

Residential care home workforce development

The rhetoric and reality of meeting older residents' future care needs

May 2010

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This study reports on how training care home staff can enhance social care and the health of older people in UK residential homes. It provides evidence of the strengths and weaknesses of different approaches, discusses barriers and facilitators, and identifies challenges for the future.

This research contributes to current debates concerning provision of a 'home for life', the funding of long-term care, better quality of life for older people with high support needs, integrated health and social care working, and inter-professional boundaries. Three approaches to workforce development involving the increased training of care home staff are explored in depth. Results are presented from the perspectives of local and national stakeholders, care home staff, and residents and relatives. The findings will be of relevance to: policy-makers, regulators, educators, residential home employers and staff, commissioners, community health and social care professionals, care home residents and their relatives, and older people and their representative organisations.

The report covers:

- new approaches to providing enhanced care in residential care homes and ways of working in practice;
- enhanced activities undertaken by care staff and sources of learning;
- the development of a professional workforce of 'new role' carers;
- residents' and relatives' experiences; and
- the implications for the future of residential care.

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About the study

This is a report of a three-year study of enhanced care approaches in three residential homes for older people in England, supported by the Joseph Rowntree Foundation. It has important messages for policy-makers, regulators, educators, residential home employers and staff, commissioners, community health and social care professionals, care home residents and their relatives, and older people and their representative organisations. Information was gathered through interviews, surveys and focus groups. National and local stakeholders, residential home managers, care staff, and older residents and their relatives were invited as participants.

The approaches to care

Site 1: This 34-bed voluntary sector home had introduced a system of flexible skill mix (FSM). This enabled fundamental nursing activities to be provided in-house by care staff trained to 'new roles' with support from a community nurse. The innovation was initiated by a champion in the parent organisation (external to the home).

Site 2: This 47-bed privately owned home offers high quality social and personal care from care staff with enhanced skills. The objective was to allow residents to remain in the home for as long as possible, with routine community nurse support. This innovation was initiated by the care home manager (internal to the home).

Site 3: This is a 40-bed local authority (LA) owned home. A dedicated in-reach team (IRT) of nurses provided 24/7 support for this home. The aim was to prevent hospital admissions through up-skilling care home staff to provide fundamental nursing activities in-house. This innovation was initiated by an LA–Primary Care Trust (PCT) partnership (external to the home).

In sites 1 and 3, the Commission for Social Care Inspectorate (CSCI) granted permission for care staff to engage in nursing activities in the home, beyond the normal residential care regulations. In site 2, where formal clinical skills training was not included, flexibility in registration was not required.

A comparator nursing home was used to benchmark some activities. This home had 32 permanent residents and was part of a large independent sector provider.

The context of care: from rhetoric to reality

The rhetoric of person-centred care for older people in residential homes appeared to be undermined by a climate of ageism. This included covert devaluation of those who care for older people, inconsistency in regulatory decision-making and an emphasis on cost containment rather than consumer benefits. The continued ineligibility of older people in residential homes for Funded Nursing Contribution to Care (FNCC), even when terminally ill, limits the ability of residential home care staff to develop and apply palliative and other enhanced care skills. This means that residents who wish to exercise their choice of remaining in a care home until their death are unable to do so. In seeking to contain the costs of residential care, local authorities inevitably load service costs for hospital admissions or transfers to nursing homes onto the NHS.

Stakeholders suggested that a more cost-effective integration of health and social care was being undermined by a lack of professional structure for 'new role' carers. Issues included poorly defined boundaries of responsibility between NHS staff and 'new role' carers, lack of incentives for role extension and use of different professional language that excluded carers. All discourage attempts to improve the ability of the care staff workforce to meet the future challenges of care provision for over a quarter of a million older people in residential care homes.

Meeting the needs of residents

Residents and relatives viewed the enhanced personal and social care approach provided in site 2 (commercial not for profit home) with the least criticism and the FSM approach in site 1 (voluntary home) with the most. They emphasised the need for compassionate qualities in staff more than knowledge and skills. Only in site 3 were relatives and non-elderly mentally ill (EMI) residents fully aware of the particular enhanced care approach adopted by their home. This was presumably because the IRT nurses were so visible.

Although all the residential care approaches aimed to provide a home for life, this was hampered by shortfalls in funding to meet additional care needs when residents became ill. In all sites, where palliative care had been given, the quality of care provided was externally praised. The care of EMI residents, in particular those with behavioural problems, presented the most challenge to care staff in sites 1 and 3. This was blamed on inadequate mental health training.

The reality of up-skilling the residential home workforce

The study's findings indicated a need for more clinical relevance in National Vocational Qualifications (NVQ) level 3 course content to support clinical skills. A standardised quality control system for assessors, assessment and maintenance of competency is recommended. This would facilitate more universal confidence in, and currency for, this qualification. Rolling out enhanced care approaches requires realistic expectations. The clinical up-skilling of care staff takes time for new learning, for adjustment to changes to ways of working and for growth in confidence in cross-sector relationships.

New ways of working and workforce development

Organisations employing the 'new role' carer workforce need to recognise that, without incentives and recognition for new learning, the delivery of improved health and social care will

become more difficult to sustain. This also could have implications for recruitment and retention of staff. All the approaches examined placed 'added value' on increased input from qualified nurses in addition to that already accessed. The enhanced quality of care achieved in site 2 supports a view that good basic health and social care can be delivered in a residential home with outreach to community nurses. However, this is dependent on a sound practice-driven relationship and care staff having sufficient knowledge to know when to seek timely nurse-led support.

The development of a carer profession needs a professional framework that promotes responsibility, accountability, competency and their relationship with liability. Crucial elements are carer registration and recognised formal qualifications. However, employers have not uniformly provided additional financial incentives in recognition of new learning and responsibilities. Links to unions could support the development of supportive structures for 'new role' care staff, although due to their relative isolation of working in residential homes, carers were largely unaware of this potential. Increased workload was associated with the undertaking of new role clinical skills and at the expense of social care giving. Employers need to address how to achieve high quality integrated health and social care without staff's workload becoming overburdened.

The influence of management style on change implementation

The three residential homes differed in the management styles adopted to bring about change. This similarly influenced the way that staff, residents and relatives perceived their experience of care. However, managers may not have been fully aware of the impact of their own particular style. Even when successful, as in the case of the 'internal champion-led' approach in site 2, sustainability could disintegrate should the champion leave. Managers in sites 1 and 3 in particular, where major changes to unfamiliar roles and ways of working had taken place, could have benefited from change management training at an early stage to support their innovative approaches.

Conclusion and next steps

If the current increases in age and morbidity on admission continue, combined with implementation of a 'stay put for life' policy in residential care, this could lead to a situation where any distinction between residential care and nursing home care would no longer be meaningful. However, without additional finance to fund these nursing care needs, the residential sector might increasingly focus on meeting the needs of self-funding rather than public sector funded residents. Thus, an equality gap in the fulfilment of choice between consumers based on personal rather than public resource could emerge.

The input of knowledge and skills from registered nurses (RNs) was recognised as essential in supporting 'new role' carers' learning and practice. As the practice interface narrows between what will be 'nursing' activities appropriate to the 'new role' carer as distinct from those of the RN, a clear accountability and a liability framework will be needed. This will protect both the 'new role' carers and the residents from unrealistic demand-led expectations.

Stakeholders visualised improvements in efficiency and ways of funding for the public sector. Pooling centrally held health and social care allocations was recommended with devolvement to joint local budgets, from which joint commissioning and service delivery decisions could be made. In the site 2 independent sector commercial home, the potential for staff's clinical up-skilling was being explored strategically. This included consideration of the efficient use of financial resources, economies of scale within the workforce and investment in community staged care developments. A further approach could be to market fixed price 'bed units' at an amount incorporating 'new role' quality care costs, against which the public sector could recoup savings from avoided hospital admission and nursing home transfer over time.

Finally, innovative residential care homes offer the opportunity to provide learning environments for multidisciplinary students. This would foster the integration of health and social care, as well as promoting recognition of the good service provided by 'new role' carers.

1 Overview of research

Aims of the report

This report provides an in-depth evaluation of different approaches adopted in three residential homes in England with the aim of improving care. These approaches involved enhancement of education and training of care staff towards extended care roles and/or new clinical roles. The report examines the strengths and weaknesses of each approach and their implications from the perspectives of residential home managers and care staff, residents and relatives, community nurses, national policy-makers and other stakeholders. Particular emphasis is placed on potential benefits to older people as consumers of residential care, if such changes were to be implemented more widely. At the same time, the key challenges for care homes, their parent organisations, and national and local stakeholders in health and local government are identified.

The broader context

Changing patterns of health care provision in the 1990s have resulted in fewer UK hospital beds, reduced length of stay and increased reliance on community health and social services for older people (Department of Health, 2000). As a result, over 18,000 care homes currently provide places for more than 440,000 clients; six out of ten places are in residential as opposed to nursing homes. The residential care home sector has therefore become an increasingly important source of long-term care, with over 260,000 places available in England compared with 167,000 beds in hospitals (Care Quality Commission, 2009). Out of every 1,000 residential homes, 700 are privately owned, 200 are voluntary and 100 are local authority owned. Care homes employ 355,000 care workers and senior care workers (Skills for Care, 2008).

Residential home care, provided by social as opposed to health care staff, is a major part of long-term care for older people. The number

of residential care places is set to increase and will exceed those in nursing homes over the next decade (Department of Health, 2008a). The majority of older residents are not private payers, emphasising the importance of local authority funding (Laing and Buisson, 2008). There are currently approximately 84,970 new local authority-supported admissions of people aged 65 or over to care homes each year (Department of Health, 2001a). Although residential homes have historically catered for less dependent older people, a recent census of residents in nursing and residential care homes observed a 'considerable overlap' in dependency and nursing care needs between the two types of home (Bowman *et al.*, 2004). This is presumably at least partly due to increased illness and/or disability as residents age. With even longer survival predicted, the ability of residential care homes to continue to meet their residents' health care needs is likely to be limited both due to their current exclusion (as non-nursing establishments) from NHS FNCC in England (Szczepura *et al.*, 2004) and due to the resulting need to rely on ad hoc support from busy community nurses and primary care based health professionals (Goodman *et al.*, 2005). Ultimately, because registration regulations restrict the range of care that a residential home can itself provide, once staff in the home feel they are no longer able to meet a resident's health care needs, an 'imposed' transfer of the resident to a nursing home is a likely outcome (Reed *et al.*, 2003). Indeed, it has been contended that the two-tiered structure of nursing and residential home care can 'lead to fragmented experiences for older people' (Reed *et al.*, 1998). Recent Department of Health policy embodied in *Our Health, Our Care, Our Say* (Department of Health, 2006) does include a commitment to equip health and social care staff with skills to enable them to operate effectively in multi-agency, cross-cultural environments. This will require the replacement of traditional models of care with ones that encompass more integrated roles, competencies

and vision (Tamsma and Kooij, 2004). It has been suggested that if residential care home staff were more skilled in *anticipating* health problems in residents or in delivering care, community nurse input could be used more effectively (Help the Aged, 2006). Pilot projects reflecting this vision have already been activated, with some success being reported following evaluation, including by the authors (Wild *et al.*, 2008; Szczepura *et al.*, 2008a; Skills for Care, 2007b).

Case study sites

Three residential homes were selected as case study sites. These were spread throughout England and represented the main types of ownership (private, voluntary and local authority). All three were introducing care improvements linked to the development of a 'new role' care staff workforce. However, they differed in terms of organisational context, the primary driver for change, their staffing and the approach they were adopting.

The three case study sites are described fully in section 2. In summary, they are:

Site 1: a voluntary sector (not-for-profit) residential care home offering residential care with nursing in the north of England. On-site staff included one practising registered nurse manager. The home had introduced what it termed a 'flexible skill mix approach'.

Site 2: a privately owned residential home, part of a large chain. This independent sector business was located in the north-east of England, had no on-site nursing staff and was reliant on ad hoc community nurse support. The approach adopted focused on social and personal care.

Site 3: an LA residential home in the south-west of England with no on-site nursing staff but a dedicated team of 'in-reach' nurses was provided by the PCT. This community health and social care approach had grown out of a partnership project established by the LA and PCT.

A nursing home was selected as a fourth site to act as a benchmark against which resident needs and workforce activities could be

considered. This was an established home with on-site registered nursing care, owned by a large chain and situated in south-west England.

Research design

The research was carried out over a period of three years. Following ethical approval, an in-depth evaluation was undertaken. A rich picture of the three approaches to enhanced residential care was built up using multiple sources. These included residents and relatives, care staff, home managers, senior managers in the organisations and local and national stakeholders. A range of methods was employed including questionnaire surveys, face-to-face interviews, focus groups, documentary review and audit tools.

The main themes guiding the study

- Key differences and similarities between the homes.
- An audit profile of staff and residents.
- Clinical skills gained by staff and sources of learning for these.
- Moving towards a 'new role' professional workforce.
- Ways of working and the impact of 'new role' care staff.
- Quality of care and resident and relative experiences.
- Implications for the future of enhanced residential care.

A total of 108 semi-structured interviews were undertaken during the study. Managers and care staff were interviewed repeatedly to observe the impact of change over time. Questionnaires were developed following baseline interviews. The first survey questionnaire was sent to all

staff (N = 141), with a return rate of 40 per cent. A second survey was sent to NVQ2, NVQ3 and NVQ4 staff only, with a return rate of 22 per cent. Focus groups were arranged with care staff, residents and relatives and care home managers. Eleven resident case studies were completed. Information was gathered through a combination of care documentation review, focus groups and interviews. An 'interview' often represented several short visits, rather than one continuous interview.

To enable comparison of residents' needs, all four homes were asked to use the same resident assessment tool (minimum data set, MDS). MDS has the advantage of not only providing resident health and social characteristics but also allowing calculation of dependency levels and estimation of nursing hours required to meet residents' needs.

Information from two staff surveys was entered into a SPSS, Version 17 database and subsequently analysed using appropriate statistics. Analysis of the extensive interview material employed two researchers who, in the first instance, independently extracted and categorised comments under themes. They then scrutinised the material together to permit agreement on initial themes and identification of any new themes and sub themes.

The primary research was underpinned by an extensive review of the international literature (Szczepura *et al.*, 2008a). More detailed reports were also produced presenting responses to survey questionnaires (Nelson *et al.*, 2010), the qualitative findings from the study (Wild *et al.*, 2010), and analysis of audit data (Szczepura *et al.*, 2010). The present summary report brings together the findings from these three interim reports.

2 Description of the residential homes and their approaches to enhanced care

Carpenter and Perry (2001) suggest that the 24-hour requirement for nursing cover in nursing homes was often not indicated as necessary following assessment of residents' needs, and O'Kell (O'Kell, 2002) observed that some tasks undertaken by nurses could be performed by care staff, thus suggesting that alternative models of staff skill mix could be viable. However, such forms of enhanced or new role working in residential homes will necessitate the replacement of traditional ways of working with more integrated staff roles (Tamsma and Kooij, 2004). The residential homes studied were committed to training and up-skilling their care staff. They all adopted the NVQ route (see Appendix).

The case study sites differed in the approaches they had adopted to up-skilling their staff. They also differed in the types of resident for whom staff were providing care (see Table 1). The

assessed care needs of clients were identified via the use of the minimum data set tool (MDS) and expressed as a percentage of the care required by an 'average nursing home resident' (case-mix index). This figure ranged between 58 per cent and 65 per cent, compared with 85 per cent for the nursing home. Thus 68 per cent, 76 per cent and 69 per cent of the level observed in the nursing home was recorded in sites 1, 2 and 3 respectively. In addition to examining any overlap in terms of care needs, the residents' MDS assessments also allowed a comparison to be made with the three Registered Nursing Care Contribution (RNCC) determination bands that preceded the single payment band for current FNCC payment (see Appendix for MDS and RNCC/FNCC). In the three residential homes, between one in four (site 1) and one in two (site 2) of residents fell into High or Medium FNCC bands.

Table 1. Characteristics of residents in four study sites (N = 151).

Characteristics	Site			
	Site 1	Site 2	Site 3	Site 4
Number of residents	33	46	40	32
Privately funded residents (%)	82	52	15	95
Age range of residents [Average age]	78–99 [89.7]	66–104 [87.5]	56–101 [83.0]	69–98 [87.5]
Residents with high level of dependency physical function ADL Score (%)	9	4	12.8	70
ADL Long Form 1 (MDS)	4.42	4.76	5.53	20.35
Residents who are independent ambulatory (%)	12.1	30.4	46.2	0
Residents who are in chair most of time (%)	24.2	15.2	5.1	60
Residents who have dementia (%)	18	37	68	44
Residents who have depression (%)	39.4	50	23	40
Residents with behaviour problems (%)	0	2.2	5.1	0
Case-mix index (average CMI for home)*	58	65	59	85
Residents who are clinically complex (%)	6	6.5	10.3	20

Note: *Average CMI = care time that residents in home should get as percentage of an 'average nursing home resident'.

The homes were similar in size, although the residential homes were slightly larger than an average home (18.5 places), and the nursing home was slightly smaller than average (45.5 places). However, the sites were dissimilar in terms of the skills base available to the care home manager running the home (see Table 2). Available care staff time ranged from 21 to 31.5 hours per resident per week (prpw) in the three residential sites. This was similar to the 32 hours prpw reported for the nursing home. However, the skill mix differed between sites. Site 1 had one in four of its care staff trained to NVQ 3 or NVQ4 level; fewer than 10 per cent of staff had no NVQ training; and there was a deputy manager on site who was a non-practising RN. Site 2 similarly had one in four of its staff trained to NVQ 3 level or above; one-third of staff had no NVQ training; and there was no RN on site. Site 3 was the residential home with the highest percentage of trained staff. Over half the care staff were trained to NVQ 3 or NVQ4; fewer than 20 per cent had no NVQ training. Although there was no on-site RN employed by the home, an in-reach team provided on-site cover. Finally, in the nursing home one in four staff were RGN qualified; one-quarter were trained to NVQ level 2; and the remaining 16 (including domestic staff) had no formal qualifications. None of the care staff was offered training to NVQ levels 3 or 4.

The three approaches

The approaches that had been adopted for up-skilling staff exhibited some similarities as well as differences between sites. There was therefore an element of overlap, often with differences in emphasis rather than actual content.

A flexible skill mix approach (site 1)

A senior manager in the voluntary organisation described the thinking behind this approach as follows:

We did have this view in our head that there should be a way of better developing the roles in the sorts of staff that we employ ... it was about up-skilling and enhancing just ordinary good care practice. I think it [flexible skill mix] does try to address the person in a holistic way as opposed to trying to look upon them as being either a social care resident or nursing resident because everybody's got multi faceted needs and none of this fits into one category.

Context: The home was a modern, purpose-built facility opened in 2004 and owned by a large voluntary, not-for-profit parent organisation. It was the smallest residential home studied, providing permanent care for only 34 older people. Residents were reasonably well off, with eight out of ten being privately funded. There was no EMI facility and the home did not admit people with nursing needs. Respite care was not provided. The CSCI had rated the home as 'good'.

Change implementation: The flexible skill mix (FSM) approach was initiated by a champion in the parent organisation. In order to establish FSM, CSCI granted some leeway in permitting nursing to take place in the home beyond the normal regulations for residential care. The guiding principle for this approach to enhanced care was that some fundamental nursing activities could be provided in-house by 'new role' care staff if trained to do so and if given support by a non-practising RN deputy manager and nurses in the community.

Table 2. Qualification level of staff in four study sites (N = 141).

Qualifications	Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)
NVQ2	46	41	28	25
NVQ3	25	22	50	0
NVQ4	11	2	5	0
RGN	4	0	0	25
Other	14	34	18	50

The underlying rationale for this approach to enhanced care appeared to be altruistic, led by the parent organisation. This approach did not seek to undermine the community nurse's role, but rather to make better use of her time and nursing skills. Examples of routine clinical support provided by the community nurse were catheter management, stoma care and continence assessments.

In addition, development of enhanced skills in the care staff workforce was thought to offer the benefit of enabling more responsive work schedules to meet the fluctuating needs of residents. A budget was available to the care home to enable purchase of additional specialist nursing input if required, over and above community nurse time, although this was not used during the study.

The FSM approach involved up-skilling care staff in social and personal care through NVQ3 training and in selected nursing skills through an add-on in-house health skills award. The practice element for supporting clinical skills development was provided by the organisation's nurse trainer/assessor. The approach to up-skilling care staff with nursing skills appeared to be mainly proactively planned with basic skills training given in advance of needs arising, but also partly reactive with specific skills training provided to meet resident needs as these arose. The budget for training was described by the home manager as 'very generous'.

Although the home did not accept residents requiring nursing care on admission, it did aim to keep residents until the end of their lives. The home had previously applied for FNCC payment on the basis of additional care costs incurred when maintaining a terminally ill resident in the home rather than transferring them to hospital. As might be anticipated, the ineligibility of residential care homes led to this application being unsuccessful.

A social and personal care approach (site 2)

A senior manager in the parent organisation described this approach as one that should be achievable in all residential homes:

I don't think we are doing anything here above what any good residential home should be aspiring to. I'm struggling to see if we do anything different than any of the Care Home Regs. What

they're [care staff] doing is doing it in a very high quality focused way ... So yes, my staff are going above and beyond, but that's not a regulatory thing, that's a quality thing and rightly so.

Context: This home was registered as a residential care provider at the outset and throughout the study. It was a purpose-built facility opened in 1991 and owned by a large independent sector care home group. It was the largest of the homes studied, with 47 residents. Half the residents were privately funded. The home had three units, catering for 24 physical frail, 11 high physical dependency and 12 EMI older people. It did not admit people with nursing needs and there was no respite care provision. CSCI had rated the home as 'excellent'.

Change implementation: This enhanced care approach was driven by an internal champion rather than originating from senior management external to the home. However, the fact that the home had achieved a particularly high quality service was recognised by the parent organisation. The guiding principle for this approach was a strong focus on high quality personal and social care provision within the context of the normal regulations for residential care. The development of enhanced skills in care staff was viewed primarily as enabling residents to remain in the home for as long as possible. There was no budget to allow purchase of additional specialist nursing input; the home was entirely reliant on traditional community nurse support.

Care staff were up-skilled in social and personal care through an NVQ3 course. This learning was supplemented by ad hoc health-related courses identified by the home manager to meet emerging resident needs. The budget for training was described by the manager as 'very small'. Some basic nursing skills were delegated and supervised informally by the community nurse, who also undertook other clinical interventions such as dressings and catheter care. Thus, the approach to enhancing the health skills of care staff appeared to be mainly reactive with specific skills training identified and provided ad hoc to meet resident needs as these arose.

The home could not admit residents if they required nursing care, but the staff were keen

to undertake appropriate care to maintain a resident until the end of their life and thereby avoid hospital admission or transfer to a nursing home. The home had previously requested a Continuing Care payment for a palliative care resident. In this case, the home's request was not granted although, unlike FNCC, as NHS patients older people in residential homes are potentially eligible for such payments.

The overall vision in this home was one of quality enhancement that incorporated clinical tasks only as delegated by the community nurse. This was set within a strong social/personal care framework. It was thought that a reputation for quality would provide added commercial value including maintaining high bed occupancy.

A local authority partnership approach (site 3)

This approach involved the care staff in the LA home and PCT community staff. From the community perspective, an LA community resource manager described the approach as:

We're trying to deliver person-centred care but it isn't easy because older people's services have been traditionally much more task orientated. We're trying to be flexible towards the individual and assess each situation on its merits, to get them to see the philosophy behind what they do. We're trying to develop a model of working whereby hopefully we empower them enough to make sensible decisions in difficult situations, always keeping in mind that it's about risk and choice and building an organisational structure so that they have support.

From the residential home perspective, the home manager also described an integrated way of working:

Well we're still having the support of what was an in-reach nursing project which has now become mainstream. The fact that it's become mainstream at the moment hasn't made any significant difference. We still have that support; we still have a very high number of care staff who have been trained in recognising certain clinical things and they have their Health Award to do

certain clinical tasks. That is still continuing and that's still very much part of the ethos as a home.

Context: This care home was registered as a residential care provider. The home was a purpose-built facility opened in 2007 and owned by the local authority. It was the second largest residential home studied, with 40 residents in total, all transferred from other LA homes after closures. Only one in seven residents was privately funded. There were two units catering for 25 EMI and 15 frail elderly; the home did not admit people with nursing needs. This was the only residential home to provide significant respite care, offering a service for approximately 65 older people per annum. CSCI rated the home as 'good'.

Change implementation: This approach to enhanced care in the home was externally driven. It had grown out of a partnership project established jointly by community health and social care. This project had focused on provision of a dedicated in-reach team (IRT) to proactively support three residential homes (Szczepura *et al.*, 2008a; Wild *et al.*, 2008). IRT staff were available 24/7 to provide nursing and physiotherapy input and to develop the skills of care home staff. For the project, CSCI had granted permission for care staff to engage in nursing activities in the home beyond the normal regulations for residential care. By the time of the present study, the IRT service had moved from an experimental status and had been established as part of a community resource centre working in partnership with existing community professionals. The frequency of routine visits by the IRT had reduced (with nurses taking a more case-based approach to meeting residents' needs). Increased responsibility was given to care home staff in the new amalgamated site. By the end of the study period, the IRT service had expanded to provide similar support to a further four residential homes (including ad hoc input to two independent sector homes). The home had never applied for FNCC or for a Continuing Care payment.

In this home care staff were up-skilled through NVQ3 in social and personal care and in their clinical skills through an add-on in-house health skills award. The practice element for supporting skills development was provided by the IRT

nurse assessors plus an in-house assessor. The approach appeared to be proactive, with basic skills training given in advance of needs arising, and added skills training provided to meet the needs of specific residents, that is, dementia and learning difficulties. The LA provided a budget for training care staff and an NVQ assessor.

The approach placed an emphasis on a 'stay put' policy, emphasising resident choice and the promotion of integrated health and social care ways of working. The guiding principle for the approach was prevention of avoidable hospital admissions and nursing home transfers. Up-skilling care home staff enabled them to provide fundamental nursing activities in-house. Enhanced clinical skills in care staff, supported by a dedicated nursing team in the community, were considered the best means of preventing avoidable hospital admissions, facilitating early hospital discharges and preventing transfers to nursing homes. There was a ring-fenced budget for provision of the IRT service.

Comparator nursing home (site 4)

A nursing home was selected as a comparator. The deputy manager described care provision and changing skills required in the home as follows:

Nursing home residents are becoming more frail and dependent; they tend to live longer so there is increased opportunity for degenerative diseases to develop. Consequently, the technological aspects of care giving have increased significantly. There are also far more prescribed procedures in place which have replaced the informal ad hoc care methods employed previously, for example, with regard to manual handling, effective hand washing, infection control and wound care.

Context: This was a middle-sized nursing home with 32 permanent residents and part of a large independent sector provider. The home was housed in a period property built in the mid-1800s with a purpose-built wing opened in 1991. Virtually all residents (95 per cent) were privately funded and where appropriate they received FNCC. The home was registered as a nursing care provider. CSCI had rated the home as 'adequate'.

Approach to care: Residents were admitted to the nursing home from hospital, from their own homes and from residential care homes. Residents were reported to have become more frail and dependent on admission. As individuals are tending to live longer, degenerative diseases were increasingly likely to develop. As a consequence, staff reported that the technological aspects of nursing care had increased significantly; there were far more procedures and protocols in place, replacing the more informal ones employed previously.

The nursing home did not consider it had a particular approach to care other than conforming to the parent organisation's requirements and CSCI's standards. However, it did subscribe to a 'stay put' policy for residents and worked closely with the PCT to safely prevent avoidable admissions to hospital. There was no EMI facility. Unlike the residential homes, reportedly only RNs performed nursing interventions. Involvement of community nurses was infrequent and largely confined to practice refresher inputs from community specialist nurses in response to a particular resident's needs. Care home nurses used a company-devised resident assessment tool with similar domains to those of MDS. Care staff development was to the level of NVQ2 and the home had no care staff trained above this level. The home employed a part-time nurse to support its training activities.

3 The context for enhanced care: rhetoric and reality

In addition to examining how enhanced care was implemented in the three case study sites, national and local stakeholders were interviewed to explore current issues and debates concerning residential care.

Regulation

In order for care home staff in sites 1 and 3 to undertake nursing tasks alongside traditional personal and social care giving, approval had to be sought from CSCI because this represented a departure from the normal regulations for residential homes. When interviewed, a CSCI representative was clear that a home in which skilled nursing activities were undertaken (or delegated) by an in-house registered nurse (RN) would normally be registered as a nursing home (see Appendix). However, CSCI adopted a flexible stance towards enhanced care approaches being introduced in residential care. This was grounded in the logic that it was reasonable to permit an older resident whose health was failing to end their days in what they considered to be their 'home'. Decisions were also made at a time of changes to regulatory bodies and the framework for regulation.

A CSCI representative provided an analysis of the initial regulatory situation and the impact of innovation as follows:

At the moment it's quite clear that if you're providing a lot of nursing care then you should be registered as a nursing home and yet as a regulator we're very supportive of trying to keep people who deteriorate in their [residential] home but the registration regulations in the Care Standards Act aren't as flexible perhaps as they might need to be. When they were suggesting to have care workers delivering nursing care, my initial sense was is this for the right reasons, could it be cost saving – if we're having difficulty appointing nurses.

Now I think that's a good thing ... they're modifying, they're developing, they're being innovative and certainly we have a growing type of service that nobody's ever thought of before, very worthy, needs to be supported, needs to be registered because they would fit easily into the categories that we have ...

The other thing that's happened is they're doing a bigger review of the Care Standards Act. Now that's overarching our framework and that's partly because the two Regulators, ourselves for social care and the Healthcare Commission ... we're officially one body ... we've got an emphasis on providing responsibility and self-improvement ...

From a local social care perspective, the flexibility of CSCI in decision-making was viewed pragmatically. It was thought this was linked to a need to protect residential care as a resource but placing increased emphasis on the ability of individual homes to demonstrate how they can meet their residents' needs. A LA community resource manager provided this summary:

I think they [CSCI] want to move the sector forward and I know that one of their aims is not to stifle businesses setting up and homes setting up and private companies, because if they do there won't be enough homes! So I think they'd like to keep it as flexible as possible ... I think that because, what CSCI have done of late, they've actually relaxed a lot of their regulations ... they're very much assessing homes on whether or not they meet the needs of the residents that are there at any given time – so that very much then puts it down to the home.

At a national level, a representative of the nursing profession considered this departure by CSCI from normal regulations was essentially a response to increased pressure on community health services. New partnership-working with care

homes was perceived to place greater emphasis on resource use and targets rather than on benefits to residents. A national nurse advisor said:

One of the difficulties with CSCI is that they are not consistent and actually the reason that they are calling [site 3] a pilot is they are outside of the care standard legislation. The legislation is very, very clear that there have to be registered nurses in a care home giving nursing care, but they will flex around a bit and half the time CSCI doesn't know what is happening. So it is not about saying we should be supporting care homes, we should be working in partnership for the benefit of patients, it is about saying we should be working with them because we have got to keep this moving because otherwise we won't meet the 18 weeks target, we won't meet this related to delayed discharges and we'll be fined ... so it's a very different emphasis I think.

From the local social care perspective, while accepting the pressure on community health services, a need for regulation at the interface of residential carers' new roles with nursing skills and those of the registered nurse was considered necessary. An LA community resource manager observed:

I think what needs to probably be regulated is this definition between nursing and higher end residential; I think that's getting quite blurry and might need to be more defined in a regulatory way.

Development of a 'new role' carer workforce

Authors have previously suggested that some tasks undertaken by nurses could be met by care staff (O'Kell, 2002; Carpenter and Perry, 2001). Through this, residential homes operating with an appropriate staff skill mix should be able to meet the increasing complexity of needs and dependency of older residents. Studies in different settings (Bozak, 2003; Ely, 2001) suggest that changing vision and practice takes time before benefits can be realised and initially could lower staff morale, produce resistance and harden the

subscription to traditional cultural values. However, despite the challenges the care home managers in the three study sites used terms such as 'demand-led', 'person-centred' and 'responsive to health and social needs' to describe the key reasons for the up-skilling of their care staff workforce. Other key drivers identified were a rise in the average age of residents, increased morbidity associated with age and more complex needs. There was recognition that up-skilling the workforce was also a means of empowering care staff and raising awareness, as one LA community resource manager explained:

And I think the more you start having a more holistic approach to care, straight away staff are having to think differently and then hopefully that's raising their whole kind of awareness of their responsibilities and their importance. I envisage over the next couple of years, these will be conversations I'll be having with people and we may need to be re-looking at the whole way we work, what we call people and what their job description actually is.

Our review of job descriptions for carer and senior carer in the three residential homes demonstrated inconsistencies in employment requirements for care staff. Only site 3 had a qualification requirement for both carer and senior carer roles. It was also the only site to emphasise the possession of health care skills and the need to undertake further training, including that for dementia/mental health.

Ageism, that is, the low value that society places on older people and by association on those caring for them, was also identified by a national nurse advisor as a hidden factor limiting advances in residential care for older people.

If you can earn more stacking shelves in a supermarket than you can earn providing care then I think that suggests that society doesn't value care work and if you put that alongside the fact that we know a Western society doesn't tend to value ageing then ... culturally you've already got a challenge before you even start to look at the services that you're trying to provide.

When considering the challenge of limited resources and pressure on service provision, the situation was analysed in detail by national nurse advisor who thought that organisations might seek less expensive options rather than employ registered nurses. This was coupled with public confusion over the definition of 'a nurse' as well as ever changing and contradictory predictions around the sufficiency of the existing nursing workforce to meet future demand. Within this context, nursing was believed to be in danger of being de-professionalised by such cost containment policy.

If society were serious about looking at skill mix and about looking at the best service home for delivering care to people in care homes then I think we have to acknowledge that we need to look beyond what would be cheaper and that's the bit that concerns me, that increasingly organisations are saying it will be cheaper if we have more care workers or they're saying we need more care workers because we can't recruit registered nurses. They don't differentiate and the fact that those health care support workers are nursing ... so what is protected is the term registered nurse, but of course the public don't understand the difference between a registered nurse and a nurse.

So we have a policy context of de-professionalising the profession; we have a policy context where we know that there has been phenomenal problems in terms of the workforce and workforce forecasts undertaken by the Department of Health and there's mismatch ... but I think we do need to be aware that there will be a temptation to reduce, and reduce, and reduce the cost of care for people in care homes.

The push for integration of health and social care

Several authors recommend the need for care homes to have greater access to NHS nursing expertise not least because care home staff were described as being isolated and excluded from main stream care systems (Chambers and Tyrer, 2002; Davies, 2001). However, as policy continues to push for a closer integration of health care and social care (Department of Health, 2006), this

implies a merger of two different forms of care in the residential care home setting. In a world where both sectors subscribe to the terminology of person-centred care, the concept of a boundary between health care and social care was believed to be artificial, as indicated by a national nurse advisor:

I think one of the difficulties ... is the very muddled thinking around the boundaries between health and social care and if one is truly looking at providing what I would call holistic, humanistic person-centred care then those boundaries are false and you can't say this is a health need and this is a social need and therein lies the problem. The reality is for everybody we have health needs and we have social needs and you don't differentiate and you don't need to differentiate that is unless you need long-term care.

A further message in current policy rhetoric, irrespective of the care settings, is consumer (client or patient) rights. The older individual's rights as an NHS patient are embedded in policy which stresses a person's right to exercise choice and to expect inclusion and equality in access to services (Department of Health, 2001b, 2006, 2008b). Yet it has been argued that this policy is not actually implemented for the older consumer, for example when in need of end of life care. If cared for in a nursing home, this person could be eligible for receipt of FNCC payment and could receive end of life care in situ (Department of Health, 2009), whereas he or she would be ineligible if nursed in a residential home and would therefore be unable to remain in place.

With residents' health failing as they age and the associated increase in staff costs, all three residential homes reported a shortfall in funding as they attempted to maintain individuals in the home. If the additional care cost could not be met by the resident or absorbed by the home, it was likely to result in transfer into hospital or to a nursing home, shifting costs to the health service. Home managers considered that this situation undermined any policy rhetoric on consumer rights and integration. It also affected a residential home's ability to provide a home for life. As one home manager said:

If you're not a traditional nursing type home they don't want to give you nursing level funding [FNCC]. We are working very hard to try and get it. There's no specific guideline as to where the nursing band level really is: there's nothing that says that is specifically 'it'. Yes, they [voluntary organisation] pick up the tab which is not really fair – it's a risk factor – a real cost and it's ludicrous – where's the common sense?

The changes introduced in the residential homes under study were viewed as one means of turning the rhetoric of integration into a reality. Innovation and training were perceived by management as breaking down barriers which had historically defined care provision as two separate entities – health and social care. An LA community resource manager described how staff's values and beliefs underpinning different ways of working and cultures were gradually being eroded. New ways of tackling problems jointly were being identified that represented a learning process for all:

As a joint effort we saw it very much about changing culture. It was about building relationships, so I guess we've done it a lot by example. We've done it a lot by integrating with the [care home] staff, being there with them, talking to them, explaining things. Then we've done it by listening to them and looking at what they perceive to be some of the barriers as to why they felt they couldn't do all of the things. ... Some were cultural barriers, but others were barriers that we could actually tackle. So what we did was we looked to changing the culture from different angles. Some of it was about just empowering the staff and enabling them to make more decisions for themselves so that they felt they could do things for residents. Some of it was about actually putting physical things in place ... some of the practical things were just about physically changing the care plan format so that we could actually get people to follow a process that made them write down all the information about people and more of a person-centred approach.

Key findings

Despite clear regulations differentiating care homes with nursing from residential homes, flexibility in CSCI regulation was crucial to residential homes' initiatives to up-skill care staff to undertake fundamental nursing tasks. However, social care and nursing stakeholders, while recognising the pressures on community staff providing long-term care for increasing numbers of old and infirm people, differed in their perception of this irregularity. For nursing stakeholders, the notion of a cheaper workforce providing nursing rather than nurses was perceived as a reflection of ageism on one hand and as de-professionalisation on the other. In contrast, a social care stakeholder took the stance that up-skilling care staff with nursing skills would both protect the residential home sector as a resource and empower the carer workforce. Both the nursing and social care stakeholders agreed that no boundary between health and social care was necessary to deliver person-centred care. However, the interface between RN activities and those of up-skilled carers may need to be addressed through regulation.

From the residents' viewpoint, policy expressing individuals' rights as NHS patients appeared to be undermined by that of FNCC, which depicts residential care residents as ineligible for funding to meet RN care when need arises in this setting. This anomaly has the further implication of undermining the residential homes' desire to offer residents a home for life as care costs increase towards the end of life; the individual resident may not be able to meet such costs.

4 Meeting the needs of residents

Older people and their views of enhanced care

Research has suggested that up-skilling care staff can produce benefits for residents in terms of improved quality of life, increased activity and stimulation, more positive interactions and relationships between residents and staff, as well as more appropriate and directed care (Fleming and Taylor, 2006; Smith *et al.*, 2005; Proctor *et al.*, 1998).

Residents and their relatives provided comments on aspects of the enhanced care they received or observed in the three residential sites. The views expressed, including specific comments, have been summarised as strengths and weaknesses for each site in Table 3. All residents, irrespective of the home, felt included in decisions about their health care.

It was evident from dialogues with residents and relatives that, to them, the human qualities of care staff were even more important than

Table 3. Views of residents and relatives on three residential homes

Site 1 Strengths	Site 1 Weaknesses
<i>'I love it – felt ready for it.'</i>	Having to comply with the imposed routine.
Responsibility for bills, plus other cares of running a house taken away.	Poor food.
<i>'Care staff have a sense of humour, caring attitude.'</i>	Some staff have a poor attitude towards some dependent residents.
Those able to live independently are enabled to retain their independence but can receive care if they require it.	Management's lack of visibility.
	Unclear as to what flexible skill mix was but there was an awareness that staff were developing new ways of working and training.
Site 2 Strengths	Site 2 Weaknesses
<i>'The atmosphere is calm, homely and the staff are helpful.'</i>	One relative thought the present regime has <i>'changed for the worse'</i> , with its current concentration on skills rather than the possession of a caring attitude.
The care workers get to know the residents: <i>'there is attention to detail'</i> .	Call-out doctors do not know the residents, so play safe and order them to be admitted to hospital for many conditions which could perhaps be resolved differently.
The manager displays a professional attitude.	There is a lack of continuity, in that staff rotate between the units, so staff cannot specialise in dementia care.
Palliative care described as <i>'good'</i> and <i>'dignified'</i> .	Due to rotation of staff: <i>'key worker not often available'</i> .
	Few residents or relatives knew that staff were adopting new ways of working to enhance personal and social care.
Site 3 Strengths	Site 3 Weaknesses
Staff show an understanding of residents' needs. Manager is <i>'fantastic'</i> .	Insufficient lounges for residents and relatives outside of rooms.
IRT described as <i>'a brilliant thing – the home should continue with the service for the good of the residents'</i> .	Relatives were either unaware that their relative had a key worker or had not been given the opportunity to meet with one.
Relatives appear happy with the quality of care: <i>'his clothes are clean, his hygiene, he's obviously looked after'</i> .	Communication between care staff in the EMI unit with relatives was poor. For example, not informing relatives of falls or medication changes.
The rooms are much better because they've got en suite facilities.	The home is like <i>'a prison'</i> .

their knowledge and skills. For example, a man whose wife had dementia observed that 'a caring disposition, plus the quality of empathy with those cared for, would be more valuable to residents than the ability to perform certain tasks'. A resident in a different home similarly commented on the importance of positive care staff attitudes above his home's physical environment: 'it's not the view, it's not the decorations, it's not the garden that makes a good home, it's the staff'.

This was highlighted by a national nurse advisor as a key factor when selecting care staff. She said:

Their [staff] value system is a starting point, how people view older people, how they behave. Their behaviour is more important than their knowledge. Whether they're kind, whether they're compassionate, whether they actually like older people, whether they view older people as valuable members of society, whether they view older people as having rights, whether they view them as having something to offer, whether there's a sense of reciprocity, whether there's a sense of a relationship, whether they truly wish to engage with the residents that they're actually working with. That kind of thing I think is much more important than what you do if the temperature is raised because I think that can be taught.

In site 1 the more independent the resident, the more positive they were about the home and the attitudes of care staff. Although, in general, care staff were described as 'nice people', some residents with higher dependency needs and their relatives commented that certain staff lacked empathy and insight. However, their communication skills were thought to be improving with training. Interviewees were unclear as to what FSM actually meant, although there was some awareness that staff were engaged in developing new ways of working and training.

Residents in site 2 appeared positive about the home both as a caring environment and as a high quality care provider. The few negative comments were largely directed towards environmental issues, although one resident did make reference to preferring the regime of the previous home

manager, which was perceived as being less task orientated. All of the residents interviewed wanted to stay in the home for as long as possible. The only circumstances in which they could envisage leaving for a nursing home would be if they really had no other option. Three residents recalled adverse experiences of nursing care in the local hospital and were fearful of a future admission.

In site 3 residents and relatives thought that care staff had a good understanding of their needs, were happy with the level of care provided and appreciated the in-reach nursing team input as a good way of enabling them to remain in the home and avoid hospitalisation or transfer to a nursing home. However, communication between staff and the relatives of EMI residents was regarded as 'poor', with relatives declaring they were dependent on one senior carer as their main source of information and comfort. Relatives were unfamiliar with the key worker and some felt the home was under a heavy workload pressure and had insufficient staff.

A resident's views of 'enhanced care'

Mrs A says that the care workers are not especially caring and that for some carers the residents are just old people. She observes that the care workers do not take the trouble to discover anything about the residents' past lives although, like her own, these are often interesting. She believes that complaints to management and carers are not always acted on, with excuses often made, and that the management approach can be disempowering when being talked at rather than with. She says she tries to keep a low profile so as not to annoy the care workers. She does not believe that the care workers have sufficient nursing skills and compares this negatively with the ability of nurses.

Relatives' views of dementia care

Mr B is a man in his early 80s who entered residential care following the death of his wife as he could no longer safely remain in his own home because of his severe dementia. The decision to enter care was made by his close relatives in consultation with a social worker. His relatives say they are happy with his general care, stating that his clothes are kept clean, his hygiene is good and that it is obvious that he is looked after well.

However, although the staff are not nasty or horrible, relatives have noticed that they are always very busy; consequently, relatives feel they are troubling them by asking questions regarding Mr B's care. The relatives like to be informed of any changes in Mr B's behavioural state and his care or medication changes. However, this only seems to happen when one particular senior carer is on duty. They feel that this may be due to a lack of continuity brought about through staff moving between different floors of the home.

Mr B had just started on a day release to the local mental health day hospital and although he has only been there twice the relatives say that they haven't had any feedback from it. They would have liked to have gone there as flies on the wall to see how he was progressing but had not been offered the chance to do so.

The relatives claimed they had never been introduced to Mr B's key worker and only found out who she was through a chance meeting in the lift when the key worker enquired about who they were visiting.

A home for life

All three residential homes aimed to meet the residents' desire for a 'home for life'. A home manager said:

Many of our residents walk in our front door and we take them right through and eventually yes they may leave and they've passed on and

they're going out the door, their funerals go from here and the families go from here and the families come back here. So we're taking them through a whole process and that is so rewarding ... because we've discussed it with residents and they get comfort in knowing that we're still there right up to the end.

A senior carer NVQ3 also emphasised the benefits of preventing unnecessary hospital admissions:

They can stay where they are, it is easier when they haven't got to go to hospital, sometimes they get frightened, they won't always tell you if they are not feeling very well because they think they have to go to hospital straight away. So that [being able to 'stay put'] is good, I think that is a good thing.

However, in reality the aim of providing a home for life was not easy to achieve. The main factors undermining this were external rather than internal to the home. Like other managers, the care home manager in site 1 identified a major challenge as the shortfall in funding when a resident's care needs increased to the point where RN care was required. He said, 'if you're not a traditional nursing type home they [PCT] don't want to give you nursing level funding [FNCC]'.

In site 2 a tendency for local GPs to admit residents to hospital would also seem to have been detrimental to the home's desire to provide a 'stay put' policy, as a home deputy manager explained:

I feel that doctors are so keen on sending them to hospital ... doctors most definitely would have an interest in that [up-skilling carers with clinical skills] because they are again quite reluctant to come and see elderly people. A little bit of support would be good when you are doing everything that we possibly can.

This tendency towards hospitalisation was also observed in the approach of out-of-hours doctors covering GP practices by a resident: 'emergency call-out doctors do not know residents, so play safe and order them to be admitted to hospital for many conditions which

could perhaps be resolved differently'. Such examples also suggest that if the opportunity to avoid hospital admissions had been taken, it might have resulted in savings to the health service.

A resident's perspective on transfer to hospital

Mrs C is a bright and articulate 89-year-old lady with a well-developed sense of humour. She has lived in the home since becoming unable to live independently because of arthritis. Recently, following an episode when her right leg became paralysed, Mrs C was hospitalised for two weeks. Following a lengthy wait for an X-ray, she was given injections and became confused on admission to a geriatric ward. She becomes emotional as she recounts her distressing memories of her stay on this ward.

She claims she was unable to eat the food although she tried. She describes being placed on a commode and left there for long periods before being put back to bed without being wiped clean and dry, resulting in sores on her bottom. She was given a pad but she says this was not changed for five days.

Mrs C says she did not do anything wrong or anything to annoy the nurses and does not know why they were so nasty, yelling at her to get back into bed.

Once back in the home, Mrs C says that she lost all her confidence and couldn't remember things as well as before. She did not want to leave her room, refusing even to get dressed. This continued for a fortnight until she was eventually coaxed out of her self-imposed seclusion by one of the care workers. She says that as a result of the skilled care received following her return to the care home, her soreness has cleared up, she now enjoys her meals and is regaining the weight. However, she says she is still suffering from this experience and if she ever had to go back to that hospital she would go mad. The home manager put in a complaint about the poor state of her health on her return from the hospital.

Because of factors such as these, care home staff were conscious that they had to manage the expectations of their new residents. In site 3, as described by a senior carer NVQ3, residents were made aware on admission that circumstances could arise in which transfer to a nursing home or hospital might be required:

We do, sort of, say "look you might not be able to stay". I mean, when they first come we all, we say to them that, you know, "this is your home as long as possible but", but we do always say the 'but' bit.

It was also acknowledged that in some cases transfer to a nursing home could be necessary for 'best care interest' or if there was the expectation of a protracted palliative phase.

However, interviews with local community nurses testified to the high quality of palliative care that could be provided by care staff. There were also personal and professional gains from this experience for both staff and those cared for, as reported by the site 2 community nurse:

They have had palliative care patients before [for] which the care has been fantastic. Which I did pass on to the staff because you couldn't wish for anything better. Because we would come in and do certain things but then you know they were being really looked after and I think that helps the family as well. It was really nice to see.

Staff in all three residential homes reported that they recorded a resident's end of life wishes and attempts were made to meet the wishes of residents and their relatives in this respect.

A home manager said:

Since January we've lost six residents – within that time ... the staff have grown in taking responsibility and confidence ... to date, three residents have been nursed at the highest Level 6, and all have died here according to their relatives' wishes.

A resident's perspective on a 'home for life'

Mrs D is a lady in her mid-80s with a neurological disease. She came into the home straight from hospital. The decision to move into a home was taken by doctors and social workers because they considered her to be unsafe on her own due to falls and scalds. Mrs D would rather have remained in her own home, but felt she had no choice in the matter. A significant concern to Mrs D is that she may have to move to a nursing home as her condition deteriorates. She worries about financing her care ahead should her nursing needs increase and the money from her house sale runs out. She knows some residents have been told that they can stay for life, but this has not been said to her.

Providing enhanced care

Several authors recommend the need for care homes to have greater access to NHS nursing expertise because care home staff have been described as being isolated and excluded from main stream care systems (Chambers and Tyrer, 2002; Davies, 2001). Older people in residential care homes have limited access to nursing skills, although they are thought to have a wide range of health needs that could be helped by nursing support (Goodman and Woolley, 2004). The audit data collected in this study (see Table 1) confirmed that the residential homes had between 68 per cent and 76 per cent of the care needs recorded for the nursing home residents. Care staff recognised that residents entering their homes had greater care needs than in the past and required increased support from care home staff from the start, as a senior carer said:

There's a significant change in the health of people coming into care. They are now more vulnerable, frail, elderly and less independent. Ten years ago the type of person entering residential care was more capable; less confused, frail or needy. They retained a certain

level of independence, but now care staff have to do a great deal more for the residents.

In sites 1 and 3 there was a strong consensus on the need for more community nurse support to enable enhanced care provision rather than for increased access to nurses in-house. Presumably this was because these sites already had access to nursing (either in-house or via in-reach). In site 2, where there was complete reliance on community nurses, a desire for increased access to nurses in-house was recorded.

Providing care for EMI residents was viewed as presenting particular challenges. This was especially the case in site 1 where 'inappropriate demands from residents' and 'problem residents' were reported by some care staff to cause the highest level of pressure by care staff. A need for more practical training was also evident as an NVQ3 carer said 'I feel I know a lot about dementia, but not how to deal with it'. That this was a challenging area of care in this particular home is unsurprising. Dementia and mental illness were conditions that lay outside this home's admission criteria.

In contrast, in site 2, regular staff rotation through the EMI unit provided an opportunity for all NVQ staff to gain experience of dementia care and other mental illnesses. Care staff (including the home manager) were more confident in their provision of care and proud of their achievements. One care worker with NVQ2 spoke of her enthusiasm for work on the dementia unit and 'the achievement of helping them live on a daily basis'. She said that work on the unit had 'opened her eyes to a lot of things' and, referring specifically to this work, that she was 'proud to do it'. In focus groups, care staff identified that it was especially crucial to be able to detect changes in the behaviour of those residents who cannot articulate their symptoms and felt that their training was very important here.

In site 3 'fear of assault at work' was a significant stressor identified for survey respondents. This home, which also had an EMI unit, had by far the highest percentage of residents with dementia and challenging behaviour (see Table 1). The fear of assault probably also reflected the relative inexperience of carers, in contrast to the more experienced care home staff in site 2.

The fact that residents with mental health and behavioural problems present particular challenges and worries to care staff did not appear to have been addressed adequately by NVQ training. As explained by a senior carer NVQ3:

They [the staff] seemed to be quite frightened to begin with ... what if somebody's got me up against the wall, you know, hands round my throat? How do I call for help? ... there was a rolling programme set up about dementia care ... the feedback I've had from staff is that the training didn't really answer all their questions, so obviously there's still an area that needs to be addressed.

However, there was a markedly positive change in staff attitudes found on this site following the hands-on intervention of community professionals such as occupational therapists (OTs) and community psychiatric nurses (CPNs) in the in-reach team. As a senior carer NVQ3 explained 'the [OT] input's been excellent, it really has, giving us ideas mainly around how we communicate with residents on our dementia floor and the environmental issues within the home'.

Of the three residential homes, staff in site 2 were the most content with their work. In contrast, care staff in the newly opened home on site 3 were identified to be under most pressure, more stressed and the least satisfied with the recognition they received for their work. Even so, they were not dissatisfied with their organisation as an employer and showed no desire to change occupation. In later interviews, these early difficulties were diminishing and staff in this site appeared to be more content and settled under the new management.

The participant residential homes also had future aspirations. In the case of site 1 a future need specific to the home was for a psychiatric nurse to support the development of specialist advanced skills within 'new role' care staff to reduce the need for resident transfer. In site 3 the vision was to create an opportunity for mild dementia residents to be placed in the home's frail elderly unit as the initial phase of a staged dementia service option for those who could no longer be cared for in their own homes.

Key findings

Residents and relatives identified positive attributes of the homes in terms of the physical environment and the care received. In contrast, where they were critical, this was predominantly directed, to a greater or lesser extent across the three sites, towards the quality of care received. In this, the human qualities of care staff were regarded as more important than their knowledge and skills with communication deficits the most frequent sources of residents' and relatives' concerns. Few of the residents or relatives were aware of the particular approach being provided in their individual home site. Site 2 had the least criticism from residents and relatives, and its staff were the most content at work.

Avoiding hospitalisation, in some cases because of adverse experiences, was raised by a few residents. However, the tendency of GPs to admit rather than allow the resident to stay put was recognised by some care managers and residents as limiting the ideal of staying in the home for life. Some residents gave accounts of their ongoing anxieties about the prospect of transfer to a nursing home should their health deteriorate to the point where they could no longer be maintained by staff in the home or by their personal finance to fund any additional care costs.

Care staff recognised that in comparison with the past, residents on admission had increased health needs requiring nursing care and this was evidenced through audit findings. Thus, more RN input was a request from all sites. Of the residents' nursing needs met by care staff, evidence suggests that palliative care practices were the most praised internally and externally for its good quality across all sites. However, care for residents with dementia was seen as problematic when care staff were inexperienced and had not had community professionals providing expert on-site support. Short training courses in this area of care away from practice areas was mostly described as inadequate.

5 The reality of up-skilling residential carers

Fleming and Taylor (2006) in a survey of home care workers found that care staff who had completed National Vocational Qualifications (NVQ) at Level 2 reported higher levels of job satisfaction and confidence. However, a mapping exercise of the development of new types of working initiatives in the south west region (Smallacombe and McHugh, 2007), including NVQ, found a diversity of training programmes for care workers and suggested that a more standardised learning pathway would provide a recognisable status and skill base that would be transferable across both health and social care environments.

Clinical skills and sources of learning

Staff with NVQ2 and NVQ3 were asked about the types of clinical skills they had developed and were using and the sources from which they had learnt. The first survey (see Table 4) showed that the majority of residential home staff who were employing clinical skills held NVQ3.

These staff were predominantly in sites 1 and 3 where NVQ3 learning had an ‘add-on’ clinical skills training award developed by their respective

organisations. Although site 2 care staff were the least likely to report that they employed clinical skills, interviews revealed that most had undertaken some monitoring tasks and minor dressings. However, this was only under the direction of the community nurse and in response to a specific resident’s needs. Clinical skills development also involved formal learning via courses (mainly free) from local colleges of further education and online distance learning courses, reflecting the lower training budget in this home.

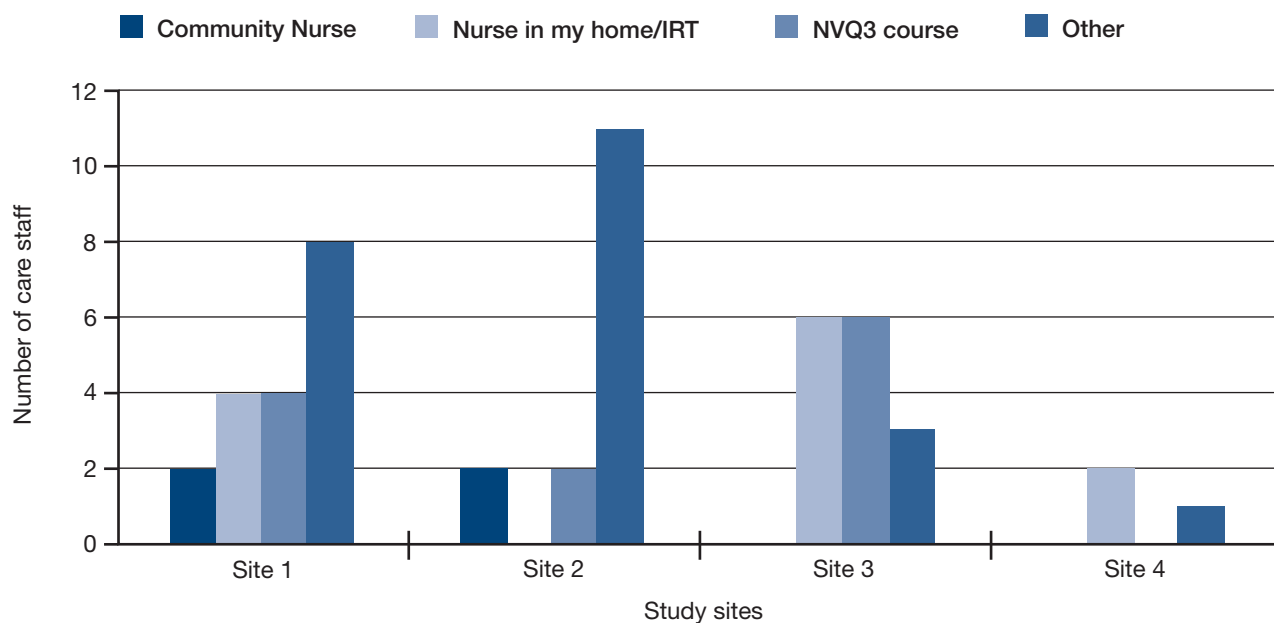
Overall, one in five carers who responded to the first survey identified NVQ3 courses as the main source of learning for their health activities (see Figure 1). A similar proportion identified in-house registered nurses (in-house RNs in site 1 and the in-reach team nurses in site 3); site 2 had no in-house nurse resource. However, two out of five carers reported they were using ‘other’ sources of learning. These were mainly knowledge-based courses provided in house or by colleges of further education; additional sources included informal learning from other care staff. This pattern suggests that current NVQ3 courses alone cannot meet ‘new role’ care staff’s clinical learning requirements.

Table 4. Clinical activities undertaken by residential care home staff

Type of task	Home		
	Site 1	Site 2	Site 3
BP	2√3√4√	2√	2√3√
TPR	2√3√4√	2√3√	2√3√
Urine testing	2√3√4√	2√3√	2√3√
Sterile dressings	2√3√	2√3√	2√3√
Non-sterile dressings	2√3√4√	2√3√	2√3√
Medications	2√3√4√	2√3√	2√3√
Other	2√ (catheter care)		4S5S (blood sugar monitoring)

Note: 2√ = activity undertaken by NVQ2 non-nursing staff employed by care home; 3√ = activity undertaken by NVQ3 non-nursing staff employed by care home; 4√ = activity undertaken by NVQ4 non-nursing staff employed by care home.

Figure 1. Sources of care staff's clinical learning, by site (N = 56)



Examples of 'other' in-house or external learning

- Courses for palliative care
- Courses for dementia care
- Courses for diabetes
- Courses for continence promotion
- Course for falls prevention

The relevance of NVQ courses

Residential home staff expressed concerns about the relevance of NVQ courses to their clinical practice. This was highlighted by a senior training manager who suggested that NVQ3 courses were not up to date in terms of informing the clinical activities being undertaken by 'new role' care staff working in residential homes: 'I really think it's because it's [NVQ3] been written for hospitals and nursing homes. Residential homes don't traditionally expect carers to be doing clinical and they've not caught up with that.'

Thus, it was not surprising that in sites 1 and 3, assessors thought that staff saw the content of

NVQ3 courses as separate from their learning for clinical practice. As an assessor said, 'the staff saw it [NVQ3 learning] as being an additional chore that they had to do, rather than as part of it all [up-skilling]'. Of further concern, as reported by a national nurse stakeholder (participating in a course for home managers), was the lack of requirement for the NVQ student to demonstrate the acquisition of knowledge beyond course work in order to meet NVQ standards:

I realised that you could actually go through a whole NVQ programme with no input ... just so as long as you produce the information that qualifies you against the criteria then nobody is actually asking about your knowledge or anything else ... it is a worry.

A site 2 assessor had addressed this problem by breaking down the standards to make the learning process more meaningful to students:

There is a self-assessment manual which should be completed by the staff. Every standard is in there. But I have had to break them down so that we can pick it up [by assessor during supervision], rather than just do a tick box thing.

Issues of assessment, supervision and maintenance of competencies

In this study, a number of issues around assessment, supervision and the maintenance of competencies for NVQ3 staff, with and without clinical skills learning, were highlighted. In site 1, the quality of external assessors was viewed as problematic if, despite holding an assessor qualification, they did not have residential care experience to enable an appropriate assessment of work-based learning. The home manager explained:

A lot of free external assessors are offered to you – especially from businesses – who may have done the assessor’s course but never have worked in care. How can you tell someone else what to do when you don’t know yourself?

The same manager also raised concerns about consistency in the NVQ system. Although various commercial NVQ courses were offered via the internet, the quality mechanisms were viewed as questionable. With respect to a carer who had self-initiated NVQ4 via an internet course, the manager said:

I said I’d never recognise it as I don’t see how you can do it through the internet. An assessor came out, I think she was a night worker, came to assess her but she didn’t do anything. I’d never recognise this.

The same doubts were echoed by the manager of the comparator nursing home in relation to the quality of a commercially purchased NVQ2 course and its assessors:

We don’t do in-house NVQ. They actually buy it in from a company that they use. Personally I don’t think that they are that good really ... I think that it is all a bit hit and miss. The assessors come into the home, and they will give the girls or chaps a series of work to do ready for another date but then they are ages with the date. It could be months before they come back so there is not a lot of continuity.

There was some difference in opinion between sites 1 and 2 as to whether the NVQ assessor should be internal or external to the home. In site 1, an internal NVQ3 assessor thought that older care staff preferred the comfort of having a known internal assessor, perhaps because of insecurity about the process of assessment:

There are a lot of mature carers, who don’t actually see that they need a qualification to prove themselves ... A lot are scared to sit down and do questions and answers. What’s worked for us is having an assessor here – they have that relationship ... we have a good laugh working side by side. If we had an assessor from outside the attitude would be “who’s this kid telling me what to do?”

In contrast, in site 2 it was the quality of the individual assessor that was described as paramount. From the home manager’s perspective, having an external assessor did not appear to be a threat:

We have assessors and NVQs are only as good as the assessor that has delivered it, so there is an awful lot of people out there that have got the same [assessor] certificate as my staff have, but I bet they are not as good because we are really, really thorough. But it’s more than that ‘cos you need somebody to come into your home and work with you.

Maintaining the clinical competencies of staff was seen as important by management in all three residential homes and in the comparator nursing home. This was particularly true for skills that may not be regularly used. It is of interest to note that in site 3, while the teaching of skills could be undertaken by a non-nurse, a nurse was deemed as essential by a community resource centre manager for maintenance of competency:

I have been having some discussions with the NVQ trainer and she feels that we can manage to deliver the awards quite easily without a nurse assessor – but what we can’t do without a nurse assessor is keep the competency up.

Motivation of care staff for further learning

Introducing change in an organisation requires an understanding of its culture and what motivates its staff (Davies and Nolan, 2002; Matosevic *et al.*, 2007). The survey showed (see Table 5) that overall the main motivation for further training among NVQ levels 2 and above was personal and professional growth. For a carer who was already trained to level NVQ2 it was observed:

[carer] did not especially want to do the extra training for NVQ level 3, but she felt that this appears to be the way that the care industry is going and to have any future career in care as a 'new role' carer, this training is becoming essential.

Increased personal pride was cited in several interviews, as a senior carer NVQ3 commented, 'they [NVQ3 carers] feel a bit proud don't they?'

An increase in pay was also viewed as an incentive to further learning, but this was not necessarily available to staff. In site 1 new role professional status and increased responsibility following achievement of NVQ3 attracted a small pay increment. The home manager said 'it's a big responsibility and I do feel it needs to be seen as an achievement, it needs some increments for a member of staff to be able to provide a better quality service'. In contrast, no financial incentives were offered to care staff in site 3. A small incentive was offered in site 2, but this was not believed to be acceptable to staff. Managers in the last two

sites considered that some form of financial recognition was necessary:

If people [carers] are going to work towards these targets, and obviously they achieve, they've got to get something for that achievement. That's not part of the council thinking though.

Local stakeholders (both qualified nurses) associated with sites 2 and 3 also highlighted the fact that clinical training would create the potential for care staff to demand an increase in pay. A community nurse observed that 'then you've probably got issues with pay. If they are doing something extra should they be getting a recognised pay rise for that?' A community matron made a similar observation, but she was also sensitive to the fact that personal growth could be another form of reward for staff:

The slight negative that you're always going to get in the background with any of these kinds of things is that, 'oh well, we're [NVQ3 staff] just doing more and more but we've got the same job and the same money but we're doing more and more nursing things'. The positive outlook on it is they feel very pleased about how they can help the residents and how much better it is and how they feel more in control of things.

In site 2 consideration of differing approaches to up-skilling staff for care improvement were being explored against the remit of efficient use of financial resources, economies of scale within the workforce and investment in community

Table 5. Key motivators for training reported by residential home staff (N = 19*)

Training motivators	Agree (%)
Formal qualifications to progress in your career	95
Feeling of achievement/boost to self-esteem	95
Greater inclusion in decision-making/planning	83
Praise/recognition from managers/those above	67
Praise/recognition from colleagues	58
Increase in salary	58
Uniform change	11
Extra time off	11

Note: *4 missing values

continuum 'village' developments. A strategic approach to ensuring financial support for 'new role' carers and their training needs could mean that residential care may need to price 'bed units' at an amount incorporating 'new role' care costs, as suggested by a senior organisation manager:

... effective commissioning could be actually buying a bed here, in a skilled up home that is going to prevent more expense later down the road. But there's a journey about how do we get commissioners down that road?

Care staff attitudes towards 'new role' learning

Only in site 2 did care staff identify achievement of NVQ3 learning as a means of enhancing quality of care through new roles: 'the enhanced skills [social and personal care] give us confidence to perform the role of senior carer'. Perhaps this was because in this home skills development was built on a familiar foundation of social and personal care experience and knowledge in the NVQ3 course. Staff were therefore not experiencing the additional challenge of formally acquiring clinical skills through an add-on in-house health skills award, as in sites 1 and 3.

In fact, some care staff expressed a reluctance to accept delegated responsibility following the attainment of new skills through NVQ3 with add-on clinical training. As one NVQ3 carer in site 1 explained, 'the up-skilling of care workers to NVQ3 should not be used as an excuse for any other professional or manager to delegate inappropriately'. Care staff in site 3 similarly appeared to find the change in their role initially challenging. For some, pressure from management to undertake NVQ3 training was evident: 'there was a lot of negativity, but I think they [NVQ3 care staff] can see the benefits'. There was also a lack of confidence related to age:

I think it is good for the younger ones because they can take that on in nursing but some of us older ones don't feel they want to do that and I don't think you should be forced into doing it [NVQ3].

However, in later interviews this lack of confidence was less of an issue for care staff when linked to developing team support systems:

I think we'd have confidence, but then if we did have problems then we just contact the district nurses, but I think between us all, as a team, we'd have the confidence and we'd back each other I think.

Stakeholders' views of NVQ level 3 learning

Towards the end of the study, local stakeholders were asked whether the 'new role' carer development had met their expectations. Stakeholders in sites 1 and 3 expressed mixed views, indicating that although some progress had taken place, in comparison with nurses, care staff inevitably had limitations in practice. As an organisation assessor manager explained:

We're inputting on an 'as needed basis', because you can't sometimes pre-empt problems before they come up. Because they're not there so you wouldn't think of putting in the training beforehand ... But I think a nurse does come with a lot more knowledge and however much training you give to these girls they're not going to have the knowledge that a nurse brings with them and they're never going to have the insight that the nurse has.

However, there was no doubt that the new role care staff were useful in the eyes of a senior organisation manager in site 1:

I think in general, the NVQ3s in this present batch are probably as good as they get but then you know they ought to be shouldn't they? I wish there were more NVQs, really, really useful.

In site 3 progress with 'new role' carers was similarly viewed with mixed feelings by local stakeholders. On the one hand, an NVQ assessor judged that staff confidence had grown:

There has been a lot of progress. There's people who have taken on the NTOW [New Type of Worker] which has enhanced skills and they feel really proud about it. A bit reluctant in the beginning, new learning, new way of documenting but that is my feeling of what they said to me about it and the way I thought it would be, very positive. I believe their confidence has grown, yes, but I don't think they come about as confident. They would say 'oh yes I can do that now', but they have learnt that and that is where they are at the moment.

On the other hand, progress in terms of developing a learning organisation was seen as being undermined by the attitudes of care staff and because managers were perceived as being insufficiently enthusiastic. As a community matron observed:

Yes, but I'm not sure that we've made massive progress with regards incorporating learning and things within the care home environment, because it's always given a lower priority, it's given a lower priority by the staff and that because it's given a lower priority by the managers.

Key findings

The study's findings indicated a need to establish more clinical relevance for NVQ3 course content. The link between care staff's knowledge-based learning and related practice appeared to be weakened by this. A standardised quality control system for assessors, assessment and maintenance of competency in order to ensure more universal confidence in, and currency for, this qualification was also considered to be desirable. Lack of incentives for care staff to undertake learning for new roles was generally recognised but this was only addressed in one site. Progress in new roles was regarded as fairly positive, with limitations arising when comparison with RNs was made. The cost of up-skilling staff and ways of this being met strategically was raised.

6 Organisational change and new ways of working

Workforce development can be organisationally, culturally and personally challenging for those involved (Nies and Berman, 2004). Staff working through change in different settings can have adverse reactions including low morale, resistance and a tendency to cling to traditional cultural values (Bozak, 2003; Ely, 2001).

Integrating health and social care

In recognition of the increased needs of older residents, most external senior managers and national stakeholders identified a holistic and integrated social and health care approach as the optimum way of working. However, as shown in Figure 2, a significant proportion of care home staff think that social care and health care involve ‘very different’ ways of working. This figure was just over 50 per cent in site 1, although lower in sites 2 and 3 and in the nursing home.

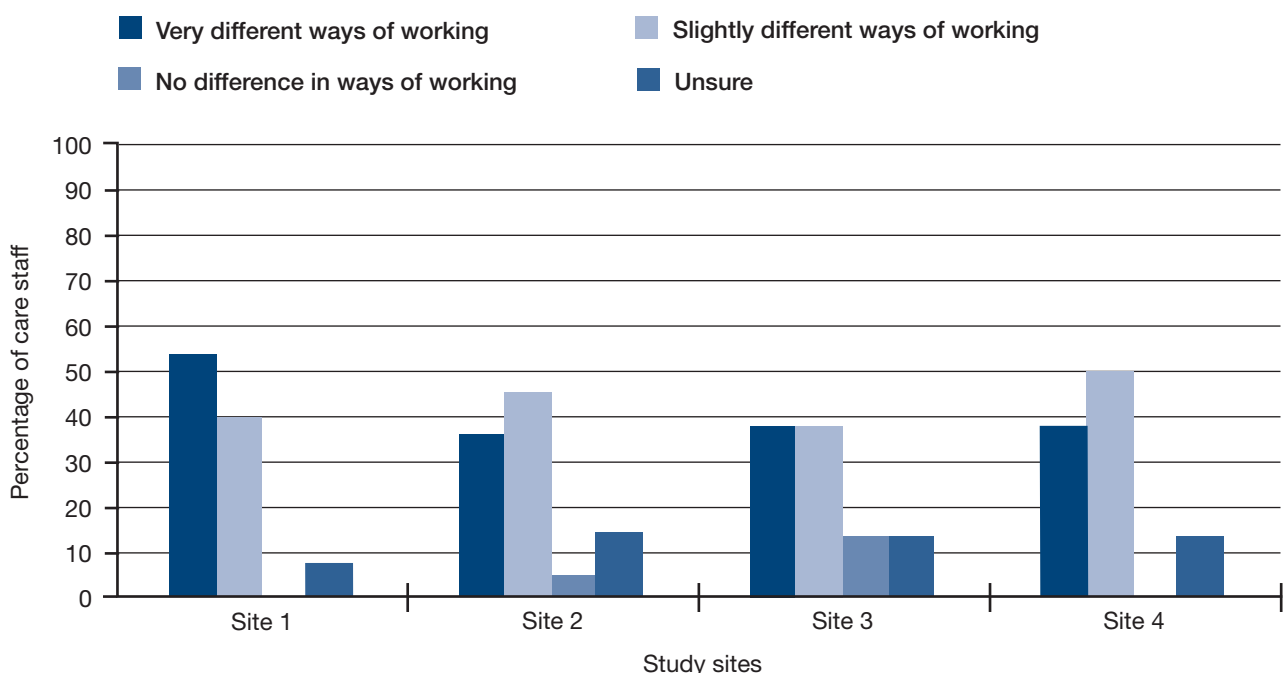
A senior manager in site 1 expressed the view that residents’ needs should be approached holistically. The role of the carer should be similar

to that of the traditional state enrolled nurse (SEN), a mixture of both nursing and social skills. However, the deputy home manager in this site (a RN) thought that nursing (see Appendix) itself had significantly changed. Thus, there was a perceived difference between nursing in the context of social care and that provided by RNs as health care:

The definition of what constitutes nursing care has changed significantly; previously, personal care was classed as something a nurse would do, but now this is classed as social care. Technical procedures such as dressings, injections, catheters, enemas, etc., are now what are regarded as constituting nursing care.

Only in site 3 was the issue of merging health care with social care addressed as a cultural process. In this, the importance of developing two-way relationships between management and staff was seen as the key to understanding and overcoming barriers to change. However, there was also recognition by an LA community

Figure 2. Care staff’s perceptions of health and social care ways of working, by site (%; N = 53)



resource manager that change can separate staff into those who embrace it and those who resist it, with the latter as a minority:

So it was a kind of a coming at it from many different angles ... you get onto the next layer and if we're honest it's only probably come down to a very handful of staff who are still [reluctant]. I think they want to move forward, so that's a plus, but they're finding it a bit more difficult to do so.

In this site, a senior carer NVQ3 also highlighted language differences between social care and in-reach nurses as a barrier to integrated ways of working:

I think we have just got to learn to work together a bit more, it has never been done before ... trained nurses, district nurses are taking on a different role and they are trying to teach us ... it is just as difficult for them as it is for us I suppose ... and they come out with all these big words that you don't understand ...

Quality of internal and external relationships

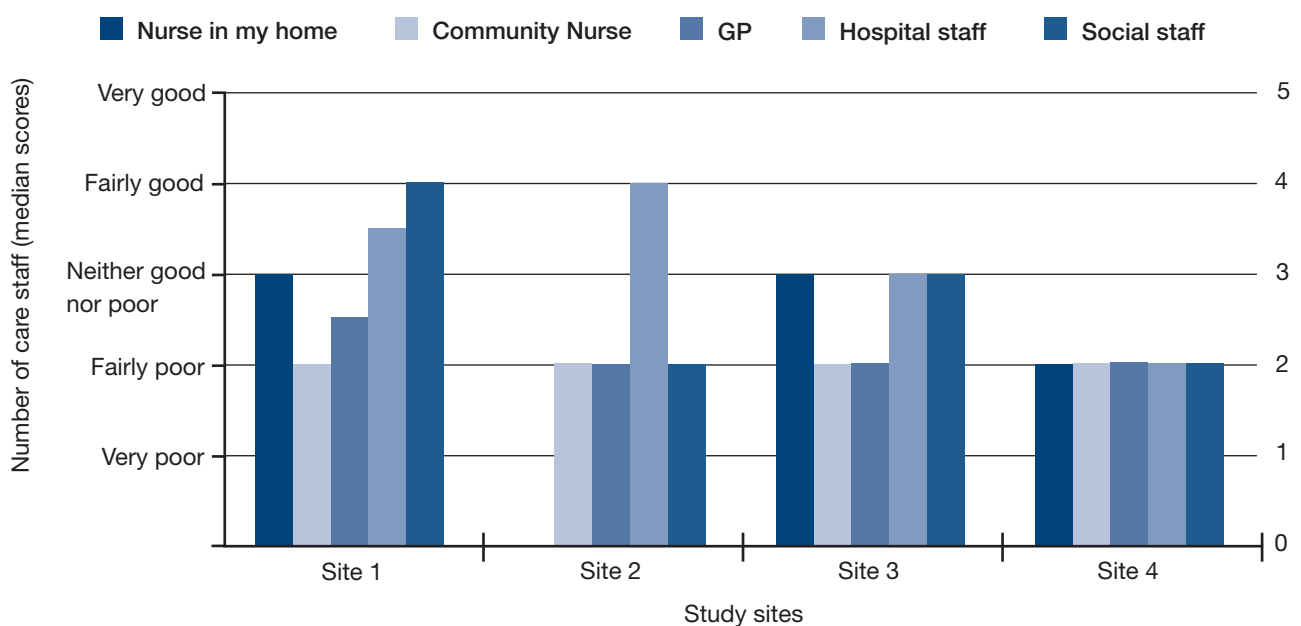
Relationships at different levels are important for any organisational change. Internal relationships

between care staff of different grades and their managers were rated as 'fairly good' or 'very good' in the surveys. In this there were no particular differences between the sites (see Figure 3). In sites 1 and 3, where there was some access to in-house nurses (including dedicated in-reach), care staff were neutral about these relationships, describing them as 'neither good nor bad'. But relationships with community nurses were viewed more positively, being described as 'good' by care staff in all homes, with comments such as, 'we get on better with our district nursing team. A really good relationship with them'.

In contrast, care staff rated their relationships with hospital staff as 'fairly poor'. Examples of poor joint-working often focused on discharge practice, including late night discharge of residents and incomplete discharge paperwork. As one care home manager described it:

Sometimes residents are discharged 11pm in a night. They expect us to pick up the aftercare and we've nothing to work with – very common. I will always go and see a resident before discharge to get as much info as possible. They'll say "I didn't know you were coming". I feel frustrated – they're just so pushed to get them out of blocking a bed ... Makes me feel residents are not important. They need a proper system.

Figure 3. Care staff's relationships with other professionals, by site (median scores; N = 53)



In survey responses, relationships with GPs were rated as 'fairly good' by care staff in all homes. But comments in interviews were sometimes less positive. Care staff described some GPs' attitudes as condescending. In particular, they mentioned use of language that excluded them and reported GP refusals to requests for visits as disempowering. One NVQ3 carer said that 'carers work with the residents every day and know when something is wrong, but the GPs don't always agree. Doctors come out with things I don't know what they're on about – [I] stand back from doctor'. Another 'new role' carer with NVQ3 explained:

I don't think they realise [about new NVQ3 role], and unfortunately the senior doctor gets a bit uppity 'cos he says he's more qualified than anybody so don't tell him what to do, so we don't basically.

Finally, only one care home (site 2) described their relationship with social workers as 'good'. In this case, as a traditional social care home, it appeared that a common social care language eased the relationship, 'I would say yes definitely from personal point of view. No qualms with social worker – no jargon from the social worker'.

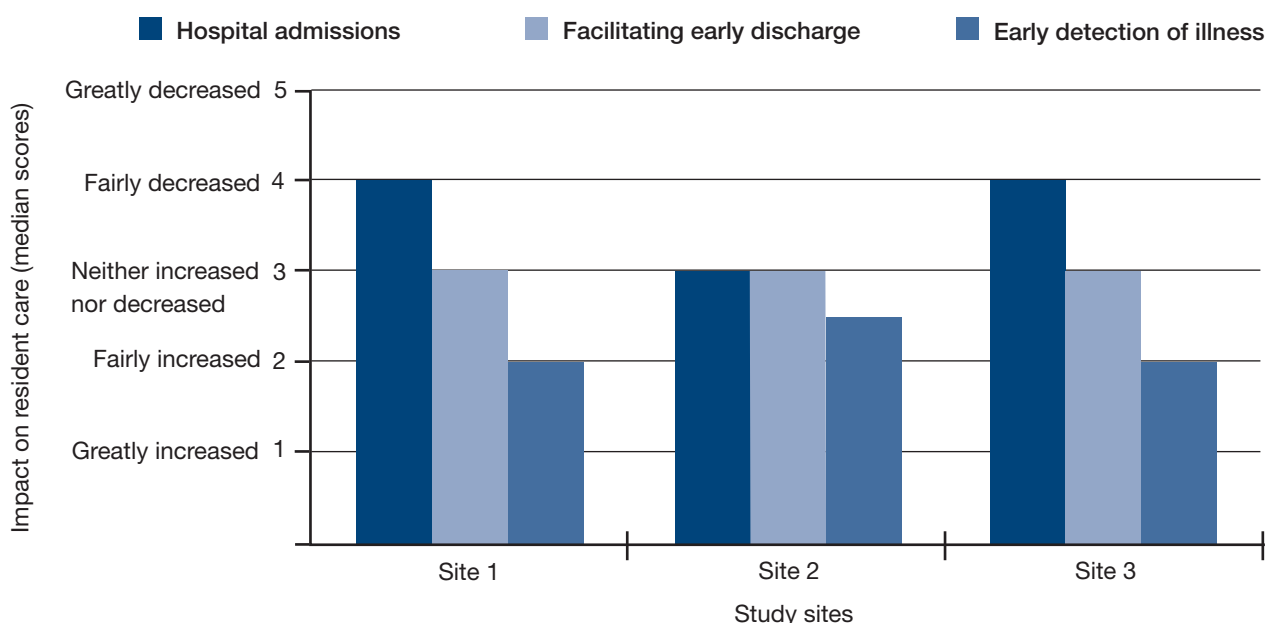
In terms of any external impact, Figure 4 shows that none of the residential homes reported that the NVQ3 role had facilitated early hospital

discharges, which is perhaps not unexpected in the light of comments on this interface. Only one home (site 3) considered that new role working had led to a decrease in community nurse and GP workloads, but only moderately so. However, in both sites 1 and 3 the introduction of enhanced care was thought to be associated with a decrease in hospital admissions as well as a moderate increase in the early detection of illness. In site 2, where this was not reported, it was possible that staff were less aware of the potential to reduce hospital admissions, perhaps because their clinical input was more limited. These findings suggest that up-skilling staff with clinical skills (sites 1 and 3) can have more wide-reaching benefits than NVQ3 training with no add-on clinical skills. Most importantly, despite limitations, sites 1 and 3 with clinical skills achieved moderate impact on safely avoiding hospital admissions and all approaches believed they reduced community nursing workload, albeit with some increase to their own.

The influence of management on change implementation

Like all change agents, care home managers had the potential to act as a catalyst or a barrier to introducing innovation in their residential home (Nelson *et al.*, 2009). The important role of the residential care home manager in implementing

Figure 4. Impact of the NVQ3 new role on resident care, by site (median scores; N = 53)



change was recognised by senior community health care staff. As one community matron put it:

I just admire residential care home managers because they have a lot to take on and a lot to do and a lot of responsibility and I think that's one thing that I've learned over the past couple of years.

Factors such as management style and leadership qualities were particularly important. In site 1, the care home manager adopted a fairly hands-off approach to leadership, with significant delegation to deputy managers. The manager viewed this as essential, but was aware of the risks: 'it's joint, ... you've got to be a risk-taker ... you've got to be very careful how you choose them [deputy managers] and be honest and tell them what we're doing is different, it is very different'. The deputy managers and team leaders appreciated her approach: 'she [home manager] isn't breathing down your neck ... she'll listen to you if you've a problem – she doesn't follow you around. If she did I'd be out of the door'. However, senior management appeared remote to care staff at NVQ level 3 and below because of the hands-off approach. This distance sometimes produced a lack of confidence in NVQ3 staff's ability to undertake additional responsibilities during times of absence of senior management. These care staff stated that they had been put in the position of having to make decisions which they did not feel confident to make. Another inherent difficulty in introducing change in this site was the diffuse concept of flexible skill mix. As a parent organisation's senior manager said, 'maybe ... perhaps we hadn't really got over the vision of what we were trying to do clearly enough'.

In site 2, the care home manager had adopted a more visible leadership champion role. This was supported by the organisation's senior management, 'you've got to have a local champion, you've got to have your home manager like [current home manager] as a champion and be seen'. The home manager also had a keen sense of her role as working jointly with her deputy manager:

I suppose I have a passion ... I want to be seen as the best really and I'm a great believer in training. You can see the benefits of that and I'm

lucky because [deputy manager] thinks very much the way that I do ... as a team ...

Comments from care staff with NVQ3 in this site confirmed that the management style was viewed as democratic as well as visible. Change was thought to be supported by meaningful structures and policies, which provided clarity and purpose. As one NVQ3 team leader explained, 'I feel I'm directed – I certainly know I can go to [the manager] for support. There's an excellent structure – there's always a reason for things ... and being part of a team.' At an operational level, this style of management was the one most appreciated by staff. Measures of job satisfaction showed that care staff were the most contented in this home. However, it should be remembered that, since the enhanced care approach was grounded in social and personal care, it could have been the least challenging in terms of necessitating major cultural change.

The partnership approach adopted in site 3, with a highly visible dedicated IRT of nurses, was probably the easiest change to explain to staff. However, this site also had the most diffuse management structure. In addition to their care home line managers, NVQ3 staff with clinical roles were also responsible to individual IRT nurses and to the community matron managing the IRT team for their clinical activities. The end result was empowerment of staff through enhanced responsibility, as an LA community resource manager explained:

But what the whole process of lifting people up and enabling them and empowering them has meant is that we've actually now been able to show the people who have embraced this much more open way of doing things and that they've got to make decisions and take on responsibilities.

This approach was perhaps also the most challenging change to stabilise. The reason was partly due to the move to a new building and closure of existing care homes and also the appointment of staff new to dementia care. This was exacerbated by a succession of care home managers. Initial measures of work stress and

job satisfaction indicated that staff here were the most stressed and least contented with their work overall. However, with the introduction of stable management and consolidation of relationships with IRT staff, by the end of the study there was noticeable improvement. The permanent home manager introduced a more open style of management. While continuing to be 'top down' in terms of the pursuit of a service-led vision, this enabled decision-making to be inclusive of practice level NVQ3 care staff:

They [managers] all exchange their views and different ways of working and it comes to an agreement ... support workers like that because they're involved in having their say ... that's how it should be, everybody should be valued at the same level really.

In comparison, in the nursing home (site 4) although the management style was described by staff as 'supportive', 'helpful' and 'reassuring' with a strong emphasis on 'team work', it was also far less challenging. Interestingly, there was little evidence of change, as reported by two nurses who were interviewed: 'it's the same routine here, no new challenges'; and 'it's stagnant in the home, the same old routine'. The nursing home, while operationally efficient, was the least dynamic. The emphasis appeared to be more on maintaining quality, as opposed to enhancing it, and up-skilling of care staff did not seem to be part of the external or internal management agenda.

Key findings

Although most external senior managers and national stakeholders identified a holistic and integrated social and health care approach as the optimum way of working, some care staff (particularly in site 3) believed that social care and health care involved very different ways of working. This suggested that care staff, in learning new clinical activities, saw these more as tasks than as skills. This in turn reflected the earlier observation that care staff tended to perceive learning as separate from practice.

Although survey results indicated that relationships between care staff with community

nurses and GPs were good, during interviews certain care staff commented negatively about the attitude of some GPs. Relationships with hospital staff involved with discharge were reported as being poor across the sites. Only in site 2 was the relationship with social workers given as fairly good. Sites 1 and 3 claimed some moderate effect on reducing hospital admissions and in the early detection of residents' illnesses.

The leadership quality of care home managers in supporting staff and residents through the changes related to their up-skilling was shown to vary according to the management style adopted. The visible, hands-on management style in site 2 seemed to create a climate of appreciation in staff and residents and relatives, whereas the detached and remote style adopted in site 1 had the opposite effect. Although all sites subscribed to a person-centred approach to care, care staff in site 1 perceived the ways of working in health and in social care as being very different, to a greater extent than those in sites 2 and 3. Only in site 3 was the issue of cultural challenge raised as an issue to be overcome in order to progress care staff within its particular approach.

7 Professionalising the carer workforce

Some authors contend that the lack of clear definition of the care worker role could be of detriment to work satisfaction and minimise role potential (Baldwin *et al.*, 2003), while others suggest that it could reduce the public perception and confidence in the skills and knowledge of the care worker (McKenna *et al.*, 2004). In the present study, a number of factors was consistently identified as important to the future development of the carer workforce as a profession.

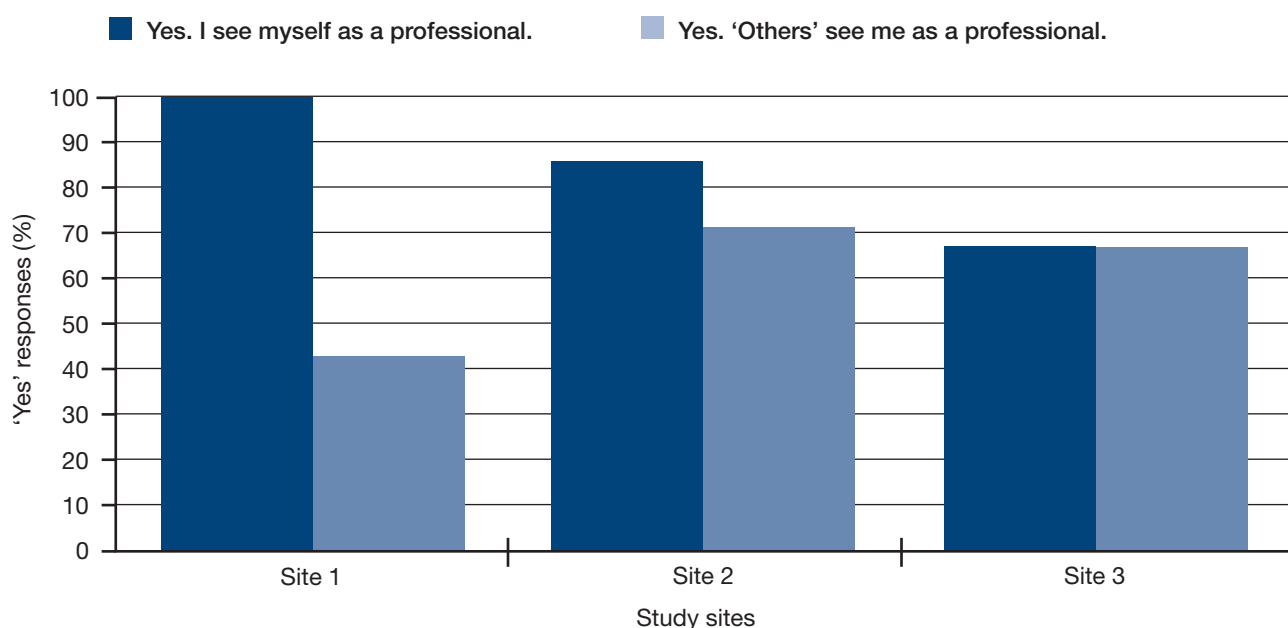
Professional growth

Perceptions of professional attributes, culture and role boundaries all emerged as important issues in interviews with carers. However, the extent to which a carer profession would develop was open to debate. As observed by an LA community resource manager, although traditionally this workforce had been placed within social care, pressure for integration with health care could create a new workforce beyond the basic support workers:

I think the level of needs of people in the homes is going up so clearly we need the staff to go up too [increase skills]. So I think at some point we're going to have to actually look at that and actually think about saying, well actually these aren't really just support workers any more.

Growing confidence is also important to professional growth. Survey responses (see Figure 5) showed that care staff in site 1 were the most confident in their sense of personal professionalism. However, staff in this site were also the least positive in terms of whether they thought the wider world regarded them as professionals. One reason given for this was the influence that 'bad press' had in undermining public opinion of residential carers. Staff in this site were also the most positive towards the introduction of formal qualifications and the registration of carers. This suggests that they had made a connection between acquiring improved status through qualifications and other formal professional structures.

Figure 5. Care staff's perceptions of professional status, by site (% of 'Yes' responses; N = 20)



In contrast, staff in site 3 were the least positive about seeing themselves as professionals or being seen by others as such. Furthermore, these staff were those who were least likely to perceive formal qualifications as an attribute of a professional. However, given its proactive clinical skills learning and requirement for new cross-cultural ways of working with IRT nurses, this was arguably the most challenged of the three sites in the approach implemented.

Differences also became apparent when responses were considered in light of the respondent's qualifications. New role learning at NVQ3 was a catalyst for promoting change in the carer workforce's attitudes, collectively and as individuals, to their professional status in all three residential homes. However, NVQ4 staff (in administrative/managerial roles) were the most likely of all staff groups to place equal emphasis on competency or skills and on possession of formal qualifications. This suggests that the higher the level of formal qualification, the greater the likelihood of care staff viewing this as a form of professional empowerment. In contrast, care staff holding NVQ2 qualifications were less likely than those with NVQ3 or NVQ4 to think that others viewed support carers as being professionals (see Figure 6).

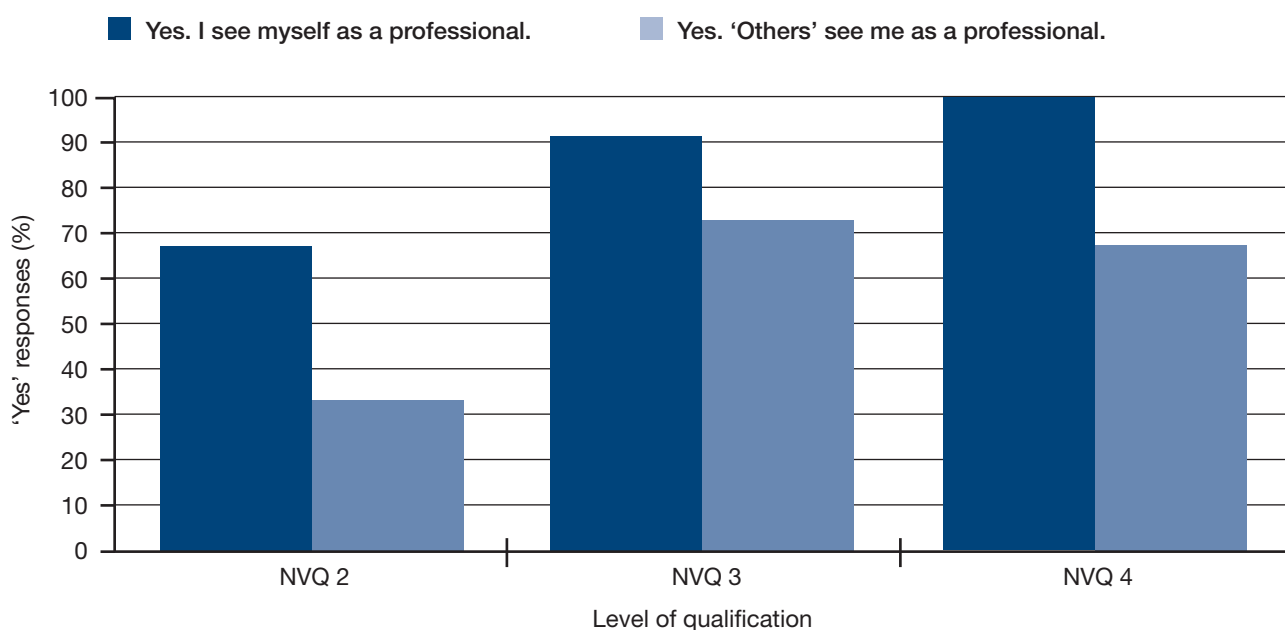
Union membership

Union membership, often a feature of established professions, was very low among care staff in all sites. Most care staff said they had little knowledge about, or interest in, union representation for either individual or professional matters. This outcome was influenced by neither the type of home nor the individual's qualifications. There was also no relationship between union membership and a desire for the registration of care staff. Some of those interviewed did comment that union membership was not part of residential homes' culture, although a link was made to its potential to raise awareness of accountability. A senior carer NVQ3 said:

Unions would help the thing about this accountability and stuff like that, I suppose if they're [care staff] not aware of maybe the accountability they don't see the use of the union maybe.

In general, responses suggested that the fact that the workforce in different care homes are isolated one from another has acted as a barrier to the spread of employment information and representation mechanisms common to other similarly sized yet closer-knit workforces.

Figure 6. Care staff's perceptions of professional status by qualifications (% of 'Yes' responses; N = 20)



Issues of accountability and liability

Awareness that accountability was an issue was evident among some care staff in all homes, but not universally so. As a result of the NVQ3 new role, accountability was described as 'fairly increased' by care staff. However, an understanding of the relationships between accountability, competency and liability related to practice was less well articulated by staff than the idea of accountability as a single entity. This lack of awareness is possibly due to the absence of a supportive and articulate professional framework akin to other professional groups, for example, nurses in the RCN. Furthermore, there was an ongoing debate around delegation of work by nurses to care staff in residential homes, as a national nurse advisor admitted:

I think that the RCN has always in its lobbying work argued that if care assistants are going to be carrying out nursing activities as delegated by registered nurses then that funding should follow. However, the difficulty with that is that we're then saying that nursing is delivered by non-registered nurses. So it's a tricky one to actually say it needs to be exactly like this.

Evidence from a focus group with IRT nurses suggested that they were not overtly threatened by carer workforce developments that include nursing skills. However, while supportive of the development of the care staff workforce in theory, they were more concerned about regulating competency than about the development of carers as a profession:

I think there needs to be regulation, because obviously they are being asked to do a lot more, and there's no way of actually seeing, you know, how competent they are and whether that's updated regularly at the moment. So I think they do need that in place, yeah.

Furthermore, when asked if professional processes should be the same as for nursing they said 'not as much'.

Some NVQ3 care staff working in sites 1 and 3 (flexible skill-mix home and community resource centre care home) mentioned a lack of confidence

in undertaking new role responsibilities. Reportedly, top down management pressure was being placed on staff to undertake 'new role' activities. From these accounts, it should not be left to care staff to determine where their new role's cut off is in terms of learning and practising new skills. On either count, and in the absence of a professional framework, unrealistic pressure could lead to unrealistic expectations that could place residents at risk. For all these reasons, it is not surprising that such 'new role' care staff showed a moderate understanding of accountability (but less of its relationship with liability) and low membership of unions. In one site (the independent sector commercial home), a manager was apprehensive about taking on such 'new roles' with clinical skills if the care staff are not protected:

It's finding the boundaries as what carers could do and the accountability bit and I feel like I want something a bit more defined before we go ahead with that, so we know that we're doing it right and we're not exposed to any kind of comebacks on that.

Impact of NVQ3 new role on workload

It is suggested that if efficient, integrated care delivery is to be provided to older people, it is essential that the workforce is sufficient in number, skilled, knowledgeable and motivated. However, the authors recommend a grading structure with remunerative incentives to attract more young people into care work. Yet the care worker turnover rate in council-run residential care homes for older people is one of the highest in the council-provided social care sector with contributory factors given as: low pay, heavy workloads, a lack of role definition and no clearly defined career structure (Skills for Care, 2008). In the initial survey, the impact of the new care staff role was reported to have increased the workload of NVQ3 care staff in all three residential sites. Notwithstanding, some differences were observed (see Figure 7). These possibly reflected different ways of working, and varying capabilities of staff on the three sites.

In site 1 the survey indicated that any additional workload due to new role working was thought to

fall more on NVQ3 grade than other staff. Interview comments also suggested that some NVQ2 staff perceived that NVQ3 staff were becoming less hands-on. A care staff focus group identified that, while the senior care workers sort out doctors' appointments and medication, it can mean that there are only two care workers (NVQ2) left to cope with the needs of the residents. This was described as leading to resentment on their part, 'since people have to be told to wait while the only available workers get through all the tasks'. This imbalance in ways of working between groups of staff was further observed by a carer with NVQ2:

There is currently so much emphasis placed on NVQ3 when it is the NVQ2 qualified staff who actually do most of the caring work and the interacting with the residents, especially personal care such as toileting, bathing, etc.

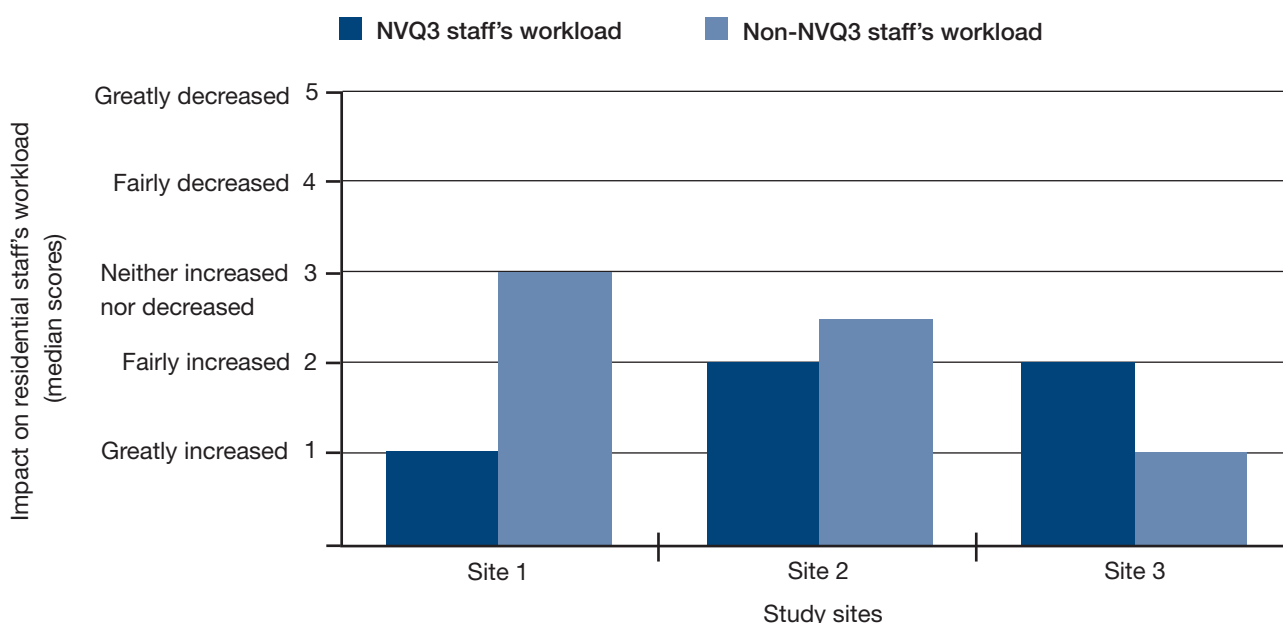
In contrast, in site 2 increased workload was reported as being more evenly spread across NVQ2 and NVQ3 grades of staff. Staff had adopted a more team-based approach to meet the fluctuating needs of residents. However, as reported from site 1, new ways of working were also thought to be taking NVQ3 staff away from hands-on care. Time was generally agreed to

be the main pressure, 'simply getting everything done. If something unexpected crops up which inevitably happens given the nature of the residents, often around 8.30am, the planned schedule has to change; being flexible is essential.' Having to 'step away from hands-on care to organise the shift' was found to be a significant change to which NVQ3 staff had to adjust.

In contrast, in site 3 care staff identified that any increased workload fell on NVQ2 staff. The IRT matron also believed that additional health-orientated care was currently being provided at the expense of social care. It was thought that the home was under-staffed, even without the addition of health care skills:

But what we became acutely aware of is that even with additional nursing type skills and knowledge, there still was never enough social care hands-on hours ... they needed more frequent changes in position, they needed maybe feeding when they were unwell, they needed more frequent skin care, more frequent changes of, you know, clinical equipment, catheters, tubes, bits, and that adds up to more care hours, that's many more care hours, you know. Is it nursing, is it care, is it social care? Whatever – they cannot provide it.

Figure 7. Impact of the NVQ3 new role on residential staff's workload, by site (median scores; N = 56)



Key findings

Care staff's understanding of issues crucial to the development of a care staff profession and the links between them was limited and inconsistent. The issues considered included: a professional framework to foster responsibility, accountability and competency; their relationship with liability; and carer registration and recognised formal qualifications. Links to unions could play a part in developing supportive structures for such 'new role' care staff, but given their relatively isolated circumstances of working in residential homes, carers were largely unaware of this potential. However, adverse press reporting tended to undermine some care staff's sense of their professional status as seen by the world at large.

The NVQ3 role was believed to have increased care staff's workload and to have put pressure on time for social care giving. All residential homes' approaches placed added value on increased input from qualified nurses in addition to that already accessed. The enhanced quality of care reported as achieved in site 2 supports a view that good basic health/nursing care can be delivered in a residential home with outreach to community nurses alone, provided that there is a sound practice-driven relationship and that care staff have sufficient knowledge to know when to seek timely nurse-led support.

8 Conclusions and next steps

Choice, control and quality of life for older people: turning the policy rhetoric into reality

The study highlights a tendency for the needs of older people in long-term care to be perceived as creating demands that overwhelm the capacity of available services to provide optimum care. The language used by certain public sector staff to view and describe older residents as ‘a burden on community services’, a reported lack of interest in residents from some general practitioners, a disregard from hospital discharge liaison teams and poor nursing provided as part of hospital inpatient care collectively indicate that negative and ageist attitudes are widely held. Despite the rhetoric of choice and control, the reality of entry to residential care is based on professionally assessed differentiation of need (for nursing, or non-nursing care) and available funding. The choice exercised by the person and significant others has lower priority and, in any case, they are often unaware of the differences between residential and nursing homes.

The study suggests that the development of ‘new role’ carers could help to make a reality of choice, control and quality of life for older people. There is certainly potential to enable those in residential care homes to remain there much longer – and perhaps to end their lives there – rather than having to move unnecessarily into a nursing home or hospital. However, it is clear that this will depend not only on the development of new skills within these homes; it will also depend on achieving much greater flexibility in the funding of care, the registration of homes and the definitions of health and social care.

Rationalising funding and pay mechanisms to improve choice and continuity

The study has highlighted the thorny issue of who pays for what and who benefits financially, in different models of care. It is apparent that enhanced care approaches can take the pressure off the health care system – despite limitations, two homes achieved moderate impact on safely avoiding hospital admissions and all believed they reduced community nursing workload, albeit with some increase to their own. But without any integration of health and social care budgets, there is little incentive for the change. PCTs need to consider how they use any resources saved through accelerated discharge from hospital: could health care savings potentially be used to support residential homes? These changes also bring their own costs, but up-skilling staff without any extra income for care homes will be unsustainable.

The study also highlighted the specific issue of funding for health needs in care home settings – and the mismatch between setting, resident dependency and funding. Although it has been difficult to quantify the impact of this economically, it is an issue that must not be avoided. The findings suggest that, in the drive for efficient use of resources, fundamental issues have been overlooked which, if unaddressed, could impede and dilute the achievement of integrated services for older people. The study has identified that the FNCC funding anomaly – whereby funding is based on the setting in which the older person resides rather than following their needs as they develop – undermines approaches to providing a ‘home for life’. As a by-product, it can also create anticipatory anxiety in the residents, who most of all wish to stay put, but who may have no financial means to do so. Thus, contrary to the policy-makers’ rhetoric, the resident is rendered disempowered and unable to exercise choice as an NHS patient. Furthermore,

seeking to contain the costs of residential care, LAs also inevitably load service costs onto the NHS, rather than introducing more cost-effective integration of health and social care.

In summary, it is essential that we move towards a system of funding that is clear, fair and adequate for the individual's needs as they change and develop towards the end of life – ideally without meaning they have to move in order to be entitled to this.

Improving training and care practice

A key part of any professional framework is the educational system underpinning roles and responsibilities. The study has highlighted the importance of a robust, respected qualification framework and its findings indicate inadequacies in the standardisation and quality control system for NVQ course content and its supervision and assessment. It appears that NVQ3 might not be the right vehicle to up-skill staff in clinical skills; in addition, there is concern that it may not be recognised in future. This undermines universal confidence in, and currency for, these qualifications.

The study also highlights the importance of training being affordable and accessible to care homes and of course materials being relevant and accessible to the staff using them.

A Skills for Care report (2007a) on care staff's workforce development has highlighted a diverse system of qualifications and titles to describe 'new roles' (although without a clear definition of what the new roles encompass) and has recommended the need for a more cohesive training strategy. It would seem timely to address these issues in relation to wider professional health and social care professions, to ensure that 'new role' care staff are professionally enabled rather than used. It is suggested that the findings of this study could usefully inform the work of the new Skills Academy (see Appendix) in developing courses that integrate leadership and management skills with practice development.

Rolling out enhanced care approaches with clinical up-skilling of care staff would seem to require time, not only for new learning,

but also for care staff to adjust to change and gain confidence in their new roles.

Strengthening cross-sector relationships

In recent years, people have tended to go into residential care at a later stage, meaning that levels of morbidity and dependency in the homes are higher. This has tipped the scales towards nursing needs from social care needs more quickly post-admission, with the effect of narrowing differences between nursing home and residential home care and between nursing and social care. The obvious response is for a more integrated approach.

The research findings highlight a need for community health professionals and, in particular, GPs, to better appreciate the burden of responsibility carried by home managers and their staff and to reassess their own responsibilities towards residents as NHS patients. The study has found that the growth in confidence generated by increased knowledge and skills in 'new role' care staff can encourage a more challenging and informative relationship between care home staff and their GPs. However, if lack of interest and support is already the norm for a particular GP, this could be exacerbated as increased responsibility is taken up by care staff, leaving these staff to make decisions beyond their expertise. This perhaps highlights the need for older people in these care homes to also have access to a gerontological specialist, as they do in hospital – although attempts to catalyse development of community gerontologists (cf. community paediatricians) have not been successful to date, despite a shift towards prevention.

In contrast, the research identified that having nursing input to all homes was viewed as essential and highly effective where relationships are good. One way of developing such relationships may be to open up care homes as a learning environment. Currently student nurses are placed in nursing homes but not in residential homes – this could be a reason why some community nurses do not view residential homes positively once they are qualified.

The study has highlighted the irresponsible manner in which residents can be discharged back to care homes. The incidents reported in the

study appeared largely to be as a result of a general ignorance of the level and nature of residential home care, especially the challenges it faces if discharges are made out of normal hours. Importantly, hospital staff seemed to overlook that they were also disregarding the right of the resident as an individual and their duty of care to them as a patient. In one home, several residents described local hospital inpatient nursing care as so appalling that they were very anxious to avoid hospitalisation in the future.

Overall, there is clearly a need for better understanding between hospital, community and residential staff about their roles and responsibilities, but also about the values and principles that underpin their work. At present this is exacerbated by the different charging and funding regimes associated with 'health' and 'social' care and the arguably artificial definition – or lack of definition – as to what falls into which category.

Sustainability of approaches to enhanced care

Those care homes that are testing out new approaches can rightly be viewed as pioneering a new way which has the potential to provide consumer-led health and social care – albeit with a reliance on community services to sustain their approaches. All are striving to find new ways of improving the lives of their residents, while working within common constraints of limited resources, relative isolation and the context of a 'forgotten sector' in terms of research and policy. However, in a resource-led climate where regulation is likely to continue to be flexible as demand increases, some caution is to be recommended. There is a risk that the emergence of the 'new role' care staff workforce – without as yet an agreed name, recognised qualification, clear professional structure or registration system, or clearly defined interface with other professions such as nursing and social work – could leave older residents with a second-class service over which there is little central control.

Analysis of the enhanced residential care being provided emphasises the importance of care home management as a crucial and influential catalyst for change. However, the study has shown how differences in management styles and philosophies underpinning their respective approaches can

either help or hinder progress. One home was helped materially by a strong and generous parent organisation yet hampered by the inability of its management to fully translate and share the vision with staff. Yet, despite limitations, sites with clinical skills achieved moderate impact on safely, avoiding hospital admissions, and all approaches believed they reduced community nursing workload, albeit with some increase to their own.

Although a flexible and transparent style of management at an operational level is important, dependence on a strong internal champion could also represent a potential vulnerability in terms of long-term sustainability. Enhanced care could disintegrate if the manager, as the 'champion/leader', leaves and other business factors come into play alongside strategic quality improvement. A management style based on positive two-way engagement with care staff, including devolved responsibility, would guard against this.

The study suggests that the sustainability and future development of new approaches is largely dependent on local management. The added challenge of introducing new roles with enhanced care means that care home managers and local stakeholders need to accept a realistic timeframe for benefits to become visible. Such leaders would benefit from expert change management support.

Professionalising and rewarding the care home workforce

The study highlighted the need for an increasingly professional workforce – both to meet the needs of (and protect) the older person, and to give the sector more of a voice and influence in improving the structures and context in which it has to operate.

Although the study has demonstrated that up-skilling can have an economic return for the NHS, this was under conditions where care home staff were not paid more. However, it may be that there is little incentive for people to up-skill to a higher level if there is no extra pay (current guidance for councils on calculating a fair market price for care suggests the same hourly rate for non-senior carers at NVQ2 and above in residential homes; see Laing, 2008). Low pay and undifferentiated pay are a key issue in this debate and are likely

to have a direct effect on morale and retention of staff. A full economic evaluation of raising pay levels in line with the skills and qualifications required by 'new role' workers would be very helpful.

Even when they have achieved NVQ3, care staff often lack confidence in undertaking new role responsibilities. Sometimes they feel pressure from top management staff to undertake 'new role' activities. If care staff are left to determine where their new role's cut off is in terms of learning and practising new skills, these pressures could lead to unrealistic expectations that could place residents at risk – especially given the absence of a professional framework. For all these reasons, it is not surprising that 'new role' care staff show a moderate understanding of accountability but less of its relationship with liability and have a low membership of unions, and that managers might feel apprehensive about taking on such 'new roles' with clinical skills if the care staff are not protected. Although up-skilling care staff with basic nursing skills does not appear to unduly threaten the role of the RN, it does raise issues as to how care staff can be held accountable and competent when using these skills, when neither their 'new role' nor its boundaries in relation to that of the RN have been defined.

The study has shown the importance of care staff feeling confident, adequately resourced and clear about their boundaries and levels of accountability. This suggests the need for a professional framework, articulated by a professional body. Currently, care workers are not required to register – although there is a pilot scheme in Scotland that is expected to be rolled out (Birch and Martin, 2009). A professional body would provide the basis for a national network and a platform for the core strategic issues such as pay and staff development. Unions could also play a part in providing more information for care staff. A professional body, a robust qualification and improved pay would do much to attract people into this sector of social care.

Next steps

In response to progressing the integration of health and social care, several national and cross-sector stakeholders suggested that a central pooling of

health and social care funding with devolvement to local joint budgets (health with social care) would better facilitate shared decision-making and subsequent allocations to appropriate community services for older people than the present system of separate resource streams. A national nurse advisor said:

We need to follow the way the money goes. If we can do something about the way the money is allocated then it should be much easier and, in fact, there are models emerging across the country of where health and social care are all working very closely together and do have shared teams. I think for me the solution is joined up services with joint budgets and those joint budgets then deliver what needs to be delivered.

Furthermore, the additional funding via FNCC or self funding top-ups from residents, to cope with extra care needs when ill or dying, needs to be fully extended to residential care to enable enhanced care to develop in practice and permit care homes to fulfil their shared aim with residents of 'a home for life'.

Developing residential care as a learning environment could be one way of supporting the growth of the 'new role' care staff's knowledge and skills. This could also attract students from many health and social care professions. If community and hospital staff were to spend time in homes as a part of ongoing training, they could better understand and contribute to residential care systems as an important learning environment. This could be one way of supporting the growth of the new role, including shared processes to safeguard discharged residents. By better reflecting the actual efforts of care staff engaged in self-improvement to a wider audience, this could act as a counter to the often biased media reporting that seems to hold to the adage that 'only bad news is newsworthy'.

Local policy-makers need to develop a more strategic view of the 'new role' carer workforce development to enable a more positive professional image with the general public, the media and other professionals. Organisations responsible for the employment of the 'new role' carer workforce need to recognise that, without incentives and recognition for the delivery of high quality care,

these roles will become more difficult to sustain beyond a 'honeymoon' period and this could have implications for future recruitment and retention of staff. An evaluation of the 'new role' care worker (Skills for Care, 2007) identified difficulty in recruitment to new roles, the need to make broad cultural change to facilitate new ways of working and tensions at the interface with professionals. Links to professional bodies and unions could become increasingly important to care staff as they take on new roles with increased responsibility, but given the relatively isolated circumstances of working in a residential home, the former bodies need to take the initiative in raising care staff's awareness of services.

Although no single approach was identified as ideal, each exhibited characteristics that, combined together, might in the future help to achieve the best residential care outcomes for older people.

Main characteristics of successful and sustainable change

- Leadership by care home manager and support from external stakeholders.
- Integrated health and social care approach.
- Adequate staffing levels to permit acquisition of health skills without diminishing staff time for social care.
- Provision of structured community nursing and medical input.
- Shared vision and commitment of shop floor care home staff to approach.
- Pay incentives for staff to undertake NVQ3 and clinical skills awards.
- Access to NHS community nursing staff as teaching/learning support.
- Development of a 'learning organisation' culture in the care home.

- Financial incentive for care homes to provide specific care (cf. FNCC).
- Quality of resident and relative experience at the heart of change.

In conclusion, the development of 'new role' carers could bring much to the world of long-term care as it evolves. Most importantly, it could improve continuity of care, quality of life and security for the individual older person, but it could also bring greater job satisfaction for the carer, lighter workloads for other community health staff and potential cost savings in health care. However, the findings also suggest that this can only happen if the key constraints and barriers are robustly addressed – these include the pay and status of care staff, the nationally determined funding and registration systems, the cultural differences in health and social care, the workloads of staff, a good understanding of change management and the need for well-supported and inspirational leadership at the organisational, as well as the manager, level.

Abbreviations

CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CSCI	The Commission for Social Care Inspectorate
DoH	Department of Health
EMI	Elderly mentally ill
FNCC	Funded Nursing Contribution to Care
FSM	Flexible skill mix
GP	General Practitioner
IRT	In-reach team
LA	Local Authority
MDS	Minimum data set
NHS	National Health Service
NMC	Nursing and Midwifery Council
NTOW	New type of worker (alias: 'new role' carer)
NVQ	National Vocational Qualification
OT	Occupational Therapist
PCT	Primary Care Trust
RCN	Royal College of Nursing
RN	Registered Nurse
SEN	State Enrolled Nurse
SfC	Skills for Care

Explanation of key terms

The following explanation of key terms is provided to aid the reader. Further information is also given in the Appendix.

Care homes: There are two types of care homes:

1. Homes without nursing care are called residential homes. Here people can live either short or long term, with accommodation, meals and personal care provided (such as help with washing and eating);
2. Homes with nursing care have registered nurses on-site 24 hours a day. They provide care for more complex health needs.

Care homes can be run by local authorities or councils, or by private businesses (independent sector), or by not-for-profit companies and charities often referred to as voluntary sector homes. See http://www.direct.gov.uk/en/HealthAndWellBeing/HealthServices/CareHomes/DG_10031513.

Regulation of care homes: The Health and Social Care Act 2008 established the Care Quality Commission (CQC) as the independent and sole regulator of all health and adult social care in England, although at the time of this study, the regulatory body for social care was known only as the CSCI. The aim of CSCI regulation was to ensure that quality standards were provided in both types of care home and, through the CQC, this aim is broadened to encompass care for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere. See <http://www.cqc.org.uk/aboutcqc/whoweare.cfm>.

Funding for care: In residential homes, accommodation and personal care costs are met by the LA and/or by the individual resident (subject to the outcome of means-testing). Funded Nursing Contribution to Care was introduced in October 2001 and revised in 2009 (see Appendix) for residents assessed as eligible in homes providing nursing care from

a registered nurse (Szczepura *et al.*, 2004). However, FNCC excludes residents in residential homes, whose health needs are met on request by general practitioners and community nurses. See <http://www.dh.gov.uk/en/Healthcare/IntegratedCare/NHSfundednursingcare/index.htm>

NHS Continuing Care funding provided directly by the NHS to an individual is given following assessment of health needs and may cover all NHS costs of care. See the Appendix and <http://www.nhfa.co.uk/?gclid=CNLI04jSnp8CFZQA4wod0navJQ>.

Staff in care homes: In nursing homes, a registered nurse is an individual who has met the standards for pre-registration nurse education, 'declared as being in good health and of good character, and has his/her name held on the Nursing and Midwifery Council Register as one who is safe and effective to practise as a nurse'. See Appendix and <http://www.nmc-uk.org/aDefault.aspx>.

In residential homes, staff comprise of different levels of social care workers normally providing personal care. In general, in this report the latter are termed care staff.

Care staff training and career structure: Skills for Care (SfC) is an employer-led authority providing £25 million for the training standards, development and qualifications of managers and care staff in England. See <http://www.skillsforcare.org.uk/home/home.aspx>.

Care staff normally undertake National Vocational Qualifications comprising mandatory units plus selection from a range of optional units in social and health care. See <http://www.qcda.gov.uk/6640.aspx>.

NVQ learning is work-related and competency-based. Social care qualifications have a range from 2–5 levels. Care staff build on their basic social and personal care knowledge and skills gained from NVQ level 2 towards taking responsibility in the role of a senior carer or team leader at NVQ level 3 (sometimes referred to as 'new role')

carers) and the more management orientated training at level 4 and 5 (see Appendix).

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Appendix

1 Care homes in the UK

1(a) Purpose of care homes

The current priority by the UK government is to keep individuals in their own homes for as long as possible, supported by home care services if required. However, there may come a time when the level of support required by an individual cannot be provided in their own home. It is at this point that they may make the decision to enter a care home. There are many types of care home available in the UK. They can be run by local councils but, increasingly, are more likely to be provided by private businesses or not-for-profit companies.

(Information provided by and adapted from Directgov: http://www.direct.gov.uk/en/HealthAndWellBeing/HealthServices/CareHomes/DG_10031513.)

1(b) Types of care homes and their regulation

There are two types of care available:

1. Care homes without nursing care are residential, which means people can live in them either short or long term. They provide:
 - accommodation;
 - meals; and
 - personal care (such as help with washing and eating).
2. Care homes with nursing care are the same as those without nursing care but they also have registered nurses on-site 24 hours a day who can provide care for more complex health needs.

The Care Quality Commission is the independent regulator of all health and adult social care in England (at the time of the present study this was known as the Commission for Social Care Inspection). Its aim is to ensure that 'better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or

elsewhere'. (See <http://www.cqc.org.uk/aboutcqc/whoweare.cfm> for further details.)

2 Funded Nursing Contribution to Care

NHS-funded nursing care, introduced in October 2001, is the funding provided by the NHS to homes providing nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible.

The registered nurse input is defined in the following terms:

services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.

(Extract from: Department of Health, 2009.)

This does not include the time spent by non-nursing staff such as care assistants (although it does cover the time spent by the registered nurse in monitoring or supervising care that is delegated to others).

The single band of NHS-funded nursing care was introduced on 1 October 2007 and replaced the previous low, medium and high bands of nursing care. All individuals newly eligible for NHS-funded nursing care since that date have been placed on the single band. The NHS is responsible for this funding. Accommodation and personal care costs are met by the LA and/or the individual (subject to the outcome of means-testing). Individuals already on the high band of nursing care will remain on this band until and unless at review they are found to be no longer eligible.

3 NHS Continuing Care

NHS continuing health care is a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs arising from disability, accident or illness. It can be provided in any setting including, but not limited to a care home, a hospice or an individual's own home. Care can be provided in a range of settings. If

in a care home it is usually a nursing home but does not have to be particularly if awarded NHS continuing health care through the 'fast track' route, have been living in a residential home and have expressed a preference to remain there.

(Adapted from: Age Concern Factsheet 20: NHS continuing healthcare and NHS-funded nursing care, <http://www.ageconcern.org.uk>.)

4 Minimum data set

The MDS was originally developed in the United States with a view to achieving a greater level of consistency in the provision of quality care to older people living in nursing homes. It has since been adapted for use in care homes in the UK.

MDS is an assessment tool covering 18 domains deemed appropriate for assessing vulnerable older people in care homes and for developing a comprehensive plan of care. It is completed initially on admission (a baseline assessment) and then at set time periods during the course of care as part of a regular review.

(*UK Long Term Care Resident Assessment Instrument User's Manual*. MDS/RAI UK. Adapted and edited for use in the UK by: Challis, D., Stewart, K., Sturdy, D. and Worden, W. (2000) York: InterRai UK.)

5 National Vocational Qualification

5(a) The qualification

An NVQ is a nationally recognised qualification in the UK (in Scotland it is referred to as a Scottish National Vocational Qualification, SNVQ). It is a work-related, competence-based qualification reflecting the skills and knowledge needed to do a job effectively that demonstrates that a candidate is competent in the area of work that the NVQ framework represents. (See Qualifications and Curriculum Development Agency, QCDA: <http://www.qcda.gov.uk/6640.aspx>.)

5(b) National Occupational Standards

NVQs are based on National Occupational Standards determined by the particular employment-led body that represents the area of work in which a candidate is based. In social care in England, this body is Skills for Care (SfC).

These standards are statements of performance that describe what competent people in a particular occupation are expected to be able to do. They cover all the main aspects of an occupation (including current best practice), and include the candidate's ability to adapt to future requirements and the knowledge and understanding that underpin competent performance (QCDA). In an NVQ, a National Occupational Standard is called a unit; you gain an NVQ by achieving a set number of units.

The candidate will achieve units by demonstrating competency at work as the NVQ is gained in the workplace, not in a classroom or exam hall. The NVQ requires that the individual has a certain level of background knowledge about his or her area of work, and may be able to use college awards (qualifications) as evidence towards the knowledge part of the requirements for the NVQ. SfC's Common Induction Standards and its knowledge sets are also useful ways to obtain knowledge that can contribute to an NVQ. (See http://www.skillsforcare.org.uk/qualifications_and_training/NVQ/NVQ.aspx.)

The thoroughness and objectivity of National Occupational Standards enable training plans and training courses to be developed to address both organisational and individual learning needs. The standards can be used to inform the content of training programmes, as they specify in detail what constitutes best practice and can therefore be used for the assessment of competence and the achievement of qualifications. They can also be used to evaluate training by defining the practice outcomes expected from a training investment. The training can then be evaluated against the outcomes, and most importantly, the actual practice of those who have been trained can be checked against the intended outcomes. Monitoring the effectiveness of the training can continue to be carried out through supervision and appraisal of individuals

(Adapted from: *A Manager's Guide to Developing Strategic Uses of National Occupational Standards*, SFC 2006; available at [http://www.skillsforcare.org.uk/developing_skills/National_Occupational_Standards/National_Occupational_Standards_\(NOS\)_introduction.aspx](http://www.skillsforcare.org.uk/developing_skills/National_Occupational_Standards/National_Occupational_Standards_(NOS)_introduction.aspx).)

5(c) The process of gaining an NVQ

- Competency for an NVQ is assessed by a qualified assessor who observes the candidate at work and discusses knowledge and understanding underpinning why the candidate works in particular ways.
- Collecting evidence of a candidate's competence to work to a set standard can include: direct observation, oral and written questioning, observing a product or outcome of their work, written testimony, expert witness statements or by the candidate keeping a record of work. Evidence collected during induction may be included as NVQ evidence.
- The means by which the candidate collects evidence will be discussed and agreed with a qualified assessor. This is called assessment planning.
- Once an assessment plan is agreed then either through direct observation or through other means the evidence of the candidate's work is collected. The assessor will then indicate how successful this has been and in addition they will provide feedback on how well the candidate is doing.
- Once enough evidence has been collected to meet the requirements of the qualification, the assessor will judge the candidate's evidence against the standards to which they are working.

When the candidate has been satisfactorily assessed in all the units for the qualification the award will be made for the particular NVQ for which they registered.

(Adapted from <http://www.skillsforcare.org.uk>.)

5(d) Levels of NVQ

In general, NVQs have five levels, with level 5 being the highest. However, NVQs in Health and Social Care begin at level 2 and end at level 4. It is a common mistake to think these are equivalent to academic levels, but in fact they describe levels of operation at work. The level at which you are expected to work should determine what level of NVQ you need. For example, level 1 indicates work

that is very highly supervised and requires very little individual decision-making (for this reason there is no level 1 in social care). Workers at levels 4 and 5 will often have supervision of others as part of their task, and responsibility for significant decisions (these are typically management posts that require a high level of competence).

The NVQs in Health and Social care are:

- Health and Social Care level 2;
- Health and Social Care level 3;
- Health and Social Care level 4 – at levels 3 and 4 candidates can choose an adult or children and young people route, dependent on the work place clients and work content; and
- Registered Managers Award (Adults) level 4/
Award for Managers in Residential
Child Care level 4.

(Adapted from <http://www.skillsforcare.org.uk>.)

5(e) Sources of NVQ-related training courses and materials

The individual candidate and organisations sponsoring candidates can obtain NVQ-related training courses and materials and the required assessor services from a number of sources but predominantly from commercial companies and colleges of further education.

6 Nursing

According to the RCN, nursing has a core definition with six characteristics. The core definition is:

The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

The six characteristics can be summarised as:

1. the promotion of health and prevention of illness;

2. the interventions of empowering people, promoting independence, therapeutic and personal care, and advice, management, teaching and policy and knowledge development;
3. the domain of nursing is people's specific responses to illness and health through the lifespan and irrespective of setting or circumstances;
4. focus on the whole person;
5. adhering to ethical values expressed as a code of ethics supported by professional regulation; and
6. commitment to partnership and collaboration while personally and professionally accountable for decisions and actions.

(The full definition of nursing can be found on the RCN website: adapted from http://www.rcn.org.uk/__data/assets/pdf_file/0003/78564/001983.pdf.)

7 Registered General Nurse

A registered nurse is a person who has:

- met the standards of proficiency for pre-registration nursing education;
- has been declared as being of good health and good character;
- has paid the registration fee; and
- whose name is held on the Nursing and Midwifery Council Register as a 'person who is capable of safe and effective practice as a nurse'.

(Extract from the Nursing and Midwifery Council website: <http://www.nmc-uk.org/aDefault.aspx>.)

8 State Enrolled Nurse

Enrolled nurses are qualified and registered second level nurses whose experience is mainly

related to the provision of direct patient care. Their initial training was two, as opposed to three years and was regarded as more practical and less academic than first level training.

In essence, the SEN held a practice-driven role, Training for this qualification was discontinued in the mid-1980s.

(Definition from: M. Milligan, 'Enrolled Nurses' Experiences of Conversion to First Level', unpublished PhD thesis, Institute of Education, University of Stirling.)

9 The National Skills Academy

The National Skills Academy for Social Care is a new employer-led organisation supporting training, development and career progression in adult social care in England. It is the first welfare-related Skills Academy in the National Skills Academy network. It provides learning support and training practice for adult social care workers and their employers with a particular emphasis on small- and medium-sized organisations with limited training and development budgets. It complements existing organisations within the sector, identifying gaps, transforming provision and promoting excellence in skills development, learning support and training practice in social care. It aims to identify and distribute information and knowledge about best practice in social care learning, development, leadership and management and to raise the ambitions of the social care workforce and enable people using services and carers to be trained and supported to meet the expectations of people using social care. Its initial focus is to promote leadership and management.

(Adapted from <http://www.skillsacademyforsocialcare.org.uk/resources/leadership.aspx>.)

The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy-makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the author[s] and not necessarily those of the Foundation.

Joseph Rowntree Foundation
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40 Water End
York YO30 6WP
www.jrf.org.uk

This report, or any other JRF publication, can be downloaded free from the JRF website (www.jrf.org.uk/publications/).

A CIP catalogue record for this report is available from the British Library.

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First published 2010 by the Joseph Rowntree Foundation

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ISBN: 978-185935-742-2 (pdf)

Designed by Draught Associates
Project managed and typeset by Cambridge Publishing Management Ltd



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Acknowledgements

The research team wish to thank stakeholders, and the managers, staff, residents and relatives of the four homes, for their patience and generous giving of time in the conduct of this research. We also thank the members of the Advisory Board, listed below, for their ongoing support and guidance. Finally, we thank the Joseph Rowntree Foundation for its support in making this study possible.

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