Innovate to Alleviate:

Exploring how the role of an enhanced care worker could address skills shortages in the social care sector

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The International Longevity Centre – UK (ILC-UK) is an independent, non-partisan think tank dedicated to addressing issues of longevity, ageing and population change. It develops ideas, undertakes research and creates a forum for debate.

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Foreword

The Rt Hon Alistair Burt MP, Minister of State for Community and Social Care

The adult social care sector is facing unprecedented challenges, and this newly developed 'Enhanced Care Worker' role has the potential to provide much needed clinical support in care homes. I welcome this report, and its analysis of the challenges and opportunities of this emerging role. It will provide valuable insight for care homes when considering how best to implement it.

Baroness Sally Greengross, Chief Executive, International Longevity Centre-UK

A large part of the ILC-UK's remit is how the UK's adult social care sector will be able to rise to the challenge of an ageing population. Exactly how the workforce can adapt to a society with more older people, often with complex support needs, is crucial to this. We were therefore delighted to be commissioned by the Department of Health to explore how the role of an enhanced care worker could address skills shortages in the social care sector; we are certain that this research, the first to explore this emerging role, will provide invaluable insights to both policy makers and care home providers across the UK.

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Executive Summary

Adult social care in England is in a state of flux. Faced with an often challenging landscape of demographic, political, and economic change, the sector realises there is a need to adapt in order to both remain financially sustainable and continue providing high quality care to residents of care homes. Part of this adaptation to the new social care landscape involves implementing new roles in care homes to address particular challenges the sector faces.

A relatively recent trend in this respect has been the development of a new position among care homes that provide nursing, where a care worker is upskilled to provide an enhanced clinical support role to the registered nurse (RN). This report examines the emergence of such roles, which we call the 'enhanced care worker' (ECW). In this research, we have explored the ECW role through a series of telephone interviews in 10 care homes where the role has been introduced, talking to managers, registered nurses, and individuals working as or training to be an ECW. Our research does not offer a systematic evaluation of the role but provides the first insights into understanding how it is being implemented across the country, what the benefits are, what the challenges are, and what lessons can be learned.

Characteristics of the Enhanced Care Worker Role

We knew in advance of conducting the research that the ECW role is not a uniform role across the care home sector. While the role is not homogeneous across the sector, there are certain similarities that run across the job descriptions in the care homes with which we conducted interviews.

- **Enhanced Clinical Support**: ECWs undertake a variety of clinical tasks, either independently or assisting the nurse, including the administration of medication and simple wound care. Other clinical tasks cited as part of the job description included: ensuring care profiles are up to date; assisting in developing care plans; taking blood pressure; helping with nutrition plans; managing vital signs; and conducting blood sugar analysis.
- **Softer Skills**: As well as qualifications such as NVQs and training in clinical skills, all interviewees noted that staff members for the ECW role needed 'softer' skills, such as learning quickly, a desire to advance their career, and 'going the extra mile'.
- **Leadership & Management** was another defining element of the emerging role, with the ability to cope well with stress, natural leadership skills, coping well under pressure, and taking the initiative important when recruiting for the role.

Key Themes on the Enhanced Care Worker

In addition to understanding what the ECW role is, our research also highlights underlying themes associated with the role in practice. These can offer significant insights into the current state of affairs for these workers and their colleagues, as well as an enhanced understanding of what works with the role and what some of the primary challenges are for introducing and developing it.

- **Training and the Development of Qualifications and Skills Specific to a Care Setting**: In addition to qualifications and soft skills, a strong theme to emerge was the idea that nursing in social care settings was quite different from nursing in a hospital setting. ECWs need to be personally motivated and able to emotionally connect with the role and the care recipients. While there were some concerns over the sufficiency of training or a lack of confidence, many interviewees noted feeling supported to both ask for further training and to receive it. However, there were also concerns over the availability of suitable opportunities and support for continued development and practice of skills, with such

opportunities only available to some homes through NHS hospitals. Finally, training was also impacted by the lack of staff availability to actually release care workers to undertake training.

- **The Relationship between the RN and the ECW**: There needs to be a strong relationship between RNs and ECWs characterised by trust and good communication for both roles to function optimally. Many interviews highlighted initial tensions, with RNs reluctant to hand over responsibilities or unsure what the ECW was supposed to do. This reluctance seemed to improve over time, however, as RNs recognised the competence of the ECW. Relationships were also strengthened by involving ECWs in regular meetings with RNs and managers, which allowed staff in all roles to voice concerns and contribute to planning.
- **Concerns over Accountability**: The relationship between the RN and the ECW was particularly shaped by concerns over accountability. Not knowing who would be responsible for any unfortunate errors or mistakes interfered with an effective collaboration between the two roles. There was a range of perspectives on how this was handled, with ECWs fully responsible for their own actions in some care homes while lines of accountability rested with the RNs in others. Some RNs felt rather wary about the situation, but accountability appeared less of an issue where the RN was actively involved in developing the ECW role.
- **Internal Development of the Role**: Many instances of the ECW role's development might be described as somewhat 'grassroots', with ECWs mostly being generated internally by care homes in response to a shortage of nursing staff. Many of the qualities that characterise the role – recognising the hard work, a dedication to caring, and a willingness to take initiative – are better observed by working with someone, making internal recruitment more effective. In addition, the role was seen by many managers as a way to keep a care worker at the home while fulfilling a desire for career progression.
- **The ECW Role Makes a Difference**: While we did not do a comprehensive evaluation of the role, there was overwhelming support from respondents in all three categories of staff that it had a strong and positive impact on delivering high quality care. The role brought additional insights that enhanced the care given, e.g. through the ECW's daily interaction with residents helping inform care plans with the RN. Indeed, a number of respondents noted the benefit of the role for residents, who sometimes seemed more open to discussing their concerns with the ECW.
- **There Needs to Be Better Support from the NHS**: It is perhaps unsurprising that there were several mentions of a need for greater support for the role from the NHS. However, the support went beyond simple financial concerns to include training opportunities and efforts to make social care nursing regarded on equal footing with nurses in the health sector. There were concerns that without proper support, the new ECW roles could collapse. Improving perceptions of social care nursing could help address the issues around staffing in the sector.

Conclusions and Lessons Learned

Concerns over the future of the social care workforce continue to impact proper planning for the delivery of high quality care in the context of an ageing society, and the development of this new ECW role offers a new approach to addressing these concerns. To our knowledge, this is the first piece of research to explore the ECW role and how it functions.

An evaluation of the role – defining how well it works – is beyond the scope of this research, therefore we are unqualified to make a recommendation that care homes implement this new role. However, the anecdotal evidence we found does suggest that the ECW role can be

beneficial for care homes for a variety of reasons, and our findings shed light on lessons that could facilitate the introduction of the ECW role among care homes interested in doing so.

- **Clear communication on the lines of accountability and the delegation of tasks**: Concerns over accountability can be mitigated by clearly establishing the relationship between the RN and the ECW and the respective roles each plays in caring for residents.
- **An open environment for communication** is beneficial for the successful implementation of the ECW role. When ECWs feel comfortable expressing their concerns about their responsibilities or confidence in performing particular clinical tasks, they can receive the kind of support that helps them do their jobs more effectively.
- **Involvement of both RNs and ECWs in regular planning meetings**: Transferring greater responsibilities in terms of care delivery to ECWs should be accompanied by greater involvement of them in planning meetings. This can improve care by giving them a voice on residents' potential needs as well as foster a sense of inclusivity that can strengthen the relationship between RNs and ECWs.
- **A focus on or recognition of softer skills**: The kind of nursing undertaken in care homes relies on a strong set of softer skills that foster an understanding of residents' emotional and psychosocial needs. Developing the ECW role may be enhanced by looking beyond clinical training and qualifications to actively recognise the importance of softer skills.
- **Recognise that there will be growing pains**: The potential benefits of the ECW role must be seen in the long-term, and care homes interested in implementing the ECW role should prepare for some short-term disruptions. While the short-term challenges may be mitigated against through proper preparation and clear communication, care homes should nonetheless be aware that the initial phasing in of the role is likely to be something of a bumpy ride.

The emerging role of the ECW may provide a partial solution to some of the expected challenges that the social care sector will face in the short- and long-term as a consequence of demographic change. This will lead care homes to explore innovative approaches to these challenges, and we hope this research will offer valuable guidance for care homes to consider whether the ECW role would be a good fit for them.

Introduction

Adult social care in England is in a state of flux. Faced with an often challenging landscape of demographic, political, and economic change, the sector realises there is a need to adapt in order to both remain financially sustainable and continue providing high quality care to residents of care homes. Part of this adaptation to the new social care landscape involves implementing new roles in care homes to address particular challenges the sector faces.

There has been a trend in recent years among care homes that provide nursing to create a new position within their workforce. This role may be named differently in different care homes, but it is generally a new role where a care worker is upskilled to provide an enhanced clinical support role to the registered nurse. For the purpose of this report, we refer to this role throughout as the 'enhanced care worker' (ECW). It should also be noted for this report that, since this role has emerged in care homes that provide nursing, where we discuss care homes with respect to the role, we are referring to those that provide nursing services.

The ECW role has emerged relatively organically across the sector, with each care home and each provider developing a slightly different, but comparable, position. Whilst each ECW role might vary in certain aspects – for example, the training provided or the scope of the clinical support they provide – there is a noticeable trend in the care home sector of responding to certain challenges by creating this new role within their workforce. The Department of Health can see the benefit of this new role and commissioned the International Longevity Centre – UK, an independent think tank, to look further into this development, and for the first time give an overview of how this role is being implemented in different care homes.

This report has been informed through a series of semi-structured telephone interviews with a number of care homes that have the ECW role. At each care home we interviewed the manager, a registered nurse (RN) and someone currently working as, or training to be, an ECW. It is important to note that it was beyond the scope of this research to undertake a systematic evaluation of the ECW role in order to evaluate any improvement in quality of care, staff retention, or other factors. However, there is great value to this research through the fact that no research has yet attempted to understand how this role is being implemented in different care homes across the country, what the benefits are, what the challenges are, and what lessons can be learned. Through the different care homes and individuals we have interviewed, this report therefore offers great value to central and local government, organisations within the health and social care environment, and individual care homes who may be interested in developing ECW roles within their organisations.

Understanding the Current Landscape in the Social Care Sector

Before presenting the findings of the research into the implementation of ECWs in the adult social care sector, first it would be beneficial to provide a brief overview of the current landscape of care homes today. Social care provision in the UK comes from both public and private providers, with public services supplied by local authorities. In addition, when thinking about adult social care, there are residential and nursing providers, depending on the degree of care need required by the care recipient. The vast majority (78%) of residential care and nursing home places are provided by the private sector, while 14% come from voluntary/charitable organisations, 3% directly from the NHS, and 5% provided by local authorities.[1] While each sector of care provision experiences its own particular set of issues in delivering care, particularly with respect to funding and staffing, there are a number of pressing challenges that affect the overall adult social care sector as discussed below.

The changing profile of residents

With an ageing population comes a changing profile of residents arriving in care homes. The UK's population is certainly ageing; the number of people aged 75 and over is expected to increase by almost 90% by the year 2039.[2] And although the numbers of older people in care homes remained relatively stable between 2001 and 2011, this is likely attributable to the increase in unpaid, informal caring by family members and a drive in health and social care policy to provide as much care as possible in an older person's own home.[3] This is, however, unsustainable, and the care home sector in the future will support an increasing number of older residents with increasingly complex needs.

Analysis of census data has shown that the average age of a care home resident is increasing; between 2001 and 2011, people aged 85+ in care homes increased from 56.5% of total residents to 59.2%.[4] Whilst this may seem a small increase, this trend could be significant to a sector that is already facing considerable challenges around funding and staffing, due to the fact that this is an age group that on average requires the most intensive and specialist care. This trend of an increasing average age of care home residents is likely to continue, with the number of those aged 85+ in the UK predicted to increase by more than double over the next 23 years.[5]

Between 2001 and 2011, **people aged 85+** in care homes increased from **56.5%** of total residents to **59.2%**.[4]

The number of people aged 85+ in the UK will more than double over the next 23 years.[5]

[1] Laing & Buisson (2013)
[2] Dunsmith & Large (2015)
[3] Smith (2014)
[4] Smith (2014)
[5] Dunsmith & Large (2015)

The changing profile of care home residents means that now and in the future there is a need for staff who have the competencies and characteristics to provide high quality care for people who have a range of highly complex and challenging needs. With an increase in the age of an average care home resident comes an increase in the prevalence of long-term conditions that require nursing care and/or complex care plans. Often those entering homes now do not just need to be made comfortable, kept entertained, and helped to the bathroom; they need to have care strategies put in place to manage their dementia, diabetes, or hypertension. The number of people living with multiple long-term chronic conditions is predicted to increase from 1.9 million in 2008 to 2.9 million in 2018,[6] and the number of people with dementia is predicted to more than double in England in the next 30 years, from 570,000 to 1.4 million.[7] More generally, the number of older people with care needs is set to increase by 61% by 2030.[8] These changes in the needs of residents mean that many homes are having to increase the level of clinical support their staff can provide, all whilst navigating through staff shortages, most crucially in terms of nursing numbers, as well as tighter budgets.

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The number of older people with care needs is set to increase by 61% by 2030.[8]

Issues related to staffing and funding

The care home sector is facing numerous workforce challenges, and this has been a significant factor in the development of new roles within the adult social care workforce. The most significant workforce challenge in care homes that offer nursing care is a lack of nurses to fill vacancies. Recent figures suggest a vacancy rate of 7.6% for nurses across adult social care, the vast majority of whom work in residential settings. This figure, coupled with a turnover rate of 32.1%, means that there are approximately 3,900 nursing vacancies to fill in the sector.[9] The lack of available nurses to fill these roles is a major cause of concern, both for care home providers themselves and regulators, with CQC citing in their annual report of adult social care that staffing levels were one of their biggest concerns.[10] Alarmingly, this trend of a shortage of nurses in the sector is likely to continue and perhaps worsen, with an ageing workforce suggesting a looming 'retirement bubble'. Whilst 13% of NHS nurses in England are aged 55+, the proportion in care homes is 30%, meaning proportionally more are retiring or are close to retirement, leaving significant workforce gaps.[11]

One answer from providers has been to plug these gaps with agency staff. This can be an answer to two challenges arising from the nature of the nursing workforce in adult social care: a shortage of registered nurses and the fact that only around half of the registered nurses in care homes work full time.[12] Agency staff are a flexible, mobile workforce that can certainly be an asset if utilised correctly. However, there is concern that they are being used as a short-

[6] Department of Health (2012)
[7] Department of Health (2009)
[8] Snell et al. (2011)
[9] Skills for Care (2015)
[10] Care Quality Commission (2015)
[11] Christie & Co (2015)
[12] Spilsbury et al. (2015)

Between 2013 and 2015 the average increase in the **use of agency workers** was **55%**, with the percentage change of agency costs as a percentage of staff costs rising by an average of **51%**.[13]

term solution to a long-term problem of a chronic shortage of financial and human resources in the care home sector. A recent survey of the largest nursing home groups reported an average increase of 55% in the use of agency workers, with the percentage change of agency costs as a percentage of staff costs rising by an average of 51% between 2013 and 2015.[13] Furthermore, utilising agency staff can only be part of the solution; good quality care requires a level of continuity in order to best know the needs of residents in nursing care. The care home sector has consequently been looking to harness their existing workforce – notably care workers – to meet these gaps in the workforce and improve quality of care for residents.

Alongside these trends in the makeup of the care home workforce is the move to continue with the professionalisation of the sector. In order to improve staff retention, encourage more people into the sector, and bring new and innovative approaches to adult social care, there is a growing movement within the care home sector to create new career pathways for care workers in order to both attract new recruits and to best use the skill sets of the best care workers already in the sector. Carolyn Downs, from the HelpCare project which looks to address the shortage of health care assistants, notes that "there is no reason why trained, experienced homecare staff can't progress through to professional healthcare roles… but there needs to be a bridge to make it happen".[14] Staff in any line of work need to have clear career paths and the knowledge that they will be appreciated for good performance; this not only motivates existing staff but helps attract the best new recruits. The implementation of new, upskilled care workers who can provide enhanced clinical support in care homes is seen by many in the sector as an important step towards enhancing professionalisation.

Financial pressures are an underlying feature of the current landscape of care homes that has been set out in this section, from staff shortages increasing the use of agency staff, to an ageing population resulting in residents of care homes needing more complex and therefore costly care. There are two issues however that have not been addressed yet. First, local authorities between 2011/12 and 2015 experienced a 40% cut in central funding.[15] This has invariably resulted in local authority funding for residential care being reduced.[16] The introduction of the National Living Wage in April 2016 is also a cause for concern in the sector; whilst higher pay for care workers, often on the minimum wage, is to be welcomed, there are severe concerns that the care home sector, often running on tight budgets and with staff costs already a very high percentage of expenditure, will find difficulty in implementing the living wage.

[13] Christie & Co (2015)
[14] Downs (2015)
[15] Local Government Association (2014)
[16] The King's Fund (2015)

Methodology

Very little available evidence or information exists related to the emerging role at the centre of the research here. As explained in further detail in the next section, the role carries different names in the various care homes where it has emerged; for simplicity, we refer to the role as the 'enhanced care worker' (ECW). As a consequence of the little evidence available, our primary aim in this research was to gather insights and perspectives into where, why, and how this role had emerged in addition to how it was functioning. To do so effectively, we recognised the necessity to engage staff working at different positions within the care homes. We therefore sought to identify care homes where such a role existed and to conduct interviews with people at three different levels: the manager, the registered nurse (RN) responsible for supervising someone in the role, and the person working as the ECW.

We identified homes with the ECW role through existing networks and umbrella bodies working in the care sector. We reached out to a number of contacts to request participation in the research and ended up interviewing staff in 10 care homes with the role; the size of the care homes involved ranged from around 30 to around 100 residents. In the end, we interviewed 23 people: 7 managers, 8 RNs, and 6 ECWs, along with three interviews with high-level representatives at organisations that oversee a number of other care homes.[17] Two of these three organisations included care homes with the ECW role, while the third had an upskilling role previously and was in the planning stages of introducing the ECW role.

Interviews were conducted over the telephone, generally lasting around 20 minutes and guided by a predetermined collection of questions to gather the information of interest from each category of staff. Interviewees were informed that no attribution to quotations would be made in this report to facilitate an open and comfortable dialogue. Respondents were also offered the chance at the end of the interview to provide any further information, perspectives, or concerns that had not arisen during the interview. While interviews were not recorded, interviewers typed notes for the pre-established schedule of questions to capture the conversations and quotations from the respondents. These documents were then reviewed to identify prevalent themes to emerge within each category of worker and across the complete set of interviews.

As part of the overall interest in the prevalence of the ECW role, we wanted to try to assess the degree to which the sector was aware of such a role emerging in different care homes. We put together an online survey to ask care homes about their awareness and presence of such a role. We distributed the survey through different sector-specific newsletters. While we received a fair number of responses to the survey, the total number is far too low compared to the number of care homes across the UK for the responses to be meaningful and therefore reported here. Consequently, we are unable to provide any indication of the overall prevalence or awareness of the ECW role in the social care sector as a whole.

There are further limitations to the research presented here. Understanding the impact of the ECW role on quality of care would have required us to speak to care recipients and their families. This would have expanded the research beyond the scope of available resources – in addition to raising other concerns over patient wellbeing and capacity to partake in the interviews – so we are unable to say anything on how the implementation of the ECW role has affected the delivery of care from this perspective. As with other qualitative research using a limited number of interviews, we must also caution on generalisation; there could be a selection effect with our sample whereby the homes to engage with us have had more positive experiences with the role. This may be reflected in the fact that our interviewees were all in homes run by private providers, and we found it challenging to gather perspectives from local authority homes.

[17] One interviewee was in a managerial role after having been in the ECW role, completing interviews for both categories.

Nonetheless, the interviews we conducted provide a range of perspectives and insights into understanding the current situation related to the ECW role. The next section outlines the characteristics of such a role, based on the responses from all those interviewed. The report then moves on to discuss a number of relevant themes to emerge from the interviews that would help any party interested in successfully developing such a role or assisting such a development.

The Enhanced Care Worker: Characteristics of the Emerging Role

We knew in advance of conducting the research that the ECW role is not a uniform role across the care home sector, having emerged on a somewhat ad hoc basis in various homes. As a consequence, for the research, we interviewed staff at an assortment of different types of care homes, ranging in scale and scope and including care homes operated by large providers, homes operated by smaller companies, specialist dementia homes, and retirement villages that offered more independent living arrangements. Whilst being careful not to define the ECW role as homogeneous across the sector, there are certain similarities that run across the job descriptions in the care homes with which we conducted interviews.

Our discussion on the ECW job description is developed from the interviews we conducted with workers in all three categories of interest (managers, RNs, and ECWs). While it might have been an interesting exercise to compare official job descriptions with those that emerged from the interviews, we did not request these from the care homes. It was unclear if such official descriptions would be available in the first instance, and we were more interested in how the different categories of worker might vary in their descriptions; not looking at official job descriptions might be considered a potential limitation in the research. Nonetheless, we describe below various aspects that can be considered part of a typical job specification for the ECW role, derived from the interviews we conducted.

Enhanced clinical support

What defines the ECW across all the sites interviewed for the project is the enhanced clinical support given by ECWs to RNs. All care homes interviewed stated that an NVQ level 2 qualification was essential, with a number of homes requiring an NVQ level 3. Some care homes also required at least two years' experience working in a care home setting when recruiting for ECWs.[18] Whilst they do not carry out the more complex clinical tasks that nurses undertake (and nor was it suggested that they ever will do), ECWs undertake a variety of tasks, either independently or assisting the nurse.

All interviewees cited the administration of medication as part of their clinical duties, with the vast majority also mentioning simple wound care. Many interviewees highlighted how administering medication is one of the most time-consuming aspects of a nurse's day in a care home, and one that can safely and effectively be delegated to a properly trained and competent ECW. Other clinical tasks cited as part of the job description for ECWs included: ensuring care profiles are up to date; assisting in developing care plans; taking blood pressure; helping with nutrition plans; managing vital signs; and conducting blood sugar analysis.

It is important to note that there are other clinical tasks that some care homes specifically stated their ECWs would not do. These included liaising directly with GPs, administering injections and IV drips, and advanced wound care. However, there were some care homes that do allow their ECWs to undertake these tasks, ensuring there were sufficient training and competency assessments in place.

Softer skills and characteristics

As well as qualifications such as NVQs and training in clinical skills, all interviewees noted that staff members for the ECW role needed 'softer' skills as well. Frequently cited were characteristics such as learning new skills quickly, a desire to advance their career in adult

[18] It may be important to note, as discussed later in this report, that in the majority of homes the ECW was recruited internally.

social care, and ‘going the extra mile’ in caring for older residents. One interviewee, a manager of a care home, stated that they were “sick of agency nurses coming in and just administrating medication, that’s it. There was no caring element at all”.

This is crucially important for the caring aspect of the role; what defines the ECW is that they can act as a bridge between RNs, who may have enhanced clinical skills but spend less time on a day-to-day basis with older residents, and care assistants, who would spend more time with residents but lack the expertise in clinical care such as administering medication.

Leadership and management

Alongside the enhanced clinical support of the ECW, we found another defining element of the emerging role is being able to offer leadership and management in the care home setting. Frequently noted by care homes when discussing what they look for when recruiting for the role was the ability to cope well with stress, natural leadership skills, coping well under pressure, and taking the initiative. In many of the descriptions given for the role, ECWs line manage care assistants or other unregistered staff members, as well as mentoring new staff when they join the organisation. Some interviewees noted that the ECWs in their care homes are put on ‘train a trainer’ courses, which teach leadership and teaching skills to their staff members.

How the Enhanced Care Worker Compares to Existing and Previous Roles

Whilst each care home or group is implementing the ECW role in different ways, there are certain similarities which run through them all, as outlined in the previous section. At the same time, it is also important to think about how the ECW role might compare with existing and previous roles in both health and social care that might be somewhat similar. For the ECW to be as effective as possible, it is important for these various roles to work well together, for there to be shared learning, and for the NHS and the adult social care sector to liaise closely to achieve high levels of care for older people.

State enrolled nurses

The state enrolled nurse, or second level nurse, was a feature of the nursing landscape until the mid-1990s. State enrolled nurses were trained over two years, with courses being a simplified version of state registered nurses, with more practical training. The implementation of Project 2000, which redefined nurse education, saw this role withdrawn in place of healthcare assistants, who notably are not registered. Tasks carried out by state enrolled nurses were comparable to many of those done by the ECW and described in this report, e.g. taking blood samples and wound care. A number of our interviewees referred to the state enrolled nurse when describing the clinical tasks undertaken by their respective ECWs.

Assistant practitioners

Assistant practitioners, or associate practitioners, is a role within the NHS in which support staff assist qualified healthcare professionals in clinical tasks. Whilst not registered practitioners, they have experience in certain areas of clinical practice.[19] Assistant practitioners are able to often work alone on certain procedures. To train as an assistant practitioner, an individual needs to have healthcare experience as well as a healthcare qualification, usually at NVQ level 3. These members of staff can also become senior assistant practitioners, who can manage and supervise other clinical support staff.

Case Study 1: **HC-One**

HC-One have introduced a Care Assistant Development Programme, which has been in place since early spring 2015. Currently there are over 100 Nursing Assistants either in training or already in post. The programme creates pathways for senior carers to receive training opportunities to work alongside nurses. To join the programme, senior carers need to demonstrate a strong commitment to learning, complete competency-based written tests, and complete a comprehensive work book. Nursing Assistants get an increased hourly rate and a nurse mentor to support them. The recruitment process is thorough; staff must have compliance in all current learning, must have completed or in the process of completing an NVQ Level 3, and have worked in health and social care for a minimum of two years. There is also a process of interviews and a written assessment. The Care Assistants Development Programme has been accredited by the RCN, and is being independently evaluated by SCIE, which will report in 2016.

[19] See https://www.healthcareers.nhs.uk/explore-roles/clinical-support-staff/assistant-practitioner

Nursing associates

In December 2015, the Government announced plans to introduce a new nursing associate role, which many compared to a modern day state enrolled nurse. The new role, designed for use across health and social care settings, will "create a new type of care worker with a higher skillset to assist, support and complement the care given by registered nurses".[20] The role would sit between a care assistant with a care certificate and a registered nurse and be trained vocationally through an apprenticeship scheme, which will ultimately lead to a foundation degree.[21] Whilst NHS employers would determine the exact numbers of nursing associates they need in each setting, the Government has indicated that from 2016 up to 1000 nursing associates could be trained.

The reasoning given to introduce this role is twofold. First, it is acknowledged that higher skilled care assistants who are highly competent need to be recognised and encouraged. Second, the role will provide a new entry into pre-registration nurse education, with the aim to encourage more people, and especially those who may be initially discouraged by the financial and time commitment needed to complete a nursing degree, into a career in nursing. The principles of the proposed new role are grounded in direct care of patients, delivering care in a range of settings, the competency to work in multidisciplinary teams, and working with a varied range of population groups with an increased emphasis on public health and community health. As important to what the new role will do is what the role will not do; nursing associates will not lead on designing care plans, manage care interventions, provide clinical expertise, or review treatment plans to make decisions on patient care.[22]

Health Education England are expected to publish the results of a consultation on the new role in late Spring or Summer 2016; it is important that the development and ultimately the implementation of the nursing associate takes into consideration what already appears to be happening organically across the adult social care sector in developing the ECW role. Throughout the interviews conducted as part of this report were calls to share knowledge and training with the NHS, in order to ensure new roles within both health and social care settings are used and developed effectively.

Case Study 2: **Barchester**

Barchester have introduced a Care Practitioners role, whereby senior carers who have at least an NVQ Level 3 are given an enhanced level of training so they can fulfil part of the nurse's role. They are aiming to have 150 Care Practitioners in the organisation by the end of the year. Barchester recruit these staff from within the company, and put them through a rigorous 9-month training programme that includes 6 months of clinical skills training. Each Care Practitioner has a nurse mentor who helps deliver training and ensure that clinical competencies are upheld to the highest level. As well as clinical skills such as medication management, the Care Practitioners also are given leadership and management training in the last 3 months of the programme.

International comparisons

To our knowledge a comparable role (upskilling care workers to provide enhanced clinical support to a registered nurse) does not exist in a formal sense internationally. A number of countries do have in place qualifications that can be compared with the old state enrolled nurse, with vocational training and the ability to carry out some of the duties of a registered.

[20] Health Education England website: https://www.hee.nhs.uk/our-work/developing-our-workforce/nursing/have-your-say-new-support-role-nursing
[21] https://www.gov.uk/government/news/nursing-associate-role-offers-new-route-into-nursing
[22] Health Education England (2016)

Case Study 3: **Maria Mallaband Care Group**

Maria Mallaband Care Group have also introduced a role called a Care Practitioner. This new role supports and assists the registered nurse with basic delegated duties once viewed as only nurses being able to do. This can include basic clinical tasks such as administrating medication, nutrition, and simple wound care. The group places a high importance on soft skills needed for the role, such as caring abilities, dedication to the care home and to their residents, being able to cope with stress, and being able to work under pressure. The initial 12-week training programme is delivered by in-house and external registered nurses and tailored for each care home. The programme and role have ensured that residents receive continuity in their care by focusing more on skill-mix of the teams based on their abilities and skills acquired.

nurse. For example, in Canada there is the Licenced Practical Nurse (LPN), who provides more hands-on care to patients, undertakes tasks such as giving injections and dressing wounds, and works under the supervision of a registered nurse.[23] Australia has a number of different levels of nursing, including the Enrolled Nurse. The Enrolled Nurse is responsible for their own limited practice and reports directly to a registered nurse (and can usually only administer medication if they complete an approved study programme).[24]

These roles, whilst still offering enhanced clinical support and carrying out some nursing duties (but not requiring an undergraduate degree in nursing and not being a full registered nurse), are not directly comparable to the ECW role in this report. The key difference is that the ECW role focuses on the upskilling of employees already within the adult social care sector, and often within the care home itself. This can be seen as an innovation from the UK adult social care sector, and there is the possibility, as more countries start to face the challenges of an ageing population and a declining adult social care workforce, that countries look to the UK when implementing workforce changes. However, it is worth noting that the roles highlighted above in Canada and Australia involve significantly more training time than offered by the UK care homes we interviewed for this project, and after their training the ECWs would be undertaking clinical tasks equal to these roles, including medication administration.

Case Study 4: **The ECW Role in Councils**

Bath and North East Somerset Council and Bristol and South Gloucestershire Council have both developed a new role which bridges health and social care work, with the aim to support workers in residential care. The support worker role encompasses traditional care roles in terms of providing personal care for older people, but also involves the support worker carrying out a range of clinical tasks, such as taking blood, applying simple dressings, and catheter care. The role has been successfully introduced in the councils' residential care homes and in three privately run residential homes in the region.

[23] See http://www.albertacanada.com/opportunity/working/hc-nurses-lpn.aspx
[24] See http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Enrolled-nurses-and-medicine-administration.aspx

Key Themes on Implementing the Enhanced Care Worker Role

So far we have outlined how various staff in different positions within the care sector describe the ECW roles that have emerged as well as how the general concept of the ECW compares to other roles in health and social care. Yet an important advantage of getting these unique perspectives and reflections on the ECW role is that we can reflect on the underlying themes associated with the role in practice. This can offer significant insights into the current state of affairs for these workers and their colleagues, as well as an enhanced understanding of what works with the role and what some of the primary challenges are for introducing and developing it.

Training and the development of qualifications and skills specific to a care setting

As discussed earlier, there was general consensus on the level of qualifications required for the ECW, but there was also an emphasis put on the importance of softer skills in delivering high quality care. This idea – that being an effective ECW requires not only clinical skills but also the ability to effectively manage relationships with both the RN and the care recipient – highlights some underlying questions about how far training can go. In fact, a recent survey found that around 70% of respondents did not believe pre-registration nursing degrees prepared the future workforce with the skills, knowledge, competencies, and experience to deliver high quality care to older residents in care homes.[25]

As noted elsewhere, the nursing workforce in care homes has been trained for work in hospitals or the community, rather than specifically for work in the care home setting.[26] There were indeed questions from some respondents, especially managers, about establishing exactly what kind of training should be required for this role, taking into consideration the differences inherent to nursing in a social care setting. As one respondent put it:

"I think there needs to be recognition that nursing in nursing homes is a speciality in its own right, but the nursing – all the skills that RNs in nursing homes have – needs to be quite different than what hospital NHS-based nurses need. Not only are we looking at health needs, but social needs and emotional wellbeing, so trying to promote physical and emotional wellbeing. Very different than someone in hospital receiving care for a specific condition. So the needed skills are quite different."

One manager noted they were involved with efforts to identify what the required qualifications for an RN in a nursing home entail. This work would certainly strengthen the approaches involved in developing the care workforce, not only with respect to creating a better fit for RNs in nursing homes, but also in any potential development of the ECW role. This could also help address another point raised by some interviewees in the ECW role, where they sometimes felt they were expected to know more than they did or even should; their position was not identical to an RN, which carries with it more knowledge and training than the ECW.

In a number of the interviews, the idea that personal motivation to do the care role was highlighted. Alongside this idea of motivation, an ability to emotionally connect with the role and care recipients was also described. In other words, suitable candidates for the ECW role not only need to be willing and capable to take on additional responsibilities, but they also need to be able to understand and empathise with the needs of the care recipient. And while the

[25] Spilsbury et al. (2015)
[26] Spilsbury et al. (2015)

ECW serves as an opportunity for career progression, this should be seen as secondary to the opportunity to provide enhanced care:

"People need to be aware that it's not just a pay rise or title, because if that's what they're after, it's not for them. Delivering the best care and supporting staff requires more emotional understanding, commitment." (ECW)

> "[Workers] can be qualified up to the hilt, but if they don't have empathy it's irrelevant." RN

Overall, reported perspectives on training were generally good in most instances. Some particular aspects of training in some specific nursing homes were felt to be insufficient – although in one interview it was noted that after raising this, further training was given. Indeed, where the ECWs mentioned a lack of confidence in their training, they also noted feeling confident to ask for it and being well supported to get it. One home mentioned a buddy system through which experienced ECWs work with new starters; serving in such a mentoring role can help reinforce training, boosting both workers' sense of confidence.

This might suggest that staff taking on the ECW role are given explicit encouragement to speak up if they feel their training is lacking in certain respects. There may also be a need for nursing homes to create an environment in which concerns can be raised. This holds the potential however to cause friction or present challenges depending on the relationship between the RNs and ECWs, where the former may have issues around trusting the latter, who in turn may be reluctant to speak up if they believe the RN has little faith in them; indeed, the relationship between the RN and ECW emerges as a distinct theme discussed below.

Obviously training and upskilling is vital, for both residents' safety and so that RNs have confidence in the new workers' competencies. But a number of interviewees said that training can be difficult, referring to the structure – or lack thereof – of suitable opportunities and support for continued development and practice of skills. This was mentioned with respect to a lack of support from the NHS, with some interviewees mentioning that the training was often obtained at hospitals, sometimes a rather large distance from their home or place of work. This was seen as a barrier to refining their skills and enhancing their confidence in them, and NHS support is also discussed later as a unique theme.

Another challenge to providing training for the ECW role was identified as simply the lack of staff availability to actually release care workers to go take the training required to be upskilled. One interviewee noted their care home got around this by only selecting those on zero-hours contracts to be upskilled to the new role; this approach is unlikely to be ideal, given the implications for the potential ECWs themselves.

> "Nurses found it hard to let go of those skills originally, but now they are seeing the benefits. They are seeing they are here to help, and the carers are actually seeing how difficult the role of a nurse actually is." RN

Ensuring an adequately trained workforce is particularly crucial in the social care sector, where the outcomes of the work directly influence the wellbeing of other people. Yet the challenges to providing such training cannot be ignored. Recent research found that almost half (49%) of care homes told to improve by the CQC were breaching regulations that require them to ensure a suitably trained and supported workforce, and of those told to improve by the CQC, 15% had training gaps in health conditions such as diabetes and epilepsy.[27] Providers were also failing to provide staff with training on pressure sores, catheter care, and invasive procedures. While it is unclear why such

[27] Carter (2015); This included a sample of 300 homes, with inspection reports published between 1 October 2014 and 31 August 2015.

training deficits exist, care homes may be able to take advantage of the ECW role as a way to address these gaps and make more effective use of their workforces.

> "The RNs aren't 100% sure what the new roles are allowed to do… The RNs are a bit protective of their roles." **ECW**

The relationship between the RN and the ECW

The discussion above related to training noted the importance of the relationship between the RN and the ECW. However, the relevance extends beyond just the area of training and skills. A motivating force behind the development of the ECW role is to allow them to take over certain responsibilities previously delegated to the RN. As a consequence, for both roles to function optimally, there needs to be a strong relationship characterised by trust and good communication.

Many interviews highlighted initial tension between the RN and the ECW. There were some issues around the functional relationship between the two, reflected in comments such as "nurses are always very protective of their PIN number". Such concerns can however lead to lower efficiency in completing certain tasks; at best, this might result in small inconveniences and short delays, but at worst, it could impinge on both the RN's and the ECW's ability to provide quality care appropriately.

The relationships between the RNs and the ECWs were also shaped by the negotiation of delegating tasks from the RN to the ECW. This was moderated to a degree by concerns over accountability, as discussed next, but fundamentally related to how willing RNs were to allow the ECWs to take over some of the clinical responsibilities. Interviewees noted that the reluctance to hand over tasks improved over time, particularly where there was a clear recognition that the ECW was competent to know what tasks they could and could not do.

Such questions around the delegation of tasks was mentioned on a number of occasions by staff in all three roles with specific reference to the administration of medication. One RN noted that the ECWs, in spending a bit more time with patients, were at times perceived more trustingly by the patients when giving them medication. However, another RN expressed concern over handing over medication responsibilities to ECWs due to how errors might be reported since the ECWs do not have a PIN number. This RN did note that assurances were given that as long as the paperwork for the ECW's competence was in place, the ECW would be held directly accountable. On the whole, however, there was a sense that transferring the administration of medication to ECWs was a key advantage of having the role, due to the degree to which it freed up the RNs to focus on other tasks, such as creating and reviewing care plans. Moreover, one manager noted that senior care staff in residential settings administer medications, so it should make sense for competent staff in nursing care settings to do so.

> "The nurses' concerns were around medication. When they are on duty, they are responsible for the actions of the [ECWs]. The [ECWs] are accountable for their own actions, but the nurses do still feel vulnerable." **Manager**

Successfully developing these relationships and taking optimal advantage of the ECW role was cited as depending on strong conversations and involvement of all workers in regular communications. Interviewees pointed out that it helps if there are regular meetings that include all staff involved, including the managers, RNs, and ECWs. Furthermore, having all involved, able to raise their voices and contribute to planning, made important headway toward reducing tensions between staff in different roles.

Concerns over accountability

A recurring theme often highlighted by managers and RNs related to questions around accountability, and these concerns sometimes strained the relationship between the RN and ECW as noted above. Particularly in the development stage or early introduction of the role, not knowing who would be responsible (i.e. held accountable) for any unfortunate errors or mistakes interfered with an effective collaboration between RNs and ECWs. It is therefore crucial for a successful implementation of the ECW role to clearly identify lines of responsibility and communicate these to both RNs and ECWs.

While the significance of accountability was discussed with all the care homes we interviewed, there was a wider range of perspectives on how this was handled than some of the other topics that came up. In some care homes, ECWs are fully responsible for their own actions, following the notion that they have completed the relevant training for their particular role and are therefore deemed competent.

Yet in other care homes, the lines of accountability rest with the RN, underlining their responsibility in supervising the ECW to ensure that training is up-to-date and appropriate tasks are undertaken. This did however leave some RNs feeling rather wary about the situation. One RN, asked if they felt comfortable with the lines of accountability resting with the RN, responded:

"No, not always. There are times [ECWs] make decisions on the RN's behalf… The RN has all the accountability but no authority."

Indeed, perspectives on the concerns over accountability were reported rather differently depending on the working role of the respondent. While those in managerial roles often spoke of such concerns as an issue that arose during initial stages of the role's implementation but were eventually sorted out, RNs were more likely than others to still express such concerns. Nonetheless, regardless of where the final decision on accountability is placed, many of the RNs' worries about accountability were relieved after training. One RN noted that the Nursing and Midwifery Council had given a talk to the nurses about delegation, which provided some relief to the RNs. Accountability also became less of an issue in the relationship between the RNs and ECWs where there was active involvement of the RN in developing the new role. Strong training and active involvement of all relevant staff are thus important in reducing any tensions that arise due to confusion over accountability.

Internal development of the role

As mentioned before, the impetus for this research was to

> "Different nurses reacted differently, some nurses were engaging, wanted to help, others were put out a bit from them [ECWs] coming in and taking over. Now is fine, it was about setting some ground rules… if an advanced wound, have the nurse continue, but if more minor, ask to let [ECW] maintain skills." **Manager, previously in the ECW role**

> "There are lines of accountability, but the [ECWs] are responsible for their own actions, because they have received the full competency training." **RN**

> "RNs retain accountability, so it's always up to the RNs that the training is up to date… In the beginning…the boundaries weren't really set [between] what the RN does and what the carers do. Over the years, we have developed really strong working relationship between the RN and workers… Everyone understands the accountability process." **RN**

gather information on this ECW role, which has emerged in various forms, at various times, in various places. In fact, many instances of the development of the role might be described as somewhat 'grassroots', with ECWs mostly being generated internally by care homes in response to a shortage of nursing staff.

> "Never thought I would be able to make a career out of being a carer, but now feels there is real career progression after 16 years in the job!" **ECW**

Many staff members told us that the fundamental characteristics of the job include a recognition that it is hard work, a dedication to caring, and a willingness to take initiative. These are all qualities that are better observed when you are working with someone, rather than through a job interview, so recruiting internally is a better way to identify workers with those qualities. Moreover, a candidate can have the necessary qualifications, but lack the other softer skills as mentioned before.

Part of the strategy behind internally developing the ECW is to retain existing staff. Many managers noted the benefit of introducing the role as a way to keep a care worker at the home while simultaneously fulfilling that worker's desire to progress in their career. Indeed, many of the ECWs we interviewed spoke of their affinity for working in their care home and how they were happy they were able to progress in their position and remain working there. There were also comments that described how taking on the ECW role had invigorated their sense of job satisfaction, providing further benefits for the workforce.

One survey found that only 35% of respondents thought that care homes provided supportive learning opportunities that encourage students to return to work in the field later in their careers, and only 41% thought that the care home industry offers challenging and rewarding career pathways for newly registered nurses.[28] Introducing the ECW role in a care home can therefore play an important role to enhance loyalty and retain workers by offering novel perspective on future career opportunities. Indeed, a number of the ECWs interviewed expressed an interest to progress further, obtaining further qualifications to become care coordinators or nurse practitioners.

Another advantage to internal recruitment is that it can alleviate some of the fears that the RNs express around accountability. If they already know that the ECW with whom they will work is responsible and good at their job, it makes it much easier to put trust in them and delegate tasks. In addition, having RNs involved in developing the role provides them with a clearer sense of exactly what kind of training the ECW has undertaken and how the two positions are supposed to interact.

Although the overarching consensus among interviewees was that it is much more beneficial for the ECW to be recruited internally, one interviewee did point out that internal recruitment could be negative. It can cause tension among the care workers who wanted to take up the position but did not get promoted. There are also costs associated with upskilling internally that the care home has to cover; the suggested solution was for there to be a specific qualification attainable at colleges or sixth forms. In addition, experience working in the NHS (in contrast to the social care sector) offers the chance to work in a multidisciplinary team and experience dealing with community nurses and primary care, which can be useful.

> "[ECWs] really are worth their weight in gold [due to the heavy burden of numbers of patients]." **RN**

It is also important to reiterate how these roles were created in response to a shortage of nurses and challenges around recruiting competent staff; these challenges are only going to deepen as the complexity of care needs for new home

[28] Spilsbury et al. (2015)

entrants will increase. People are now able to stay at home for longer as they age, so when they do need to transition to care homes, they are arriving with more complex needs than was the case in previous years. This accentuates the need to ensure staff are competent as well as able to identify a range of issues and effectively communicate these to their colleagues.

> "Yes, definitely [the support given by the ECWs is helpful]. They're a hidden gem." RN

The ECW role makes a difference

Although the objective of the research here was simply to gather information on the ECW role rather than to do any comprehensive evaluation of it, we were naturally interested in whether there had been any efforts by those employing the role to assess its effectiveness. We found no concrete example of any formalised approaches to measure the impact of the role, but there was overwhelming support from respondents in all three categories of staff that this new working role had a strong and positive impact on delivering high quality care.

> "When we're doing the care plans, it's great to have different perspectives. The new workers have daily conversations with the residents, and they have sometimes a closer understanding of a resident." RN

Moreover, the perceived benefits of the ECW role extended beyond the notion of how they were taking over clinical responsibilities from RNs. The enhanced carer role brought with it additional insights that contributed to an enhanced delivery of care. One example is how the ECW's daily interaction with residents can provide a deeper understanding of their needs and inform care plans with the RN.

This interaction between the ECW and the resident also fostered a stronger bond between the two, and a number of our respondents explicitly mentioned the ECW role as being positive for residents. Some interviewees suggested that residents sometimes seemed more open to discuss concerns with the ECW, perhaps feeling comfortable asking them questions coupled with the idea that their clinical training made them better qualified to provide answers.

The ECW role by its very design is meant to provide benefits to the RNs, and several comments by interviewees recognised this to be the case on the ground. It was highlighted, however, that the ECW role cannot take the place of the RN. Some respondents indicated they felt it would be better or more ideal to have more RNs rather than staff in the ECW role, but they nonetheless recognised the staffing challenges in the sector and how the ECW was an overall benefit.

> "Nursing is becoming more admin based, and also upskilling carers means that we can spend more time on DoLS[29], care plans. So it is a benefit… giving precious man hours back to the RNs." RN

In some of the other themes highlighted above, we have noted how there have been some growing pains in the development of the ECW role, such as in establishing trust with the RN or clarifying lines of accountability. Perceiving or identifying the role as beneficial was also something that evolved over time, as the positive ways the ECW role can influence care delivery may not always be immediately apparent. Other care homes seeking to implement the ECW role will need to recognise this, raising awareness among staff at all levels that adjusting to the introduction of the role will be a process that reshapes some aspects of the workforce overall.

[29] Deprivation of Liberty Safeguards: These refer to legislative protections for people who lack mental capacity when it may be in their best interest to deprive them of certain liberties through such things like detention or restraint.

There needs to be better support from the NHS

The final theme to emerge from our research, perhaps unsurprisingly, was a call for greater support, especially from the NHS. However, the support that respondents identified went beyond simple financial concerns, as training opportunities were also mentioned in addition to efforts to make social care nursing regarded on equal footing with nurses in the health sector.

From the financial perspective, as in many areas related to health and social care, there was concern over the potential for these new ECW roles to collapse without proper support from the NHS. Some managers noted the challenge of their funding being insufficient to cover the costs of the post. In addition, some cases of the ECW had been developed due to the availability of appropriate training through NHS institutions like hospitals. However, an issue raised by one respondent was the proximity of training opportunities; where there is a great distance between the ECW's home or place of employment and where they receive training, this can stifle their ability to practice their newly acquired clinical skills on a frequent basis. In addition, although the notion of apprenticeships was not mentioned by any of our interviewees, there may be scope to consider such schemes to provide vocational training for the ECW role in consideration of current plans related to the nursing associate role (see page 17). Yet it does remain unclear how well this might be received by the sector or if offers of apprenticeships would encourage more people to pursue such careers.

> "The RNs benefit from this new role – but crucially the residents do." **ECW**

> "It is hard for the RNs to let go… [They] realise they can care for the patient better if they're not doing every little thing; they can take a step back." **RN**

> "Bit of a disruption originally, but it's getting better. And the nurses will see the benefits in the next few months [after ECWs begin administering medication]. They are now seeing the [ECWs] leading, leading other carers. This is really positive, taking burdens off the nurse." **RN**

While funding concerns were indeed highlighted, especially by managers, there were also calls for more to be done so that social care nursing – and by extension, the ECW – would be seen with the same regard as nurses in the health sector. This disparity in the perceived status of social care nurses compared to NHS nurses may partially explain some of the difficulties in attracting nurses into care homes. As one care home manager expressed it, some people carry a negative perception that one is "not a proper nurse if you work in a nursing home." It was also noted that the difficult hours as well as less frequent use of clinical nursing experience created a barrier to attracting nurses into the social care sector.

Another care home manager also raised this point:

"For me the issue is in the NHS you see new roles developed all the time, no one seems to question band 5, band 4 specialist roles, that's accepted, the fact that NHS created them, no one questions. The minute care homes start to create new roles, there is suspicion raised, people question, they wonder how valid development and training is. It's not on a level playing field. A lot of questions raised. It does irritate me that we're not recognised for our expertise and the roles that are required."

Given the important need to consider better coordination of health and social care, as noted by a number of our respondents, there is certainly scope for the NHS to play a role in highlighting the importance of social care and support any efforts in the sector toward innovation like the ECW role.

Conclusions and Lessons Learned

Concerns over the future of the social care workforce continue to impact proper planning for the delivery of high quality care in the context of an ageing society. Challenges over a shortage of qualified nurses have subsequently led to the development of this new ECW role in a number of care homes, and this offers a new approach to addressing these concerns. To our knowledge, this is the first piece of research to explore the ECW role, interrogating how the role functions from the perspectives of three different staff roles within care homes that provide nursing.

An evaluation of the role – defining how well it works – is beyond the scope of this research, therefore we are unqualified to make a recommendation that care homes implement this new role. However, the anecdotal evidence we found and presented above does suggest that the ECW role can be beneficial for care homes for a number of reasons; our findings subsequently shed light on a number of lessons from those who have implemented the ECW role that could facilitate the introduction of it among care homes interested in doing so.

- **Clear communication on the lines of accountability and the delegation of tasks**: While there is no consensus on the degree to which the RN should remain responsible for the ECW's delivery of care, our findings do suggest that concerns over accountability can be mitigated by clearly establishing the relationship between the RN and the ECW and the respective roles each plays in caring for residents.
- **An open environment for communication**: Aside from clear messages on responsibilities, successful implementation of the ECW role appears to benefit from an open environment for communication. When ECWs feel comfortable expressing their concerns about their responsibilities or confidence in performing particular clinical tasks, they can receive the kind of support that helps them do their jobs more effectively, whether by engaging in further training to refine their skills or simply clarifying next steps in delivering a care plan.
- **Involvement of both RNs and ECWs in regular planning meetings**: Transferring greater responsibilities in terms of care delivery to ECWs should be accompanied by greater involvement of them in planning meetings. Not only can this improve care by giving them a voice on residents' potential needs, but it fosters a sense of inclusivity that can strengthen the relationship between RNs and ECWs. This can enhance RNs' faith in the ECW while helping the ECW to feel appreciated and valued as an important part of the team.
- **A focus on or recognition of softer skills**: By its nature, the ECW role requires further training and development of new skills. However, there is also a general sense that the kind of nursing undertaken in care homes relies on a strong set of softer skills that foster an understanding of residents' emotional and psychosocial needs. This may not be restricted to the ECW role, but developing such a role – and indeed looking for other nursing staff – may be enhanced by an approach that looks beyond clinical training and qualifications and actively recognises the importance of softer skills.
- **Recognise that there will be growing pains**: For some care homes, the ECW may be an advantageous solution to addressing current issues related to staff shortages. The potential benefits of the role, however, must be seen in the long-term, and care homes interested in implementing the ECW role should prepare for some short-term disruptions. Current staff who move into the role will need to undergo training, which can create staffing pressures to accommodate their absence. In addition, there may be issues in the early stages in helping RNs navigate their new responsibilities both in managing the new role as well as delegating their own tasks to the ECW. While these short-term challenges may be mitigated

against through proper preparation and the establishment of clear communication lines, care homes should nonetheless be aware that the initial phasing in of the role is likely to be something of a bumpy ride.

In addition to such lessons on what care homes should consider if they plan to develop the ECW role, there are other insights from our interviews that may be less under the control of care homes. Such external influences may present particular challenges to care homes developing the ECW role, but awareness of them from the planning stages should help the implementation process go more smoothly. For example, funding will likely continue to be an issue into the future, but it is important for care homes to remain vigilant over their own financial planning so that new positions like ECWs can be sustained over time. This is relevant not only for paying the worker but also recognising the need for continued skills development. In addition, the growing recognition of an increased complexity of care needs for new care home entrants may result in greater demands placed on RNs in providing and planning care, and the ECW may be one way to help adapt to these changes.

Indeed, at least from the interviews we conducted as part of this research, the emerging role of the ECW may provide a partial solution to some of the expected challenges that the social care sector will face in the short- and long-term as a consequence of demographic change. This will lead care homes to explore innovative approaches to retain existing workers, entice more people to seek employment in the sector, and address concerns over financial viability. We hope this research will offer valuable guidance for care homes to consider whether the ECW role would be a good fit for them.

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Appendix A: Interview Questions

This appendix includes information on the areas of inquiry that we included in our schedule of questions used in conducting the interviews with staff in the three job categories we examined for the research. All interviews began with a brief introduction of the interviewer, ILC-UK, the purpose of the research, and the plan for the interview, including our interest in this hybrid role where care workers were given clinical responsibilities previously done by RNs. Interviewees were asked if they had any questions before the interview began. All interviews asked respondents to provide the basic information of the role in their home, covering the specific job title, what was in the job description, the necessary qualification, skills, and experiences, the characteristics of the job, and how they understood it had been developed. Interviews also ended by asking if there was anything further the interviewee would like to mention that had not been covered in the course of the interview.

For each specific category of staff, the interviews covered the areas indicated below. The selection of questions was reviewed by experts familiar with the role to ensure we addressed the most relevant topics. It should be noted, however, that interviews were conducted organically, i.e. some questions were not explicitly asked by the interviewer as the information had emerged naturally over the course of the interview.

Managers

Basic information on the care home

- How many residents are there?
- How many registered nurses are there?
- How many care workers/other support staff work there?

Their role in managing the RN/ECW arrangement

- What is your role in managing the working relationship between the registered nurse and the new worker?
- What were the main reasons for creating this new role?

Are there any evaluation measures in place to identify the impact of the new role?

- What is your general feel on the impact of the new role? (Either from formal evaluation measures or an informal perceived sense)
- What could have been done differently?

Registered Nurses

Involvement in developing the new role

- Please tell me about your involvement in developing the new role.
- Did you feel that there was a need for the new role?

Their role in the accountability process

- Please tell me about your involvement in managing the new role
- What are the lines of accountability? Do you feel comfortable if you are directly accountable for the actions of the new hybrid care worker?

How many such roles have been created (i.e. is there just one in each site)?

Are the new roles recruited from within or new hires?

What kind of training/information were you given to help you prepare to supervise the new role?

Have you been involved in developing training for the new role?

- If yes, could you please tell us a little bit about the training?

Is the support given by the workers helpful? (Or, in contrast, is the arrangement more of a burden, e.g. supervision, having to correct errors?)

How do you ensure the staff are adequately trained (e.g. administrating medication)?

How do you assess the competence of the worker in the new role?

- How frequently is competence assessed?
- Is competence assessment for this role different from that for other staff?

Enhanced Care Workers

Are you aware this is a new role?

- Or do you think you have just been asked to do more?

How do you feel the role is different than your previous responsibilities?

- What do you think is good about the new role? (Strengths)
- What do you not like about the new role? (Weaknesses)
- How could things be improved?

What kind of training have you been offered?

- If you had training before or as you started the new role, have you received any further training more recently?

Do you feel adequately supported in the new role?

- Do you feel like you get enough support from the registered nurse and other senior managers at the care home?

Do you enjoy the added responsibility?

- Do you see this as career progression?
- Does it make you interested in pursuing further opportunities or gaining further qualifications?

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