progression. He noted that other colleagues who began similar programmes have since left, adding to his sense of uncertainty.

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At the end of the pilot it was agreed by Ebury Court and the DN team that delegation would continue, addressing some of this uncertainty. Supporting ongoing career progression is outside the scope of this evaluation and will depend on the RNA's discussions with his current employer and wider opportunities as they arise.

3.4 Outcomes and benefits

The pilot has produced benefits across clinical, operational, and relational dimensions. This section draws together evidence from all sources to present a consolidated picture of what the model has achieved.

Immediacy and responsiveness of care

Having a clinically qualified professional on site means residents receive prompt attention when problems arise, without waiting for a community nursing visit. A care coordinator described the difference: *"Before, if a resident's catheter was blocked, we had to call the nurse and sometimes wait half an hour or longer. Now, if the RNA is here, it gets sorted straight away. It makes such a difference - the resident doesn't have to go through all that pain and distress."* Ebury Court's management team echo this strongly, noting that "benefits to our residents include both an immediacy and continuity of clinical care" and that they feel this dimension is underrepresented in evaluation evidence to date. [Source: written feedback from Ebury Court management team, May 2026].

Continuity of care and trusted relationships

For many residents, particularly those living with dementia, receiving clinical care from an unfamiliar professional can be distressing and may result in non-compliance or unsuccessful interventions. The RNA's established presence means residents know and trust him. District Nurses observed that residents now experience greater consistency in their care: previously some became distressed by visits from unfamiliar community staff; now they are often cared for by someone they recognise. Ebury Court's management team highlight this as especially significant, noting that timely clinical intervention in residents with dementia stops pain, distress, and suffering, and that *"this is just not possible from our hard-pressed DN colleagues who, through no fault of their own, our residents do not know or trust."* They note that previously "interventions were often difficult, challenging and sometimes unsuccessful."

RESIDENT EXPERIENCE

Mrs A has been a resident at Ebury Court for four years. Now aged 101 and with full capacity, she developed a wound on her spine requiring dressing three times a week over a period of five months. Her wound care was delivered on site by the RNA.

“I am so pleased that Ajeesh could treat my wound quickly and regularly as he is here all the time. I know and trust him, and he is a lovely, gentle, kind young man.”

Mrs A, aged 101 — Ebury Court Care Home

Prevention and early intervention

A significant part of the RNA’s value lies in identifying early warning signs and acting before conditions deteriorate. District Nurses highlighted specific instances: the RNA recognised signs of a urinary tract infection leading to delirium and hypertension, took a full set of observations, and escalated appropriately; in another case, he identified a palliative resident’s rapid decline and arranged anticipatory medications, enabling a well-managed end of life. Ebury Court’s management team particularly highlight his preventive role in skin care and diabetic management, noting that he *“supports staff to quickly recognise symptoms for example signs of various infections thus enabling early intervention often resulting in reducing the need to go into hospital.”* They emphasise the well-documented risks to elderly people of hospital admission, including corridor care and hospital-acquired infection.

Reduced demand on ambulance and district nursing services

Health service use data show that ambulance callouts at Ebury Court remained consistently low throughout the pilot period, typically between zero and two per month, with only one emergency admission recorded in the sample period. While a direct causal link cannot be established, staff attributed this in part to the RNA’s ability to manage and escalate situations on site. Ebury Court’s management team share this view, noting that the post has delivered *“a reduction of both ambulance and DN call outs with a consequent and not insignificant reduction in costs”* and that this *“enables more time to be freed up for the DNs to undertake more complex tasks in the community”*. This aligns with the DN team’s own observation that delegating routine tasks has freed up capacity for community nurses to focus on more complex cases.

Staff confidence and wider team capability

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The presence of the RNA has raised the overall level of clinical awareness at Ebury Court. Through both formal sessions and ongoing day-to-day support, he has helped care staff recognise and respond to early warning signs more effectively. A senior staff member noted: *“He always explains things, like with infections or sepsis, so we can understand and act quicker. I’ve improved my knowledge a lot from working with him.”* For colleagues, his presence also provides reassurance: *“If something happens, he’s there. That gives us confidence.”* This contribution to the broader team’s capability extends the impact of the role well beyond the tasks he directly carries out.

Indicative cost avoidance for the District Nursing Team

The following figures illustrate the potential financial value of the RNA role to the district nursing team by estimating the costs that would otherwise have been incurred by NELFT staff to carry out delegated tasks. It is important to note that these are **not net savings**: they do not account for the supervision, delegation, training, or assessment time contributed by district nurses, any associated coordination costs, or the RNA’s own salary, which is met by the care home. They should therefore be read as indicative cost avoidance figures rather than a true financial saving to the system.

The timeframe for delegated tasks varies considerably depending on the reason for referral to the DN Team. Some tasks are lifelong in nature, for example where a patient has a long-term catheter or is receiving palliative care, while others, such as wound care, are time-limited and depend on wound type and individual patient factors including age, comorbidities, mobility, and nutritional status. Given this variability, a conservative assumption of four weeks per delegated task has been applied throughout.

Had these tasks not been delegated to the RNA, they would have been carried out by band 3–6 staff within the district nursing team. For the purposes of this estimate, each task has been costed at one hour of an entry-level Band 4 clinician’s time (£47, based on PSSRU Unit Costs). Across the seven-month pilot, there were 34 instances of delegation, resulting in 259 individual delegated tasks. On this basis, the estimated cost avoidance to NELFT amounts to £12,164 over seven months, or approximately £20,852 annualised.

4. Conclusion

This pilot has demonstrated that cross-organisation delegation from a District Nursing team to a Registered Nursing Associate employed by a non-nursing residential care home can work safely, effectively, and to the clear benefit of residents, staff, and the wider health system. What began as a structured pilot has, by its end, become business as usual: both Ebury Court and the DN team have confirmed that delegation will continue within the governance and supervision framework tested during the pilot, a decision that reflects the confidence all parties have developed in the model.

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The findings make a compelling case for the additionality that registered status brings. This is not a story about delegating routine tasks to care staff with enhanced training, a model with its own merits and one receiving considerable national policy attention. It is a story about what becomes possible when a qualified, NMC-registered professional is embedded within a care home that would not otherwise have access to that level of clinical expertise. The RNA at Ebury Court has been able to take on delegated clinical responsibilities of a depth and complexity that registered status alone makes appropriate: wound and pressure ulcer management, catheter care, palliative support, and the early identification and escalation of deterioration. Crucially, he has done this as someone residents know and trust, a factor that is particularly significant in a home where many residents live with dementia, and where the distress caused by unfamiliar clinical visitors has historically been a real barrier to effective care.

The benefits that have resulted span clinical, relational, and operational dimensions. Residents receive faster, more consistent, and more person-centred care. The DN team has been able to redirect capacity towards more complex community cases. Care home staff have developed greater clinical awareness through working alongside the RNA day to day. And the low levels of ambulance callouts and emergency admissions recorded throughout the pilot period, while not attributable to the RNA role alone, are consistent with a model oriented towards prevention and early intervention rather than crisis response.

The indicative cost avoidance figure of approximately £20,852 per year, based on conservative assumptions and reflecting what NELFT would otherwise have spent on band 4 staff time, gives a sense of the financial value of the model to the health system, though the true picture is richer and more complex than any single number can convey.

Ebury Court's management team, reflecting on the pilot, put the case directly: the post has delivered clear and substantial benefits to residents and to the NHS alike, and the value of having a registered clinician who is known and trusted by residents, particularly those living with dementia, is something that cannot be replicated by a visiting professional, however skilled.

The pilot provides a strong and replicable blueprint for embedding Registered Nursing Associates in residential care settings as a sustainable component of community health delivery. The governance framework, supervision model, and communication structures developed at Ebury Court are transferable, and all partners are agreed that the model merits wider adoption. For this to be realised, commissioners, providers, and workforce planners will need to consider how the career pathways and long-term sustainability of the RNA role can be secured: both for the individual concerned and for those who might take on similar roles in future.

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5. Appendix

Appendix A: Delegated Clinical Tasks

(from DN team records, Sept 2024 – May 2025)

Task Delegated	Frequency	Notes
Wound care	Weekly	Regular dressing changes and monitoring
Pressure ulcer care	Twice weekly	Includes prevention and treatment
Palliative support	Monthly	End-of-life comfort interventions
B12 administration	Every 3 months	Injections provided on site
Catheter care	PRN and 12-weekly for routine changes	

Appendix B: Health Service Use (Jan 2024–May 2025)

(from Ebury Court records)

Month	GP Contacts	DN/Other Community Contacts	Ambulance Callouts	Emergency Admissions
Jan 2024	67	5 DN, 17 phlebotomist	1	0
Feb 2024	55	21 DN	0	0
Mar 2024	72	18 DN, 10 CPN	1	0
Apr 2024	73	11 DN, 8 CPN	1	0
May 2024	67	11 DN	0	0
Jun 2024	76	15 DN, 13 phlebotomist	0	0
Jul 2024	93	28 DN	0	0
Aug 2024	73	35 DN	1	0
Sep 2024	57	11 DN, 7 RNA	2	1
Oct 2024	102	9 DN, 9 RNA	1	0
Nov 2024	73	6 D/N, RNA 4, 1 Phlebotomy	2	1
Dec 2024	89	8 D/N, RNA 6	2	1
Jan 2025	67	6 D/N, RNA 4, 2 NELFT Podiatrist	0	0
Feb 2025	54	7 D/N, RNA 2, 1 NELFT Podiatrist	0	0
Mar 2025	64	9 D/N, 6 Phlebotomy, 8 RNA	1	0
April 2025	70	33 Covid 19 vaccination, 13 D/N, 10 RNA	1	0

May 2025	62	12 D/N, 12 RNA	1	1
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